WCHD

Winnebago County Health Department

Serving Our Whole Community

IPLAN 2025-2030

Community Partner Assessment

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OVERVIEW OF CPA

The Community Partner Assessment (CPA) is a survey tool designed to guide community partners through a critical evaluation of their individual systems, processes, and capacities, as well as assess their ability to collectively impact health inequities.

As one of three (3) assessments that are part of the Mobilizing for Action through Planning and Partnerships 2.0 (MAPP 2.0) framework, Winnebago County Health Department (WCHD) developed and completed a Community Partner Assessment (CPA) with partner agencies representing the local public health system in Winnebago County. As part of the initial introduction of the CPA, WCHD first brought together community partners at a workshop to review elements of the Power Primer to allow for self-assessment of the partner's power dynamics with the clients served by their agency and their agency's ability to influence change.

The CPA has five goals:

1. Describe why community partnerships are critical to community health improvement (CHI) and how to build or strengthen relationships with community partners and organizations.

2. Name the specific roles each community partner has in supporting the local public health system (LPHS) and in engaging communities experiencing inequities produced by systems.

3. Assess each MAPP partner's capacities, skills, and strengths to improve community health, health equity, and advance MAPP goals.

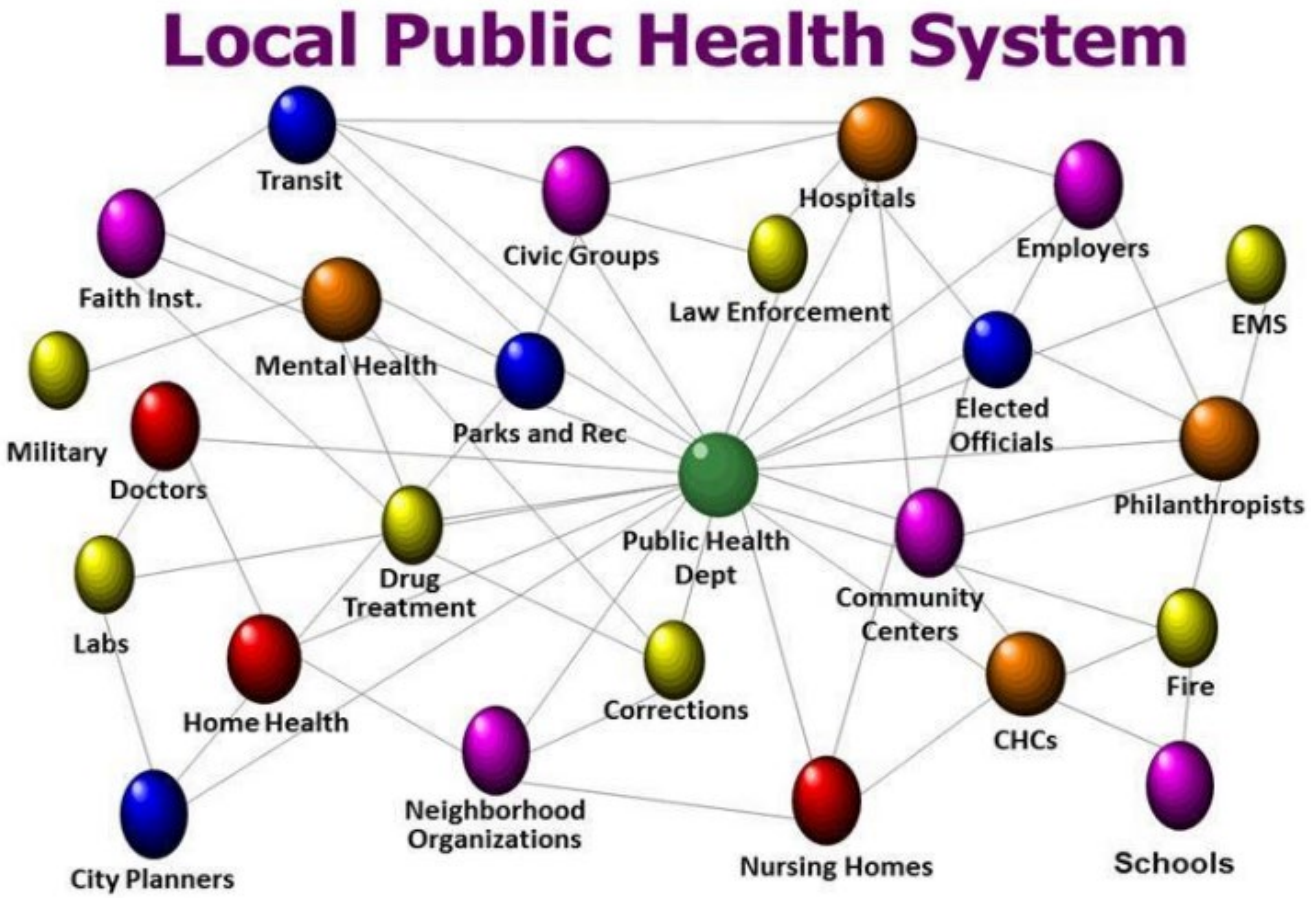
4. Document the landscape of MAPP community partners, including grassroots and community power-building organizations, to summarize collective strengths and opportunities for improvement.

5. Identify whom else to involve in MAPP and ways to improve community partnerships, engagement, and power-building.

Engaging CPA Partners

Community partners were recruited to participate in a Community Partner Workshop and the follow-up CPA survey in November 2023. Community partners were initially recruited based on prior relationships with WCHD. Additionally, the Collaborators Strategic Plan Workgroup was tasked with expanding outreach to potential community partners who had not previously worked with WCHD. The goal was to recruit participation from the multiple sectors conceptualized as part of the Local Public Health System as shown on Figure 1.

Figure 1: Local Public Health System



ADDRESSING COMMUNITY POWER

The MAPP 2.0 Framework highlights the significance of power dynamics in addressing health equity. WCHD brought community partners together to introduce MAPP 2.0 and the Power Primer at the Community Partner Workshop held on November 29, 2023 (Attachment A). The workshop introduced community partners to the MAPP 2.0 framework, highlighted changes and improvements made by MAPP 2.0, and discussed the significance of power dynamics in addressing health equity (Attachment B). WCHD adapted content from the MAPP 2.0 Power Primer Supplement to develop questions to initiate discussion of the impact of power imbalances on health inequities and resultant health disparities in the community among community partners. A total of 54 community partners from 39 organizations attended the Community Partner Workshop.

The Community Partner Workshop launched the CPA Survey. Partners and organizations participating in the Community Partner Workshop were asked to complete the CPA Survey and share with their partners (Attachment C).

Method

Foundational to MAPP 2.0 and the CPA is an assessment and discussion of community power. Power imbalances and structural oppression have been identified as root causes of health inequity. Achieving health equity must be community-driven and requires the transfer of decision-making authority for the Community Health Improvement Plan to the community.

As part of the Community Partner Workshop, participating organizations were asked to "unpack their power and privilege". Frameworks for understanding power in public health were presented as personal versus collective power and power over versus power with. Participants were asked to consider how powerful they were as individuals and then as an organization/agency across six areas of influence:

- Serving Community Members
- Collaborating with Community Members
- Impacting Clients
- Improving Health Outcomes
- Improving Health Equity
- Working with Legislators to Achieve Goals

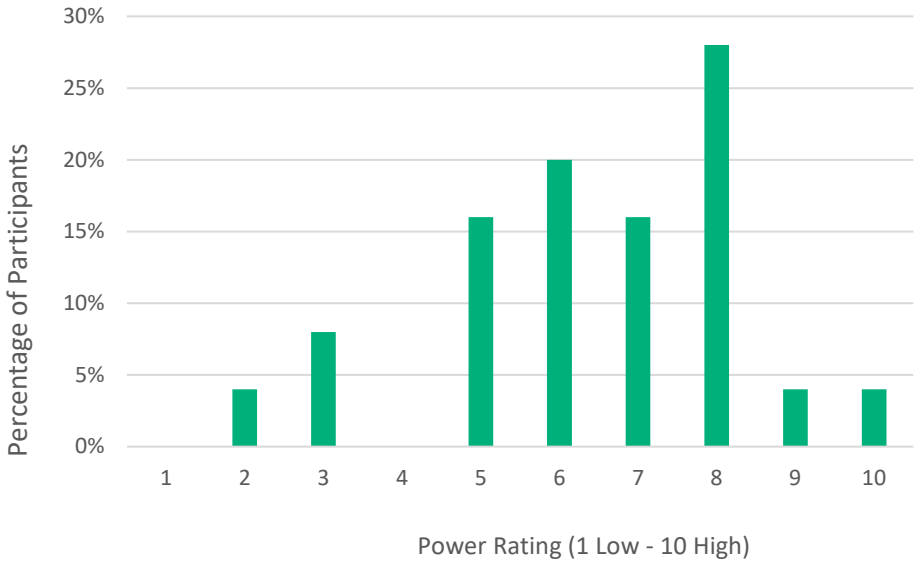
Poll Everywhere was used to collect responses anonymously and allow for immediate review and discussion. Members of WCHD's Internal Steering Committee (ISC) and the Organizers Strategic Plan Workgroup (OSPW) developed a tool to provide examples of the different forms of power to facilitate discussion of power at the workshop (Attachment D). Forms of Power (Attachment E) were made available to workshop participants at the event. The ISC and OSPW lead discussions with community partners at the tables on the results that were displayed through Poll Everywhere. For each question, individuals were asked to rank power on a scale of one (1) to ten (10) with ten (10) being the most powerful.

Results

To start the power discussion, participants were asked to determine how powerful they are as individuals on a scale of one (1) to ten (10) with ten (10) being the most powerful. Twenty-eight percent (28%) of individuals ranked their individual power at eight (8), which was the most frequently selected option. The average ranking was 6.4.

Discussion focused on why individuals ranked themselves at a particular level. Considerations included their roles within their organizations, their families/personal relationships, the community, and the world. Themes regarding money, sex/gender, political views, race/ethnicity were shared (Figure 2).

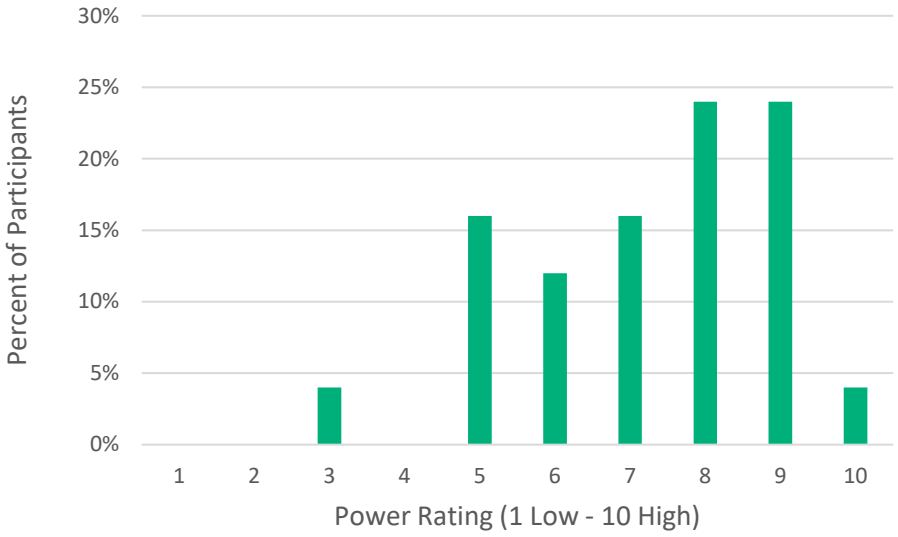
Figure 2: Individual Power



Organizational power can apply to the ability to improve the lives of the those they serve. Power can also influence effectiveness at working with the community or legislators.

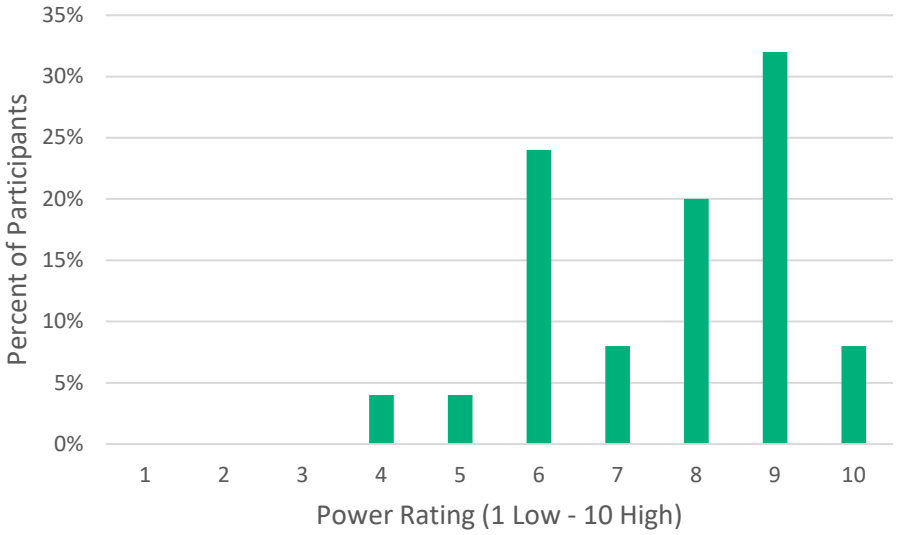
Respondents were asked to determine how powerful they are as an organization or agency in serving community members. Twenty-four percent (24%) of individuals ranked their organizational power at eight (8) or nine (9), which were the most frequently selected options. The average ranking was 7.2 (Figure 3).

Figure 3: Organization/Agency Power In Serving Community Members



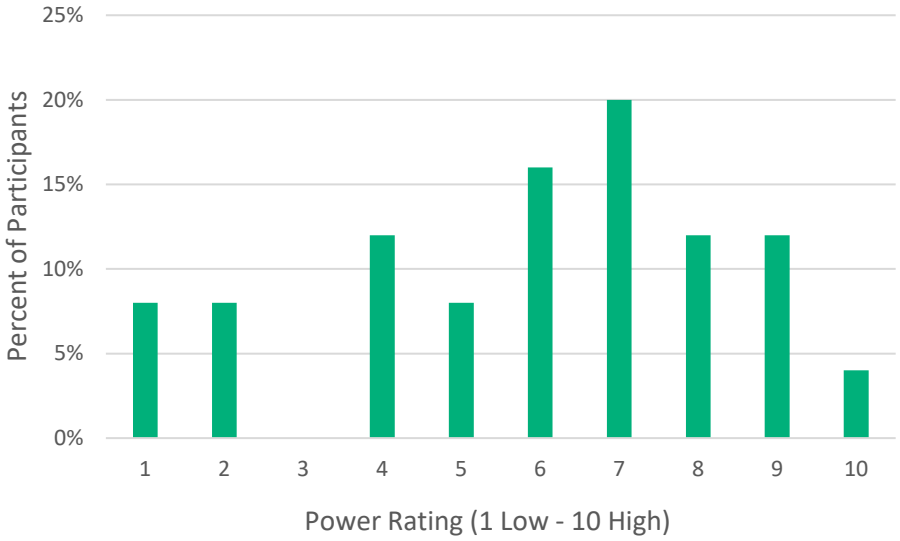
Overall, organizations ranked themselves as exerting their organizational/agency power in impacting clients. Thirty-two percent (32%) of individuals ranked their organizational power at nine (9), which was the most frequently selected option. The average ranking was 7.6 (Figure 4).

Figure 4: Organization/Agency Power In Impacting Clients



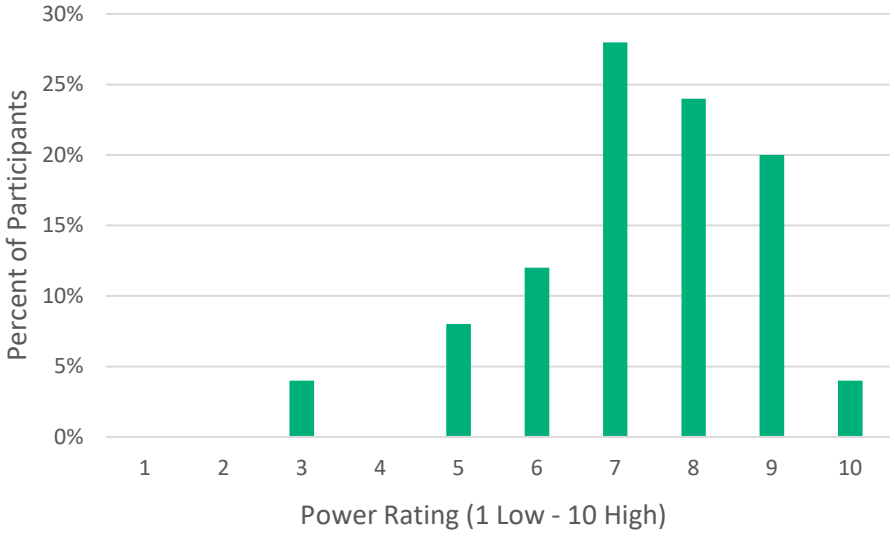
There was more variability and a lower average ranking in the use of their organizational/agency power in improving health equity. Twenty percent (20%) of individuals ranked their organizational effectiveness at seven (7), which was the most frequently selected option. The average ranking was 5.9 (Figure 5).

Figure 5: Organization/Agency Effectiveness In Improving Health Equity



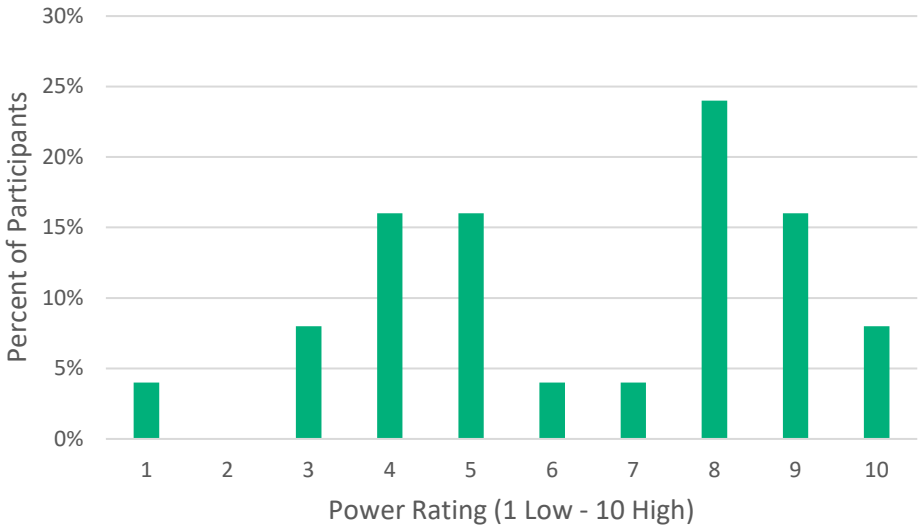
Twenty-eight (22%) percent of individuals ranked their organizational power in collaborating with community members at seven (7), which was the most frequently selected option. The average ranking was 7.3 (Figure 6).

Figure 6: Organization/Agency Power In Collaborating With Community Members



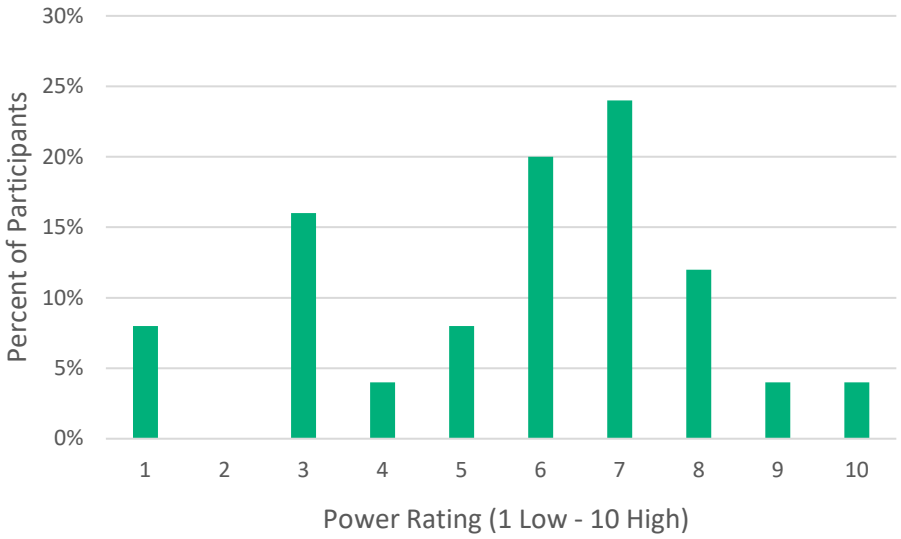
Twenty-four percent (24%) of individuals ranked their organizational effectiveness in working with legislators at eight (8), which was the most frequently selected option. The average ranking was 6.4 (Figure 7).

Figure 7: Organization/Agency Effectiveness In Working With Legislators To Achieve Your Goals



Twenty-four percent (24%) of individuals ranked their organizational effectiveness at improving health outcomes at seven (7) which was the most frequently selected option. The average ranking was 5.7 (Figure 8).

Figure 8: Organization/Agency Effectiveness In Improving Health Outcomes



Overall, individuals indicated that their organization had the most organizational power in impacting their clients, followed by effectiveness in collaborating with community members, and serving community members (Table 1). Organizational power was least effective in improving health outcomes and in improving health equity.

Table 1: Power Utilization	
Power Utilization	**Average**
Organizational power in impacting your clients	7.6
Organizational power in collaborating with community members	7.3
Organizational power in serving community members	7.2
Individual Power	6.4
Organizational effectiveness in working with legislators to achieve your goals	6.4
Organizational effectiveness in improving health equity	5.9
Organizational effectiveness improving health outcomes	5.7

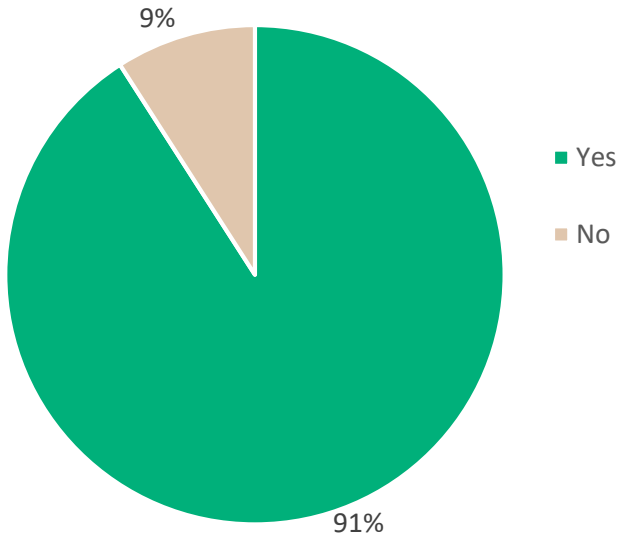
Discussion focused on the importance of knowing available resources and contact information. Collaboration and development of a network of resources are critical since a single organization cannot provide all services. Participants emphasized the importance of active networking to ensure "a seat at the table" and to invite other partners and community members to participate because power is infinite when shared.

Forms of Partner

Participant organizations were asked to consider different forms of power and their organization's expression in the community. The expression of power influences what actions organizations can take and their impact.

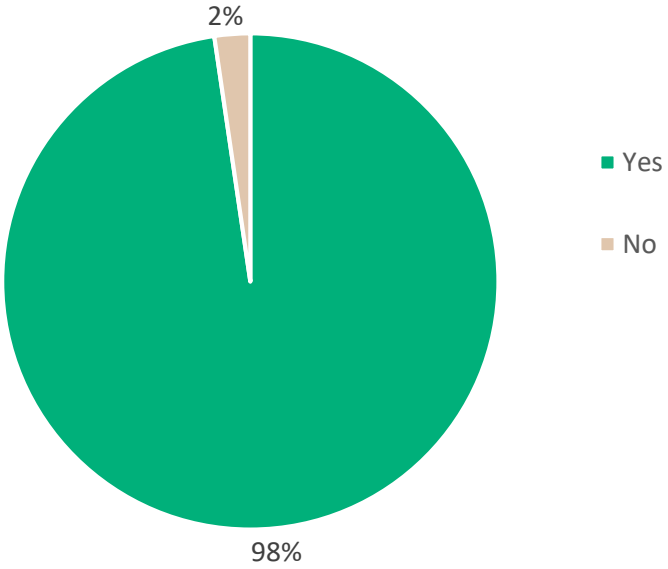
Positional power comes from organization authority or position. This form of power can often be overlooked by people with power, but is rarely forgotten by those without it. Ninety-one percent (91%) of organizations reported having positional power (Figure 9).

Figure 9: Positional Power



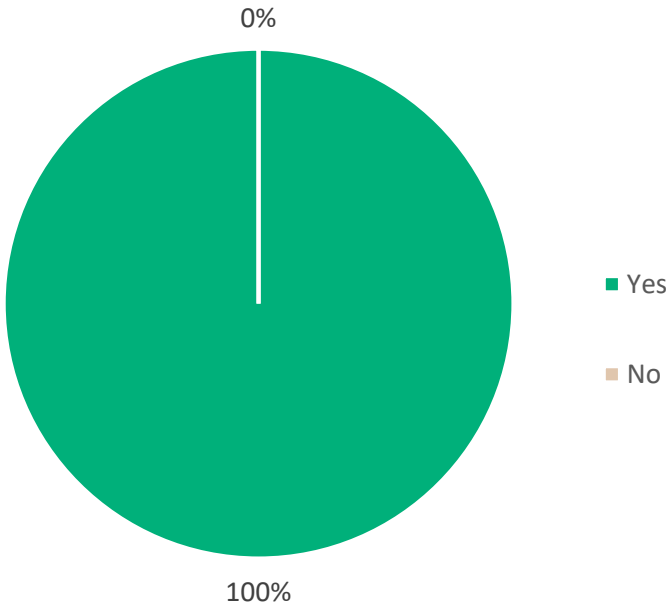
Referred power comes from connection to others. This can be through networking with other community organizations. With their strong self-assessment of community engagement as part of the Essential Public Health Services (EPHS), 98% of organizations expressed having referred power (Figure 10).

Figure 10: Referred Power



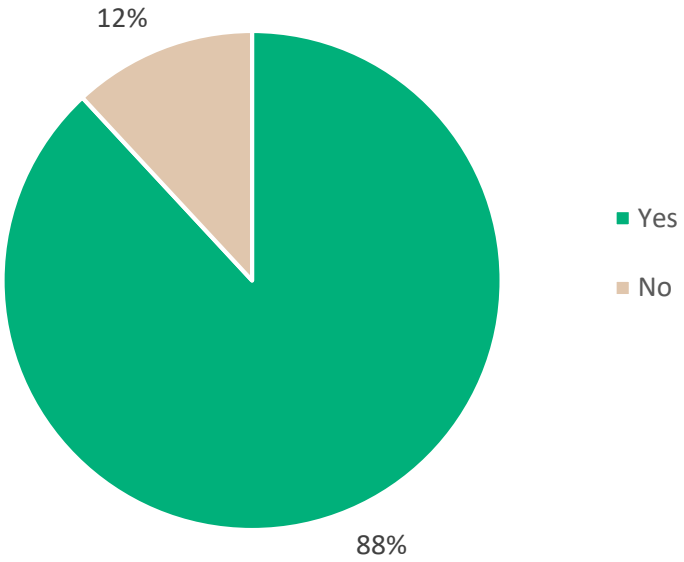
Expert power comes from wisdom, knowledge experience, and skills. All organizations indicated that they have expert power (Figure 11).

Figure 11: Expert Power



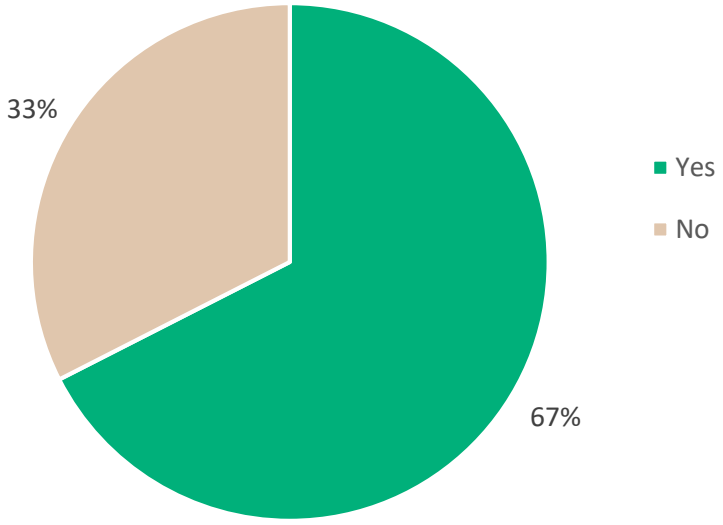
Ideological power comes from an idea, vision or analysis. This can be an original idea or thought. This can also be an ideal such as democracy, altruism, or any other developed ideology. The majority of organizations (88%) reported ideological power. Given the sectors represented, the strong expression of ideological power is not surprising (Figure 12).

Figure 12: Ideological Power



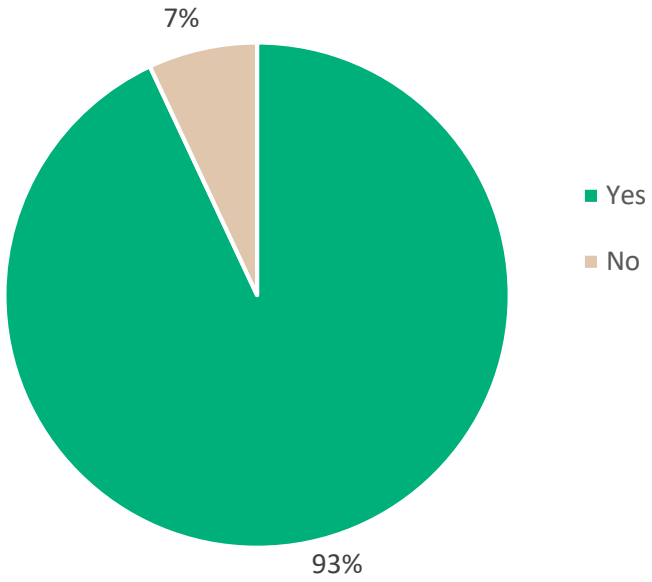
Obstructive power stems from the ability to coerce or block whether implicit, threatened, or demonstrated. Many activists are experts in its use through demonstrating or protesting. Approximately two-thirds of organizations (67%) reported obstructive power (Figure 13).

Figure 13: Obstructive Power



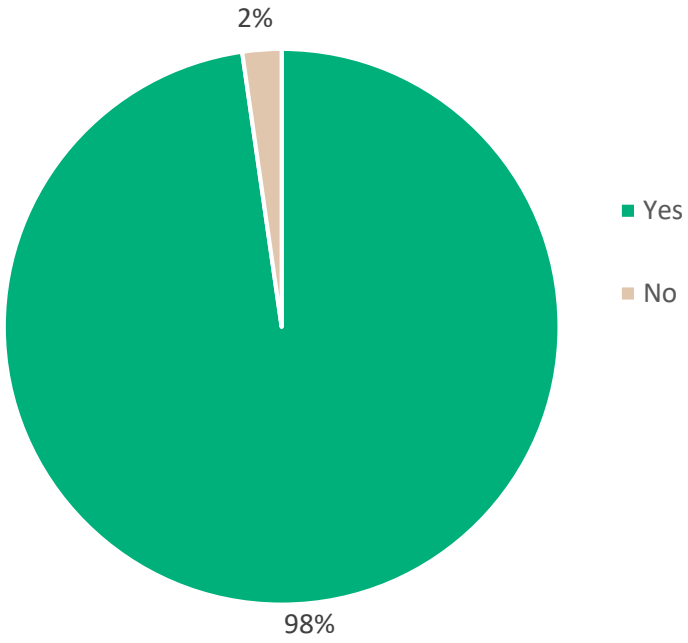
Personal power is the manifestation of an individual's energy, vision, ability to communicate, capacity to influence, emotional intelligence, or psychological savvy. This can apply to influencers or spokespersons. Ninety-three percent (93%) of organizations expressed personal power (Figure 14).

Figure 14: Personal Power



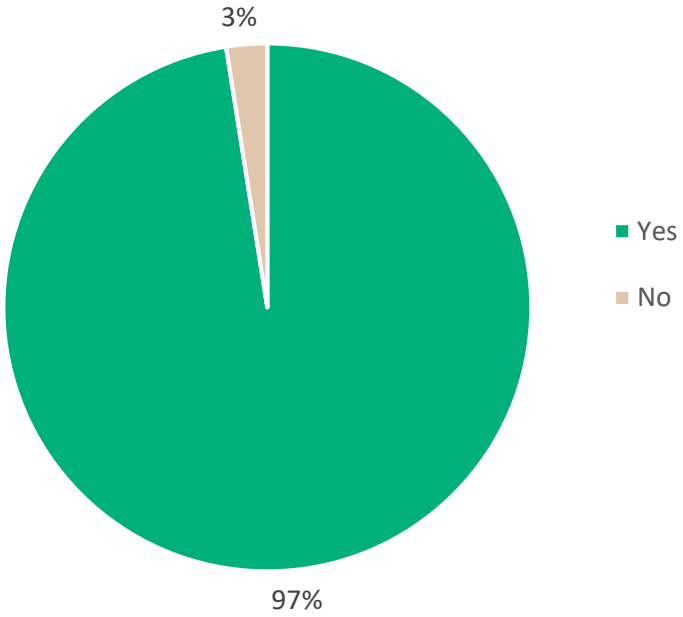
Co-powering is the responsibility of individual leaders to mindfully work toward supporting the personal power of others through modeling, validating, and giving feedback. This can apply to role models within the community. The majority of organizations (98%) reported the ability to co-power (Figure 15).

Figure 15: Co-powering



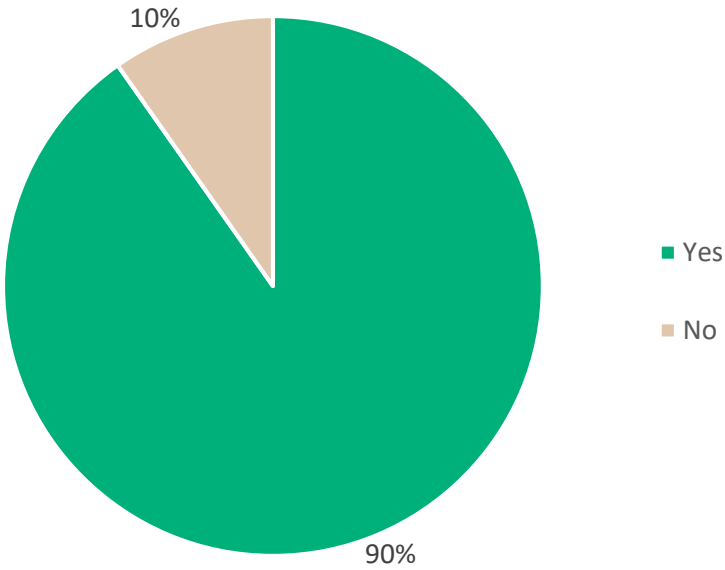
Collaborative power refers to the ability to join energies in partnership with others in pairs, teams, organizations, communities, coalitions, and movements. Similar to co-powering, 97% of organizations expressed collaborative power (Figure 16).

Figure 16: Collaborative Power



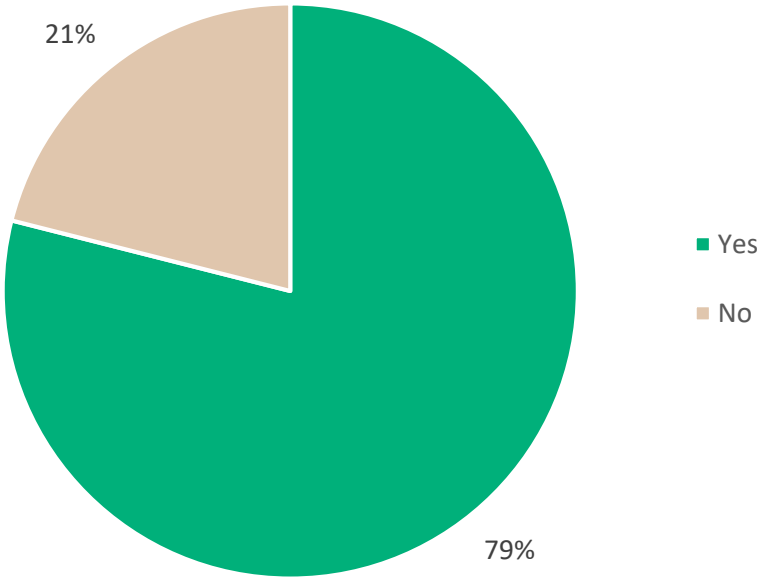
Institutional power refers to the economic, legal, and political power directly wielded by institutions apart from individuals who work there. Organization and programs must follow existing federal guidelines and follow evidence-based guidelines. While 90% of organizations have institutional power, 10% indicated that they did not have institutional power (Figure 17).

Figure 17: Institutional Power



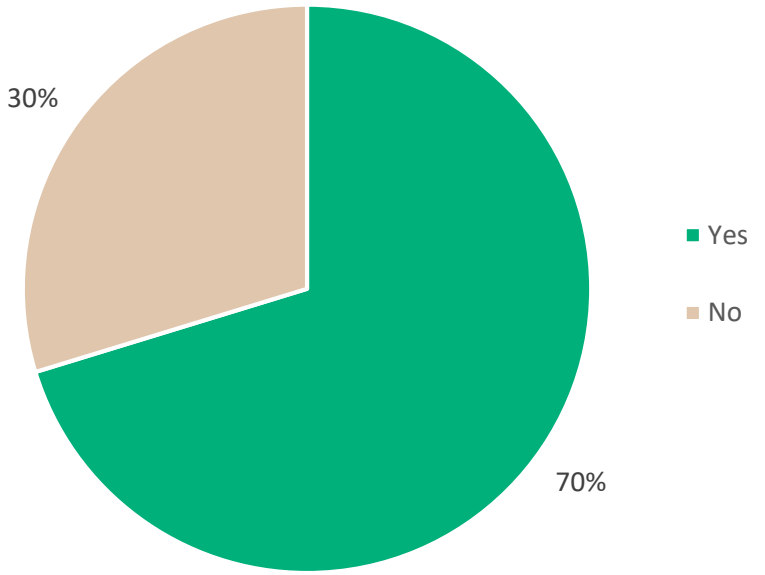
Cultural power refers to the cultural norms and conditioning regarding race, class, sexual orientation, gender identification, and age that accrue power and privilege to the dominant group from the perspectives of oppressed peoples. For oppressed individuals, it can also refer to a consciousness of community or culture that serves to empower. Nearly 1 in 5 participating organizations (21%) indicated that they did not have cultural power (Figure 18).

Figure 18: Cultural Power



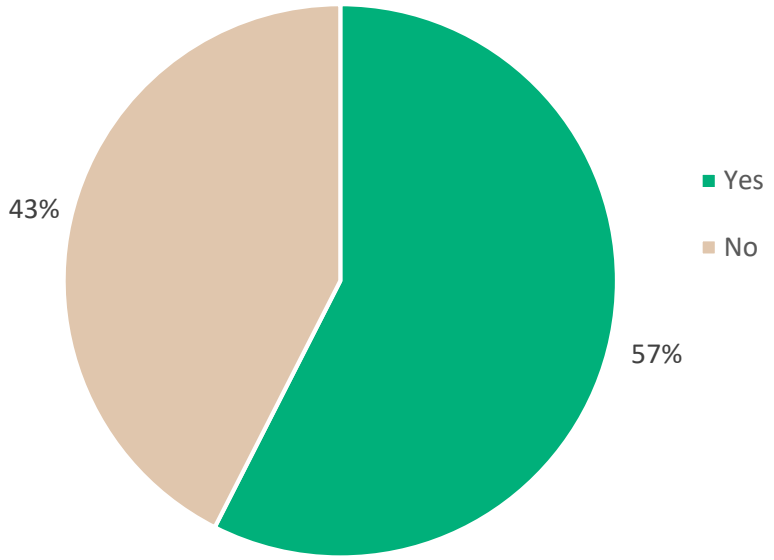
Structural power is covertly or implicitly exercised through the dominant institutions of society. While 70% of organizations reported structural power, 30% did not (Figure 19).

Figure 19: Structural Power



Transcendent power comes from one's connection to something larger than oneself including a connection to a Creator or Spirit, the natural world, ancestral lineage, or history. Fifty-seven percent (57%) of organizations have transcendent power (Figure 20).

Figure 20: Transcendent Power



The most common types of power held by organizations were: expert power, referred power, co-powering, and collaborative power. The least common types of power were transcendent power and obstructive power (Table 2).

Table 2: Forms of Organizational Power		
Type of Power	**Yes**	**No**
Expert power	100.0%	0.0%
Co-powering	97.7%	2.3%
Referred power	97.7%	2.3%
Collaborative power	97.5%	2.5%
Positional power	90.9%	9.1%
Personal power	93.0%	7.0%
Institutional power	90.2%	9.8%
Ideological power	88.1%	11.9%
Cultural power	78.9%	21.1%
Structural power	70.3%	29.7%
Obstructive power	67.5%	32.5%
Transcendent power	57.5%	42.5%

Further discussions focused on the importance of collaboration when considering power. Differences in experience and perspectives, both positive and negative, were shared. Collaboration was identified as important to avoid duplication of effort, promote community trust, and best utilize limited resources while recognizing the expertise of organizations. Discussions also focused on the importance of making one's services available to the community. For example, improving access by allowing walk-ins instead of requiring appointments.

CPA SURVEY

Method

The CPA survey was based on the NACCHO (National Association of County and City Health Officials) model CPA Survey and modified with input from the University of Illinois College of Medicine Rockford - Health Evaluation and Research (UICOMR-HER). The survey instrument included 33 content items, including questions about the demographics of those served by the organization, areas of focus, organizational commitment to health equity, organizational accountability, organizational ability to collect and analyze data, community engagement and community advocacy (Attachment F). The survey had a variety of question types including multiple-choice, select all that apply, and open-ended questions. To avoid data gaps, participants were required to respond to the majority of questions. The survey was built into the Qualtrics XM platform and administered through a digital link. The CPA survey was sent to partners on December 1, 2023 and closed on January 18, 2024. Of the 93 respondents who started the survey, the majority completed the survey (73 = 78.5%). Completed surveys represented approximately 70 community partner agencies/organizations. The average time to complete the survey was 22 minutes.

Results

Respondents to the CPA survey were asked to select all categories that identified their roles in their organizations. All respondents identified their role in their organization; fourteen (14) respondents identified more than one role. The majority of respondents served in a leadership/management role.

Table 3: Organizational Role Of Respondents (n=93)	
Organizational Role	**Percentage**
Senior management level/unit or program lead	37.6%
Leadership team	24.7%
Administrative staff	20.4%
Supervisor (not senior management)	11.8%
Community leader	7.5%
Community member	7.5%
Front line staff	5.4%
Other	16.1%

The following responses were identified by those selecting “Other”:

- *Activist*
- *Associate Pastor*
- *CEO*
- *Communications Manager*
- *CSBG Advocate*
- *Elected Supervisor*
- *Executive Director*
- *Faculty*
- *Founder and ED*
- *Medical Imaging Manager*
- *President Think People - VP of RAA*
- *Recovery Support Specialist*
- *Superintendent*
- *Trauma Coordinator*

Respondents were asked to select categories that best describe their organization. All respondents described their organization. Forty-four (44) respondents selected more than one category. Fifty-two (52%) percent of respondents identified as non-profit organizations, 26% identified as social service providers, 13% identified as mental health providers, and 13% identified as a school or education providers. Other city government agencies, housing providers, grassroots community organizing groups/organizations, emergency response, faith-based organizations, other county government agency, and hospital associated healthcare system were identified by less than 10% of respondents. Other state government agency, centers for independent living, colleges and universities, for-profit organization/private business, foundations/philanthropies, libraries, long term care facilities, and private clinics were identified as the organization type by less than 5% of respondents. Twelve percent (12%) of respondents identified their organization type as other.

Table 4: Organization Type (n=93)	
Organization Type	**Percentage**
Non-profit organization	51.6%
Social service provider	25.8%
Mental health provider	12.9%
Schools/education (PK–12)	12.9%
Other city government agency	9.7%
Housing provider	8.6%
Grassroots community organizing group/organization	7.5%
Emergency response	6.5%
Faith-based organization	6.5%
Other county government agency	6.5%
Hospital associated healthcare system	5.4%
Other state government agency	4.3%
Center for Independent Living	3.2%
College/university	2.2%
For-profit organization/private business	2.2%
Foundation/philanthropy	2.2%
Library	1.1%
Long term care	1.1%
Private clinic	1.1%
Other	11.8%

The following types of organizations were identified by those selecting “Other”:

- *Activist organization*
- *Community action agency*
- *Fire department*
- *Food distribution*
- *Food pantry*
- *Grant funded coalition*
- *Head Start*
- *Other unit local government*
- *Public organization*
- *Substance use disorder*
- *Intensive outpatient provider*
- *Criminal justice experts*
- *Mental health treatment provider*
- *Therapeutic day school*

Respondents to the CPA survey were asked to select what their organization's interests were in participating in the Community Health Improvement Plan. Respondents were allowed to select up to three (3) responses. Fifty-six percent (56%) of respondents stated that their organization wanted to participate in the community health improvement process to build networks and relationships; 34% wanted to deliver programs effectively and efficiently while avoiding duplicating efforts; 33% wanted to create long-term, sustainable social change; 32% wanted to obtain or provide services for clients; 27% wanted to increase communication among groups; 13% wanted to pool resources; and 13% wanted to engage community groups that are working independently on similar issues (Table 5).

Less than 10% of respondent's organizations wanted to engage in the community health improvement process to plan and launch community-wide initiatives, gain access to data, improve communication from government to communities, improve communication from communities to government decision-makers, or improve public relations.

Less than 5% of respondent's organizations wanted to develop and use political power to advocate for services or other benefits for the community, break down stereotypes, or revitalize groups that are trying to do too much alone.

Six percent (6%) of organizations selected "other" as one of their reasons for engaging in the community health improvement process.

Table 5: Organizations Top 3 Interests In Participating In Community Health Improvement Process (n=93)

Interest	Percent
Build networks and relationships	55.9%
Deliver programs effectively and efficiently and avoid duplicating efforts	34.4%
Create long-term, sustainable social change	33.3%
Obtain or provide services for your clients	32.3%
Increase communication among groups	26.9%
Pool resources	12.9%
Engage community groups that are working independently on similar issues	12.9%
Plan and launch community-wide initiatives	9.7%
Gain access to data	7.5%
Improve communication from government to communities	7.5%
Improve communication from communities to government decision-makers	7.5%
Improve public relations	6.5%
Develop and use political power to advocate for services or other benefits for the community	3.2%
Break down stereotypes	3.2%
Revitalize groups that are trying to do too much alone	2.2%
Other	5.4%
Missing	4.3%

The following interests for participating in the Community Health Improvement Process were identified by those who selected "other":

- *Be a resource for the mentally challenged in our community.*
- *Implement cohesive, innovative techniques to improve communication between organizations.*
- *Increase capacity for assessment.*
- *Minimize the impact the foster system has on kids and families.*

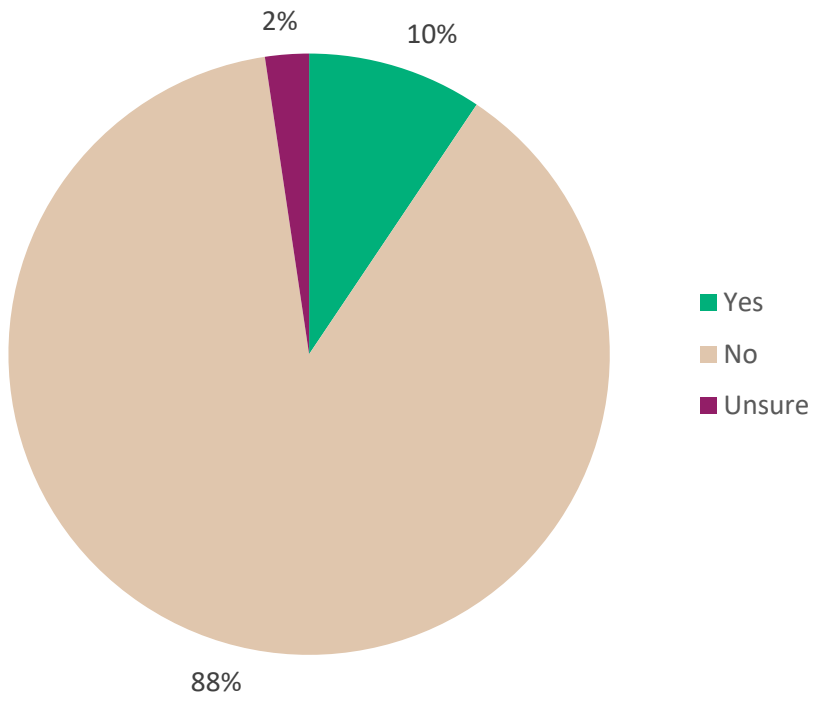
Demographics Of Population Served By Community Partners

WCHD's community partners serve a diverse population with a variety of demographic characteristics. This section describes the demographics and characteristics of clients served.

Racial and Ethnic Focus

Respondents to the CPA survey were asked if their organization focused on a specific racial or ethnic population. The majority of the respondents (88%) indicated that their organization does not focus on a specific racial or ethnic population (Figure 21).

Figure 21: Focus On A Specific Racial Or Ethnic Population



Of those organizations who indicated that they served a specific population, most served more than one identified population. The specific populations served by these originations serve is detailed in Table 6.

Table 6: Racial/Ethnic Populations Served (n=8)	
Racial/Ethnic Populations	**Percent**
Black/African American	75.0%
African	62.5%
Latinx/Hispanic	62.5%
White/European	62.5%
Pacific Islander/Native Hawaiian	62.5%
Native American/Indigenous/Alaska Native	50.0%
Asian American	50.0%
Asian	50.0%
Middle Eastern/North African	37.5%
Other	25.0%

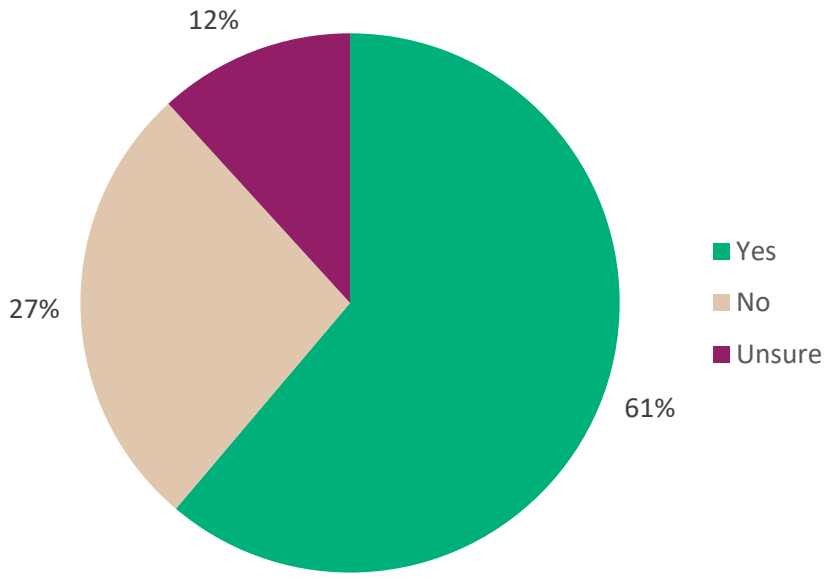
Of those respondents that selected Other, the following response was detailed.

- *BIPOC (Black, Indigenous, and People of Color)*

Immigrants, Refugees, and English as a Second Language

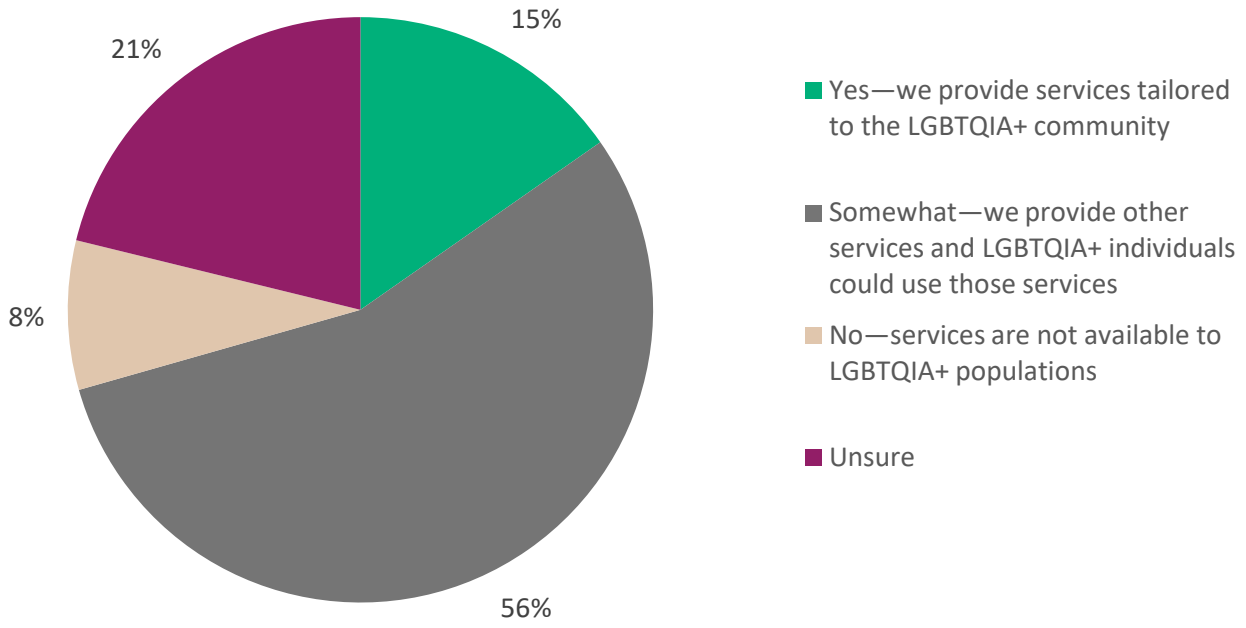
Respondents were asked if their organization worked with immigrants, refugees, asylum seekers, and/or other populations who speak English as a Second Language (ESL). The majority of organizations (61%) reported working with these populations (Figure 22).

Figure 22: Work With Immigrants, Refugees, Asylum Seekers, And/Or Other Populations Who Speak English As A Second Language



Respondents were asked if their organization offered services tailored to transgender, nonbinary, and other members of the LGBTQIA+ community. A minority or organizations responding (15%) reported providing specific services, while the majority (56%) indicated that individuals from the LGBTQIA+ could use their services and eight percent (8%) indicated their services were not available to LGBTQIA+ populations (Figure 23).

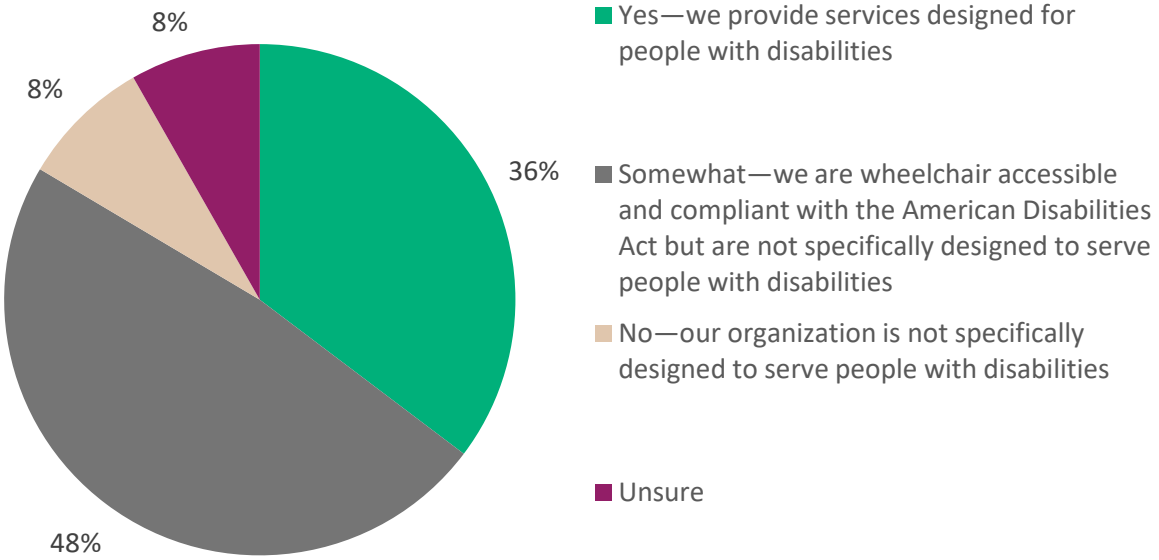
Figure 23: Offer Services Tailored To Transgender, Nonbinary, And Other Members Of The LGBTQIA+ Community



Disability

Respondents were asked if their organization offered services designed for people with disabilities. Less than half (48%) indicated that their organization was wheelchair accessible and compliant with the American Disabilities Act but were not specifically designed to serve people with disabilities while 36% indicated that they provided services designed for people with disabilities. Less than ten percent (8%) indicated that they were not designed to serve people with disabilities (Figure 24).

Figure 24: Offer Services Designed For People With Disabilities



Organizations were asked if they worked with other populations or groups that were not addressed in previous questions. Written responses are as follows:

- *All*
- *All groups as we are a community, non-profit organization hospital*
- *All populations*
- *All populations in the Rockford and surrounding areas*
- *Any; mental illness knows no bounds*
- *At-risk youth*
- *Children in foster care; DCFS involved youth*
- *Girls*
- *Homeless, low income*
- *Homeless, under employed, seniors*
- *Individuals with behavioral disorders*
- *Justice involved individuals, dislocated workers, and youth populations*
- *Low income*
- *Low income populations*
- *Older adults*
- *People affected by substance and mental health disorders, criminal justice population, Medicaid population*
- *Persons with mental, substance abuse and other disabilities*
- *Poverty population(s)*
- *Returning citizens*
- *Seniors (aged 60+)*
- *Survivors of domestic violence*

- *Low-Income*
- *SPED, 504, all groups of students*
- *Teen family support, early learning services*
- *Teen moms, other developmental disabilities, students who need therapeutic educational placement*
- *The village provides its services to all populations and groups*
- *Veterans*
- *Youth 14 and older*
- *Youth with mental illness and their caregivers*

Organizational Capacity

Different organizations have different skills. Some have more expertise in dealing with data, some have more experience in community engagement or advocacy. It is important to encourage collaboration among our partners to ensure that organizations lend their expertise to improve the health of the community.

Languages Spoken

The overwhelming majority of organizations (90%) spoke English with over half of organizations (55%) also speaking Spanish. Fifteen percent (15%) indicated that members of their organization could speak at least one other language. Less than ten percent (9.7%) were able to provide American Sign Language. While organizations may not speak all of the languages of the clients they serve, several respondents specifically indicated that they used support services including contractors, interpreters, and professional translation/interpretation services to support their work with clients.

Table 7: Languages Spoken At Organizations (n=93)

Language	Percent
English	90.3%
Spanish	54.8%
Other	15.1%
American Sign Language	9.7%
Arabic	5.4%
French and French Creole	5.4%
Chinese	2.2%
Tagalog (Filipino)	2.2%
Vietnamese	2.2%
Missing	8.6%

Other languages included in the written responses are as follows:

- *Congo, and several others*
- *Italian*
- *Language line is utilized for all others*
- *Language line offered*
- *Many more*
- *Russian, Ukraine, Ethiopian*

- *Serbian, Bosnian*
- *Some others, unsure of details with our interpreters*
- *Swahuly, Kinyarwanda, Chin, Karen, Sango, Kibembe, Serbian, Croatian, Bosnian, Turkish, Ukrainian, Russian*
- *Think People has Spanish speaking contractors*
- *Ukranian, Russian, Etheopian*
- *Various eastern European*
- *We have a interpretor service for all languages that we pay for*

Community Assets

Community assets are the collective resources, capabilities, and capacities within the community that can be used to address local issues and improve the quality of life. The CPA included questions to identify existent community and identified a wide array of services being provided by partners to improve the lives of community members.

The most common service offered was education at 37%, followed by human services at 33%, family wellbeing at 27%, early child development at 20%, youth development and leadership at 19%, healthcare access and utilization at 18%, housing at 17% and food access and affordability at 16%. All other programs and services represent less than 15% of organizations. Nine percent (9%) of organizations indicated that they offered other programs and services than the ones listed (Table 8).

Other services provided are as follows:

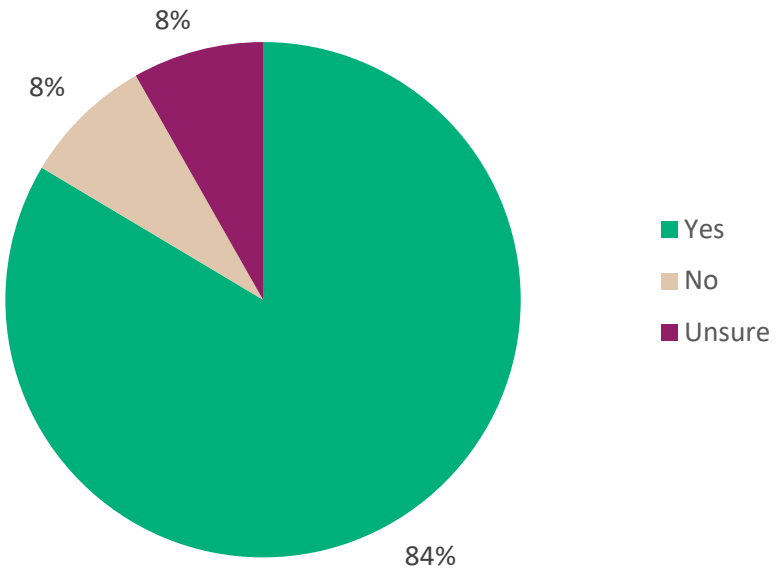
- *Advocacy for minors in care*
- *Business growth*
- *Civil legal services - PSLS represents clients primarily in resolving legal disputes that impact a basic human need (i.e., housing, public benefits, family, safety). PSLS also does criminal sealing and expungement.*
- *Community garden, support services for first responders, defendants, youth development*
- *Mentorship*
- *We provide education and resources for the mentally ill and their families*
- *None*

Table 8: Programs And Services Offered (n=93)	
Programs/Services	**Percentage**
Education	36.6%
Human services	33.3%
Family well-being	26.9%
Early childhood development/childcare	20.4%
Youth development and leadership	19.4%
Healthcare access/utilization	18.3%
Housing	17.2%
Food access and affordability (e.g., food bank)	16.1%
Criminal legal system	11.8%
Public safety/violence prevention	11.8%
Community economic development	10.8%
Disability/independent living	10.8%
Faith community	9.7%
Jobs/labor conditions/wages and income support	9.7%
Seniors/elder care	9.7%
Economic security	8.6%
Other	8.6%
Racial justice	8.6%
Transportation	8.6%
Utilities	8.6%
Gender anti-discrimination/equity	7.5%
Other	7.5%
Public health	7.5%
Veterans' issues	7.5%
Government accountability	5.4%
LGBTQIA+ anti-discrimination/equity	5.4%
Arts and culture	4.3%
Immigration	4.3%
Environmental justice/climate change (conservation)	2.2%
Financial institutions (e.g., banks, credit unions)	2.2%
Land use planning/development	2.2%
Business and for-profit organization	1.1%
Food service/restaurant	1.1%
Parks, recreation, and open space	1.1%
Missing	15.1%

Data Collection and Analysis

Respondents to the CPA survey were asked if their organization collected data (Figure 25). The majority of organizations collect data (84%).

Figure 25: Organization Collects Data



Respondents who indicated their organization collected data or were unsure were asked if their organization collected assessments including basic needs assessments, community health assessments, and neighborhood assessments. Sixty-four percent (64%) indicated that their organization conducted assessments while 19% indicated that their organization did not.

Respondents were asked what methods they used to collect data. Seventy-two percent (72%) of respondents indicated their organization used surveys; 48% used data tracking systems; 43% used feedback forms; 34% used interviews, 34% used focus groups, 22% used secondary data sources, 21% used electronic health records, and 18% used notes from community meetings. While the trend has been toward digitization and use of video/short clips, less than 5% of organizations used photovoice (3.0%) or videos (1.5%).

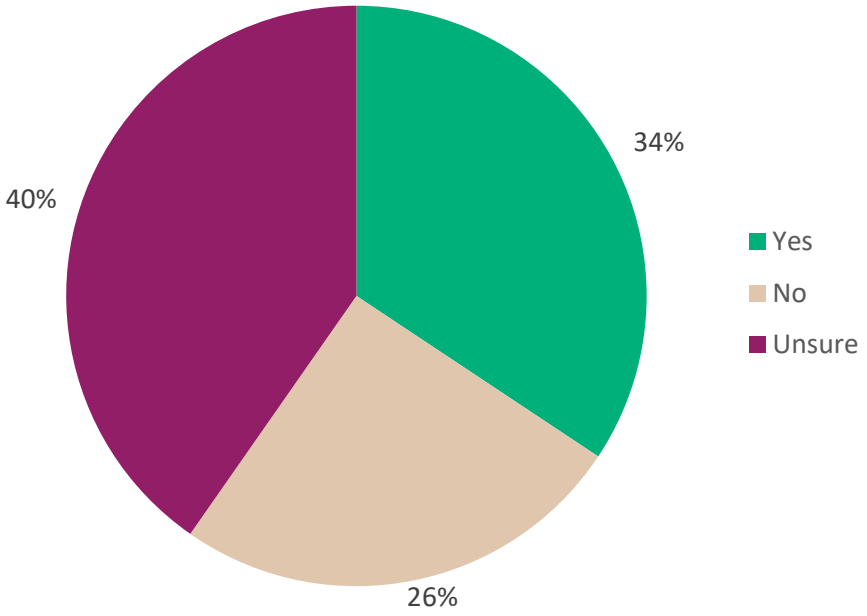
Table 9: Data Collection Method (n=67)	
Data Collection Method	**Percent**
Surveys	71.6%
Data tracking systems	47.8%
Feedback forms	43.3%
Interviews	34.3%
Focus groups	34.3%
Secondary data sources	22.4%
Electronic health records	20.9%
Notes from community meetings	17.9%
Other	4.5%
Photovoice or other participatory research	3.0%
Videos	1.5%
None of the above/we don't collect data	4.5%

Other data collection methods included:

- *Assessments on our youth to determine risk factors so we can case plan to help reduce the risk of recidivism*
- *Demographic intake data*

Respondents whose organizations collected data were also asked if their organization analyzed data with a health equity lens. A health equity lens supports the analysis of data to address disparities in health indicators across groups. The majority of responding organizations were unsure (40%) with 34% of organizations reporting using a health equity lens and 26% indicating that they did not use a health equity lens. (Figure 26.)

Figure 26: Analyze Data With Health Equity Lens



Community Engagement

Respondents were asked what methods their organization used for community engagement. Fifty-one percent (51%) of organizations used social media, 37% used customer or patient satisfaction surveys, 34% used community forums or events, 33% used surveys, 30% used presentation, 26% used memorandums of understanding with community-based organizations, and 23% used advocacy.

Fact sheets, community organizing, focus groups, open houses, public comments, community-driven planning, videos, billboards, interactive workshops, and citizen advisory committees were each used by less than 20% of organizations. House meetings, participatory action research, consensus building, participatory budgeting, and polling were each used by less than 10% of organizations. Approximately 8% indicated that they did not do any community engagement.

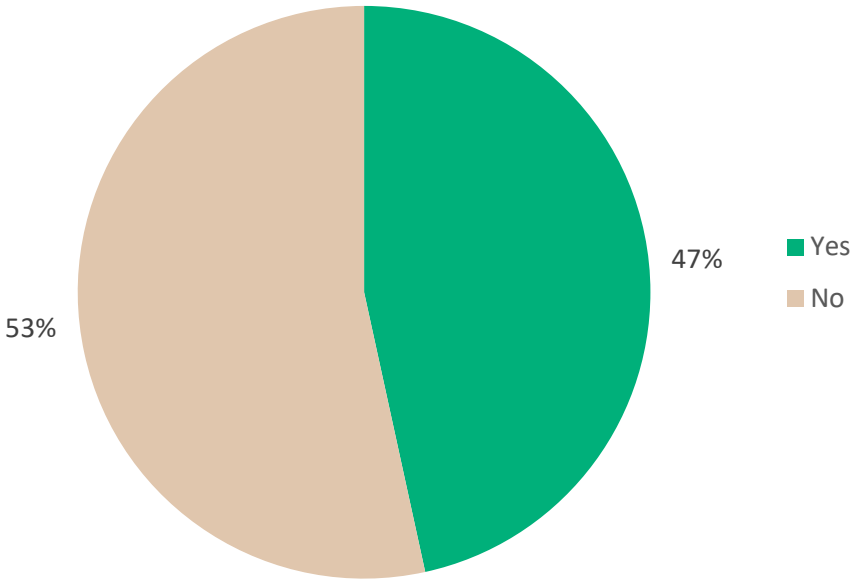
Table 10: Methods Of Community Engagement Used (n=93)

Engagement Method	Percent
Social media	50.5%
Customer/patient satisfaction surveys	36.6%
Community forums/events	34.4%
Surveys	33.3%
Presentations	30.1%
Memorandums of understanding (MOUs) with community-based organizations	25.8%
Advocacy	22.6%
Fact sheets	18.3%
Community organizing	17.2%
Focus groups	16.1%
Open houses	14.0%
Public comment	14.0%
Community-driven planning	14.0%
Videos	12.9%
Billboards	12.9%
Interactive workshops	11.8%
Citizen advisory committees	10.8%
House meetings	6.5%
Participatory action research	5.4%
Consensus building	4.3%
Participatory budgeting	2.2%
Polling	1.1%
We do not do community engagement	7.5%
Missing	21.5%

Policy Or Advocacy Work

Respondents were asked if their organization engaged in external policy or advocacy work. Less than fifty percent (47%) engage in external policy or advocacy work (Figure 27).

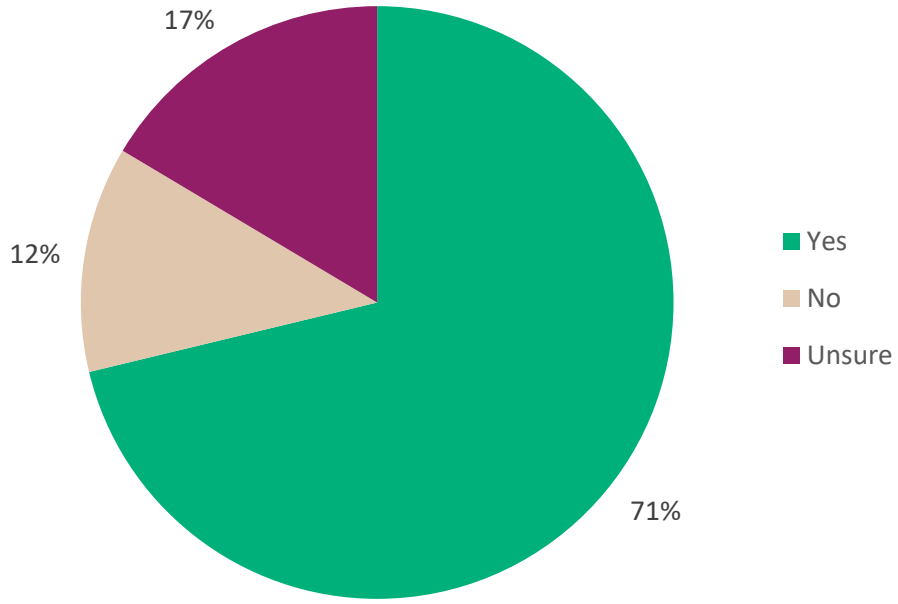
Figure 27: Engage In External Policy Or Advocacy Work



External Communications

Respondents were asked if their organization regularly engaged in external communication. The majority of organizations (71%) engage in external communication (Figure 28).

Figure 28: Engage In External Communication



Respondents whose organizations engaged in external communication were asked what methods their organization used to communicate. The majority reported the use of social media (85%); 64% used external newsletters to members or to the public; and 62% used press releases or conferences. While traditional print and television media has declined over the past years, the majority of organizations (56%) reported ongoing and active relationships with local journalists and media organizations. Internal communications included newsletters to staff. Less than ten percent (10%) of organizations have external facing data dashboards to the community.

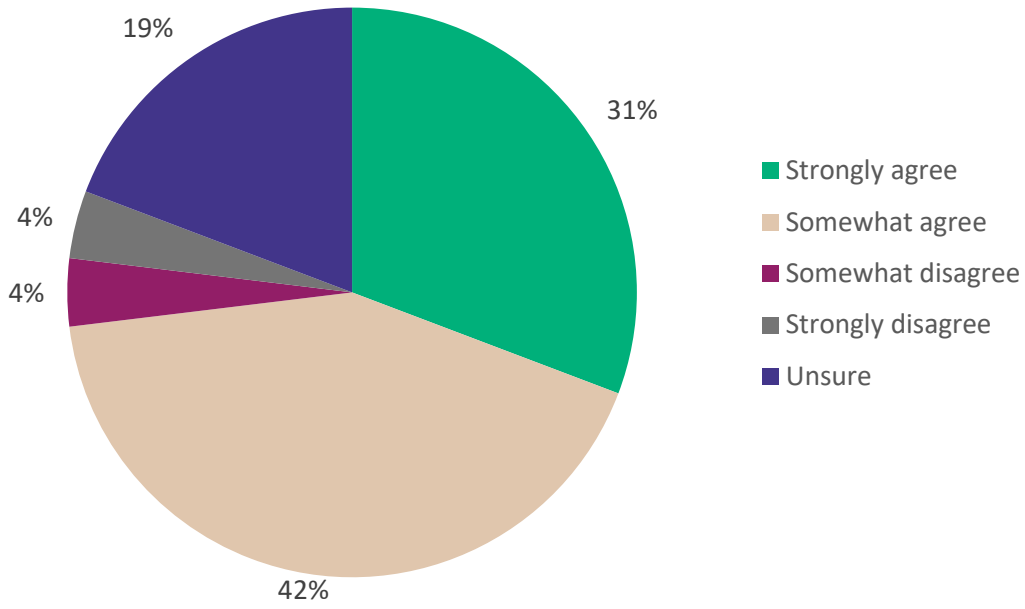
Table 11: Method Used To Communicate (n=52)	
Method	**Percent**
Social media outreach (e.g., on Facebook, Twitter, Instagram)	84.6%
External newsletters to members/the public	63.5%
Press releases/press conferences	61.5%
Ongoing and active relationships with local journalists and earned media organizations	55.8%
Meet internally to discuss narrative and messaging to the public	46.2%
Internal newsletters to staff	44.2%
Ethnicity-specific outreach in non-English language	25.0%
Data dashboard	9.6%
Other	7.7%

Other methods used to communicate included:

- Annual Report
- Multiple

The majority of organizations that engaged in external communication (73%) strongly or somewhat agreed that an equity lens was used for their external communication and engagement work. Thirty-one percent (31%) strongly agreed that their organization used a health equity lens, 42% somewhat agreed, 4% somewhat disagreed, and 4% strongly disagreed. The remaining respondents were unsure (Figure 29).

Figure 29: Equity Lens For External Communications And Engagement Work



Capacity To Support Community Health Improvement

Essential Public Health Services

In the prior iteration of MAPP, organizations would have participated in the Local Public Health System Assessment (LHPSA) to assess the activities, competencies, and capacity of the local public health system. In the CPA, questions focused on the 3 Core Functions (Assessment, Assurance, and Policy Development) and the 10 Essential Public Health Services (EPHS). The EPHS describe the activities that the local public health system should engage in to promote optimal health of the community while addressing the systematic and structural barriers that have resulted in health inequities. The CPA survey asked respondents if they engaged in the EPHS as follows:

- **Assessment:** My organization conducts assessments of living and working conditions and community needs and assets.
- **Investigation of Hazards:** My organization investigates, diagnoses, and addresses health problems and hazards affecting the population.
- **Communication and Education:** My organization works to communicate effectively to inform and educate people about health or well-being, factors that influence well-being, and how to improve it.
- **Community Engagement and Partnerships:** My organization works to strengthen, support, and mobilize communities and partnerships to improve health and well-being.
- **Policies, Plans, Laws:** My organization works to create, champion, and apply policies, plans, and laws that impact health and well-being.
- **Legal and Regulatory Authority:** My organization has legal or regulatory authority to protect health and well-being and uses legal and regulatory actions to improve and protect the public's health and well-being.

- **Access to Care***:* My organization provides healthcare and social services to individuals or works to ensure equitable access and an effective system of care and services.
- **Workforce:** My organization supports workforce development and can help build and support a diverse, skilled workforce.
- **Evaluation and Research:** My organization conducts evaluation, research, and continuous quality improvement and can help improve or innovate functions.
- **Organizational Infrastructure:** My organization is helping build and maintain a strong organizational infrastructure for health and well-being.

Twenty-two (22%) of respondents did not complete the EPHS questions. The largest percentage of work was in the area of community engagement and partnerships with 47% of agencies working in this space. The lowest percentage was in the area of legal and regulatory authority at 9.7%.

Table 12: 10 Essential Public Health Services (n=93)	
Essential Public Health Services	**Percent**
Community Engagement and Partnerships	47.3%
Communication and Education	37.6%
Assessment	33.3%
Workforce	30.1%
Access to Care	28.0%
Policies, Plans, Laws	25.8%
Evaluation and Research	23.7%
Organizational Infrastructure	20.4%
Investigation of Hazards	14.0%
Legal and Regulatory Authority	9.7%
Other	4.3%
Unsure	16.1%
Missing	21.5%

Additional responses provided in the Other:

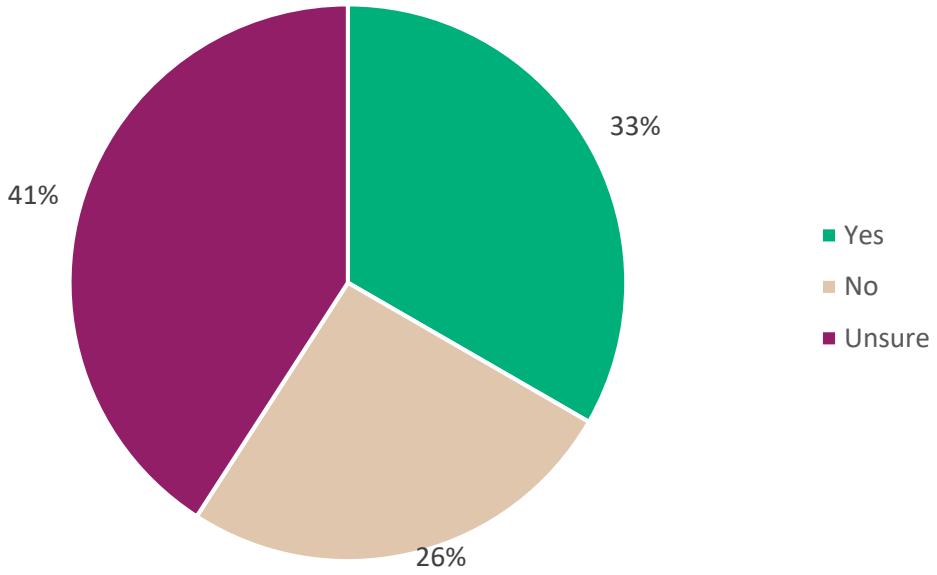
- *Faith and spiritual access, care and services.*
- *Social support for older adults and adults with disabilities.*
- *The listed options are not a focus of our organization.*

Support For Improving Community Health

It is important to engage a wide variety of partners in the Community Health Improvement Plan (CHIP) process. Experienced partners can lend their knowledge where new partners can provide novel insights and opportunities. Furthermore, internal organizational changes may create opportunities for new representation in the process.

Respondents to the CPA survey were asked if they had ever participated in the CHIP process. Only one-third (33%) of respondent organizations had participated in the CHIP (Figure 30).

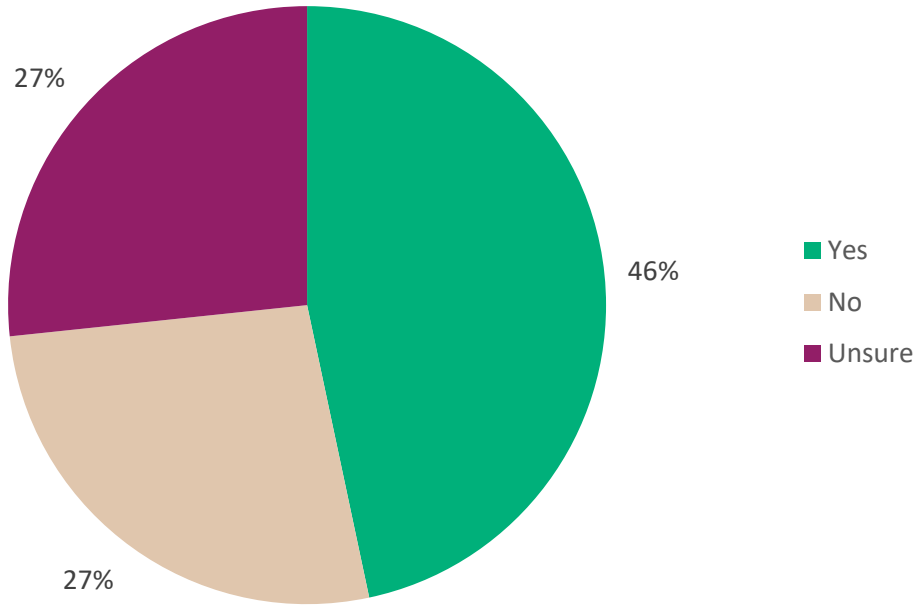
Figure 30: Experience Participating In The Community Health Improvement Process



Addressing Health Equity

The CPA Survey asked organizations if there was at least one person in their organization dedicated to addressing diversity, equity, and inclusion internally and externally in the community. Fewer than half of the organizations (46%) indicated having staff to address diversity, equity, and inclusion.

Figure 31: Person Dedicated To Addressing Diversity, Equity, And Inclusion Internally And Externally In Our Community.



As defined by the Centers for Disease Control and Prevention, health equity is the state in which everyone has fair and just opportunities to obtain their highest level of health. Approximately one third (34%) of organizations review data in their organizations using a health equity lens focused on addressing health disparities.

Respondents were also asked to select barriers encountered while working on health equity within their organization. While 41% encountered no barriers, 29% reported staff shortages, and 25% reported resistance (staff and community).

Table 13: Barriers To Health Equity (n=93)	
Barrier	**Percentage**
No barriers	40.9%
Staff shortages	29.0%
Community resistance	16.1%
Staff resistance	8.6%
Missing	19.4%

Respondents were also asked to share their organization's definition of health equity. Responses are depicted in the Word Cloud detailed below.

Image 1: Word Cloud Organizations Definition Of Health Equity

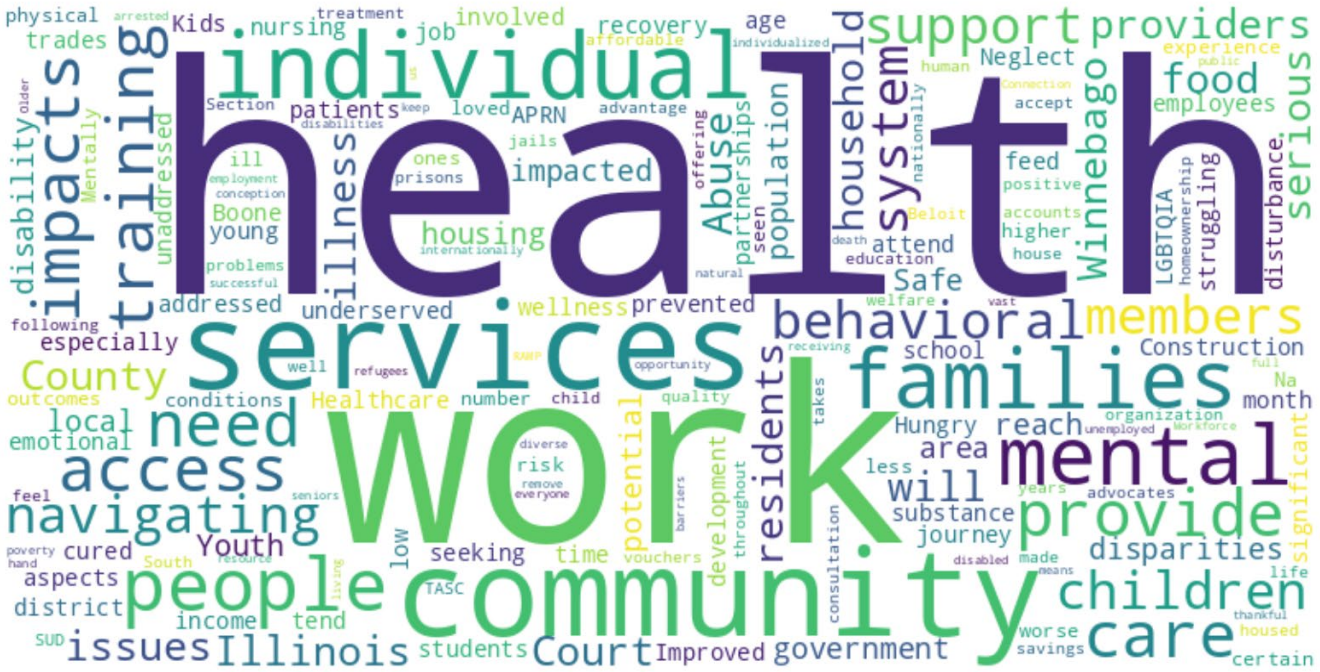
- *By fostering healthcare access for everyone, including at risk and underserved populations, we can help to cultivate healthier, thriving communities.*
- *EDDR - Education, Design, Development, Research*
- *Education design development resource that was good*

- *In order to operate as inclusively as possible, the leadership of Stepping Stones promotes accessibility that strives to provide a respectful and nondiscriminatory quality of life for individuals served and employees, which meets legal and regulatory guidelines and is responsive to the expectations of our stakeholders and community. The organization operates a continuous quality improvement process towards identifying and removing accessibility issues and barriers.*
- *Lack of education, internal beliefs and biases, as well as misconceptions, all contribute to social detriments to health. We can break those barriers through learning and unlearning we can educate ourselves and others to be as equitable as possible.*
- *Offer lead safe units.*
- *Our Mission: Through excellence in healthcare and compassionate service, we care for our community. Our Vision: Remarkable healthcare.*
- *Remedies Renewing Lives serves any individual who has been a victim of domestic violence or struggles with addiction or mental health issues.*
- *The Y is made up of people of all ages, from all walks of life, working side-by-side to strengthen communities. Together, we strive to ensure that everyone, regardless of ability, age, cultural background, ethnicity, faith, gender, gender expression, gender identity, ideology, income, national origin, race or sexual orientation has the opportunity to reach their full potential with dignity. Our core values are caring, honesty, respect, responsibility and faith and they guide everything we do.*
- *Unsure*
- *We engage all citizens in building stronger communities.*
- *We talk about equitable, accessible, and affordable services a lot but we have not defined it has a collaborative. I love this question because it would be in our best interest to define for our coalition, so folks better understand what it means for us.*
- *What We Value RAMP's work is guided and informed by our beliefs and commitments to: Inclusiveness/Inclusion – We respect people, value diversity and are committed to equality. Participation – The opportunity to participate in all aspects of society. We all benefit when everyone reaches their full potential and contributes to our communities. Accountability – The willingness to accept responsibility and account for one's actions. Autonomy – We value the freedom to be the driver of your own results.*

Accountability

When considering systems of power, it is important to consider who is directly impacted by the efforts of community partners and to whom these community partners are accountable to. As part the CPA survey, respondents were asked who was impacted by their work. Responses are depicted in the World Cloud (Image 2) and detailed below.

Image 2: Word Cloud Representing Those Impacted By The Organization's Work



- *All individuals seeking support in navigating their behavioral health recovery journey.*
- *Because we work with nursing and APRN students, our work impacts all aspects of health, community health, underserved populations*
- *Community families, especially those with young children.*
- *Community members navigating the mental health system of care and providers that provide the services in Winnebago and Boone County.*
- *Community members of families with children that will attend the school district we work for.*
- *Construction trades, job development*
- *Health issues are addressed and prevented or cured.*
- *Healthcare providers, employees, patients and partnerships.*
- *Hungry people who need food to feed themselves and/or their household each month.*
- *Illinois residents, age 6 and up, struggling with significant mental illness.*
- *Improved health and wellness*
- *Individuals with serious mental illness or serious emotional disturbance.*
- *Kids and families involved in the Winnebago County Abuse and Neglect Court. Most of the time we work with low income households and there tends to be unaddressed mental health and substance abuse issues.*

- *LGBTQIA+ people experience a number of health disparities. They're at higher risk of certain conditions, have less access to health care, and have worse health outcomes. These disparities are seen in the areas of behavioral health, physical health, and access to care.*
- *Mentally ill and their loved ones.*
- *NA*
- *Our organization is local government. I feel our local government has made positive impacts on the quality of life for the residents of South Beloit over the years.*
- *Our population takes advantage of the following once housed: Safe housing, human services, education/training in-house, potential for savings accounts and homeownership*
- *Safe and affordable housing. We accept sec 8 vouchers*
- *TASC advocates for people in courts, jails, prisons, and child welfare systems who need treatment for SUD/Mental health problems. We reach over 40,000 individuals throughout Illinois as well as offering training and consultation services nationally and internationally.*
- *The disability community*
- *The people most impacted by our work are seniors, refugees, disabled, and unemployed.*
- *The Workforce Connection is a resource for employment and training needs. Individuals are impacted by our work because they have the opportunity to access individualized services that remove any barriers that will keep them from being successful in this area.*
- *Those living in poverty.*
- *We hand food out to the public! They are very thankful to us for receiving it!*
- *We provide services and support to individuals with disabilities so they can reach their full potential. The disability community is vast and diverse, which means RAMP's work impacts everyone.*
- *We provide services to individual/families from conception to natural death.*
- *Youth and older*
- *Youth who have been arrested and their families.*

Respondents were asked to whom they are responsible. Respondents could be accountable to more than one group. Approximately one-quarter reported accountability specifically to community members (23.7%) and customers/clients (22.6%); however, the highest response rate for accountability was to a Board of Directors/trustees, followed by state government (33.3%) and federal government (30.1%).

Less than 10% of organizations were accountable to the following: internal and external advisory board, national/parent organization, shareholders, voting members, or voters.

Table 14: Organizational Accountability (n=93)	
Accountable Group	**Percentage**
Board of directors/trustees	47.3%
State government	33.3%
Federal government	30.1%
Community members	23.7%
Customers/clients	22.6%
City council, board of supervisors/commissioners, or other elected legislative officials	19.4%
Members of the organization/association	18.3%
Mayor, governor, or other elected executive official	17.2%
Other government agencies	14.0%
Foundation	11.8%
Other:	10.8%
Internal and external advisory board	9.7%
National/parent organization	7.5%
Shareholders	3.2%
Voting members	2.2%
Voters	1.1%
Missing	20.4%

Additional accountable groups detailed in the Other:

- *CARF*
- *Diocese of Rockford*
- *Donors*
- *Funders*
- *Grant providers*
- *Healthcare system*
- *HUD for section 8*
- *Legal Services Corporation*
- *School board*
- *That would be Marcia Cook*

Social Determinants of Health

Respondents to the CPA survey were asked to consider their organizational focus on the social determinants of health. The social determinants of health as defined by Healthy People 2030 are Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community context.

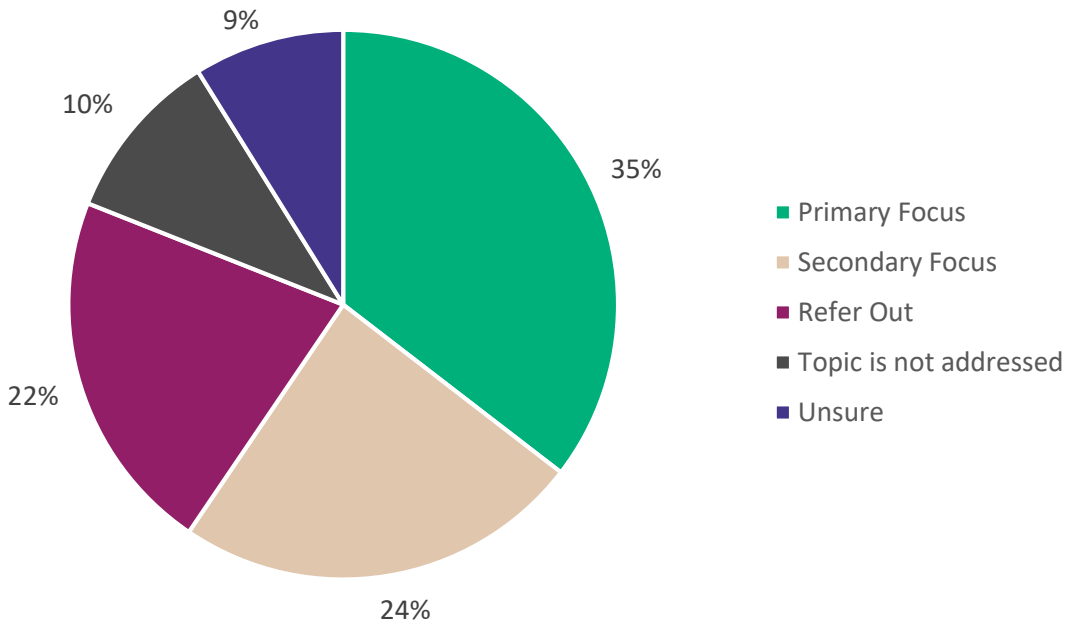
Respondents were asked to quantify the focus using a scale: the main focus or capacity of the organization; a secondary focus means they can address this aspect internally but is not a primary focus; refer out meaning the organization does not have internal capacity but will refer clients to other organization; topic is not addressed, or unsure.

Economic Stability

Economic stability is the connection between people's financial resources, including income, cost of living, and socioeconomic status, and their health. Examples include poverty, employment, food

security, and housing stability. Thirty-five percent (35%) of respondents indicated that economic stability was the primary focus of their organization (Figure 32).

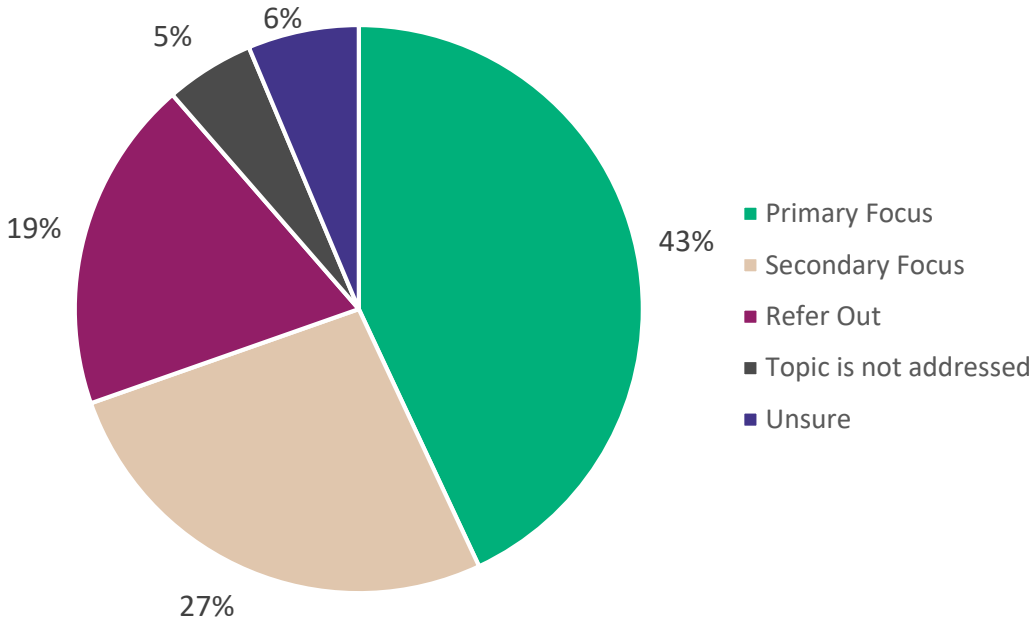
Figure 32: Social Determinates Of Health: Economic Stability



Education Access and Quality

Education access and quality are strongly correlated with health. Indicators include graduation rates, language and literacy, and early childhood education and development. The majority of organizations (60%) reported that it was either their primary or secondary focus (Figure 33).

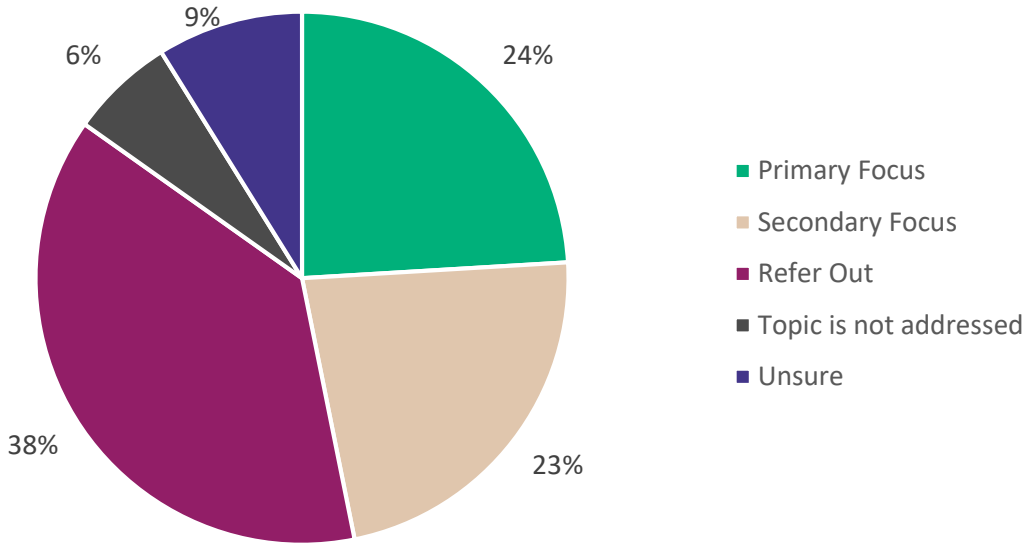
Figure 33: Education Access And Quality



Healthcare Access And Quality

Healthcare access and quality include key issues such as access to health care, access to primary care, health insurance coverage, and health literacy. The majority of organizations participating (38%) indicated that they would refer out; while 24% indicated that it was their primary focus (Figure 34).

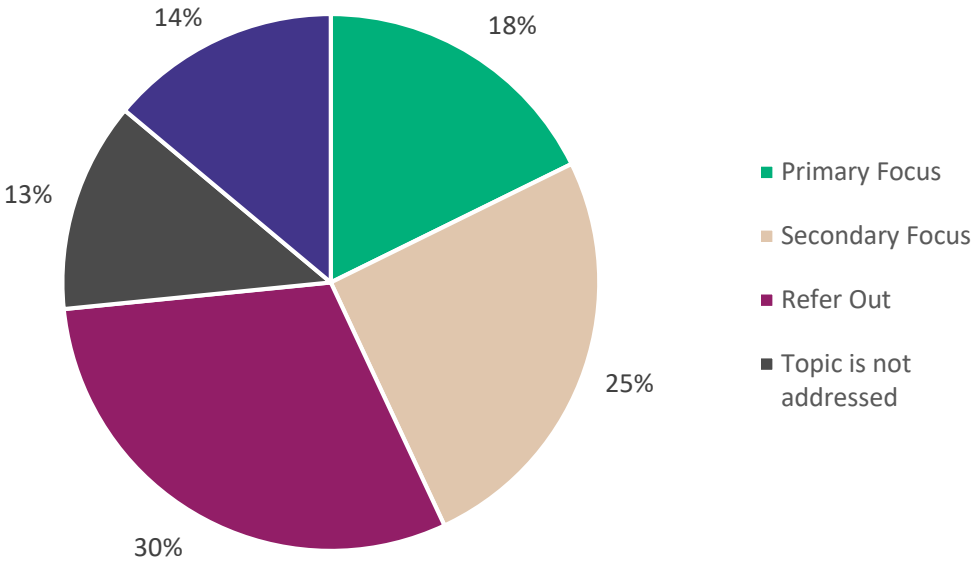
Figure 34: Healthcare Access And Quality



Neighborhood And Build Environment

Neighborhood and Built Environment is the connection between where a person lives—housing, neighborhood, and environment— and their health and well-being. Indicators include quality of housing, access to transportation, availability of healthy foods, air and water quality, and public safety. Forty-three percent (43%) of organizations indicated that neighborhood and built environment was their organization's primary or secondary focus while 13% did not address (Figure 35).

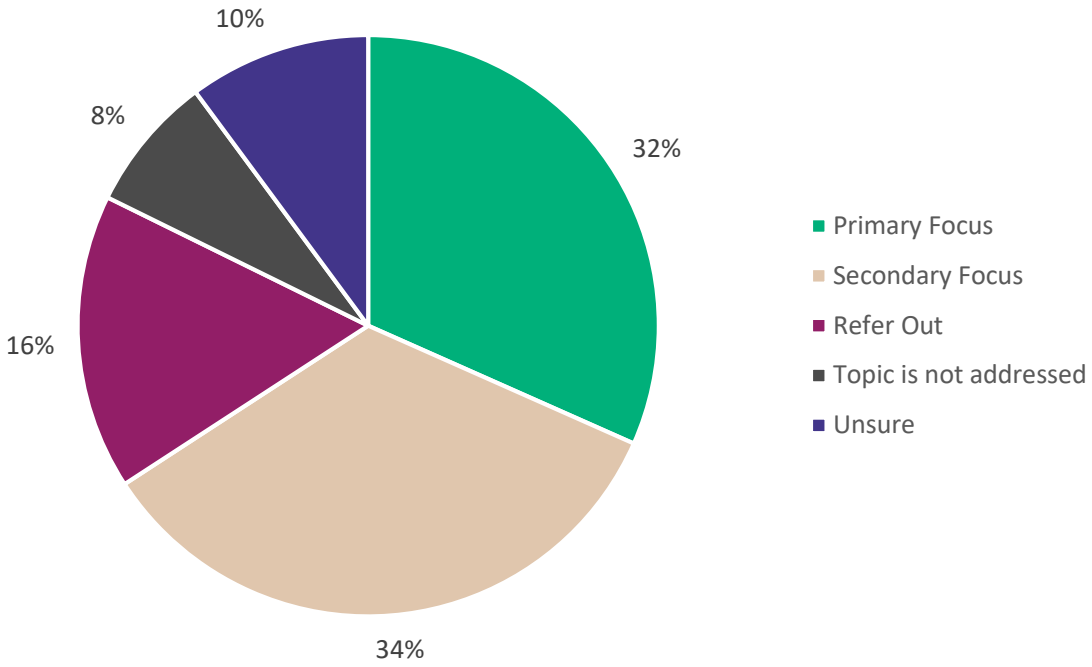
Figure 35: Neighborhood And Built Environment



Social And Community Context

Social and Community Context refers to the impacts of relationships and the social settings in which people live, learn, work, and play, on their health and well-being. Factors include cohesion within a community, civic participation, discrimination, conditions in the workplace, violence, and incarceration. Thirty-two percent (32%) of respondents indicated that social and community context was the primary focus of their organization, 34% indicated it was their secondary focus, 16% refer out, 8% do not address the determinate, and 10% were unsure.

Figure 36: Social And Community Context



Community Strengths

WCHD's community partners represent a wide array of assets dedicated to improving the quality of community life for the diverse population of Winnebago County. Each community partner entity has strengths, capabilities, capacity, and expertise specific to their organization's mission. Through collective impact and engagement, strategies can be developed with the community health improvement plan and aligned with community partner organizations. Each community partner also brings a passion and commitment to the specific audiences served through their organizations, including early childhood, justice involved, refugee/immigrant, and underserved/underrepresented communities.

These community partners were willing to look at how power and privilege exhibited by their organization, influenced their clients and the greater community of Winnebago County with the goal of working toward health equity.

While no single organization can address all the needs of the community, through collaboration and collective effort all needs can be addressed. Education, human services, family well-being, early childhood development, youth leadership, healthcare access, housing, and food access are services that are well-represented by

community partners. The majority of responding organizations (58%) address multiple community issues through their programming and services.

Fifty-nine percent (59%) of organizations engage in services related to economic stability as either the primary or secondary focus. Seventy percent (70%) engaged in education access and services. Forty-seven (47%) percent engage in health care access and quality services. Forty-three (43%) percent engage in services related to the neighborhood and built environment. Sixty-six (66%) percent engaged in services related to social and community context. WCHD's community partners also value health equity with 46% of organizations have one person dedicating to addressing diversity, equity, and inclusion internally and externally in the community. Image 3 represents the commitments of the Community Partners in their work.

Image 3: Word Cloud Representing Commitments Of Community Partners

WCHD's community partners also have a wide array of skills and expertise to serve the unique needs of their clients. Sixty-one percent (61%) work with immigrants, refugees, asylum seekers, and/or other populations who speak English as a second language. Seventy-one percent (71%) have experience working with members of the LGBTQIA+ community, and 84% serve clients living with disabilities.

Community partners also have developed skills in the areas of data collection to support their work with 84% of organizations collect data using a wide variety of methods including: surveys, data tracking forms, feedback forms, interviews, focus groups, and secondary data sources. Organizations use a wide array for tools of community engagement including: social media, customer satisfaction surveys, community events, surveys, and presentations. Community partners also demonstrate skills with external communication through social media outreach, external newsletters, press releases, and relationships with local journalists. Community partners (47%) have also demonstrated skills with external policy and advocacy work.

Other Responses

At the end of the CPA survey, individuals were asked if they had any additional questions, comments, or suggestions about the WCHD's MAPP 2.0 process and ways to work together to improve community health. Written responses are as follows:

- *As a representative of a statewide, non-for-profit agency, I am willing to participate in roundtable discussions, forums, surveys, etc. to add value to improving community health.*
- *Getting together to get ahead is always a good idea.*

ONGOING COMMUNITY PARTNER ENGAGEMENT

Community partners who participated in the CPA survey also assisted in sharing the Community Context Assessment (CCA) through their communication channels to encourage participation from their clients, staff, and neighbors. As trusted communicators, they were asked to use appropriate powers to influence individuals to participate in the CCA. Their reach out was valuable in eliciting responses to the CCA survey. Community partners were also asked to co-sponsor focus groups for under-represented populations as part of the CCA.

Some community partners also participated in the Partner Steering Committee (PSC). The PSC determined data categories for the Community Status Assessment (CSA) and reviewed data throughout the process for inclusion. The PSC reviewed questions and content for the CCA that was shared with the community between February and March, 2024.

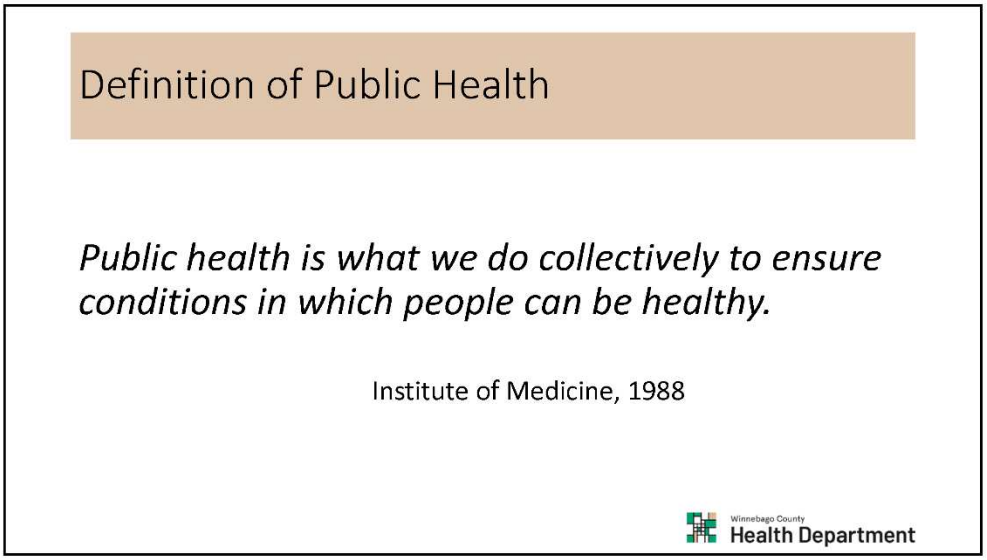
During Phase III (Continuously Improve the Community) of the MAPP 2.0 Process, the PSC worked with the Internal Steering Committee (ISC) to develop the tools for prioritization of the health issues. Community partners were also engaged to participate in the determination of health priorities, consideration of strategies, and alignment of community partners and resources for the Community Health Improvement Plan.

ATTACHMENTS

- Attachment A – Community Partner Workshop
- Attachment B – Community Partner Workshop Presentation
- Attachment C – Sample Email to Community Partners to complete Community Partner Assessment
- Attachment D – Examples of Forms of Power
- Attachment E – Forms of Power
- Attachment F – Community Partner Assessment Survey Questions

Attachment A: Community Partner Workshop

Attachment B: Community Partner Workshop Presentation



IPLAN 2025

How Did We Get Here

Assessing the Health of the Community

- Illinois Project for Local Assessment of Needs **(IPLAN)**
  - Community Health Assessment (CHA)
  - Planning process
  - Conducted every **5** years by all **local health jurisdictions** in Illinois
  - Required for **Local Health Department Certification** under Illinois Administrative Code

    http://app.idph.state.il.us/
- Community Health Needs Assessment **(CHNA)**
  - Assess the needs of the community it serves
  - Planning process
  - Conducted every **3** years
  - Required for **charitable hospital organizations** under IRS Section 501(r)(3)

    https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

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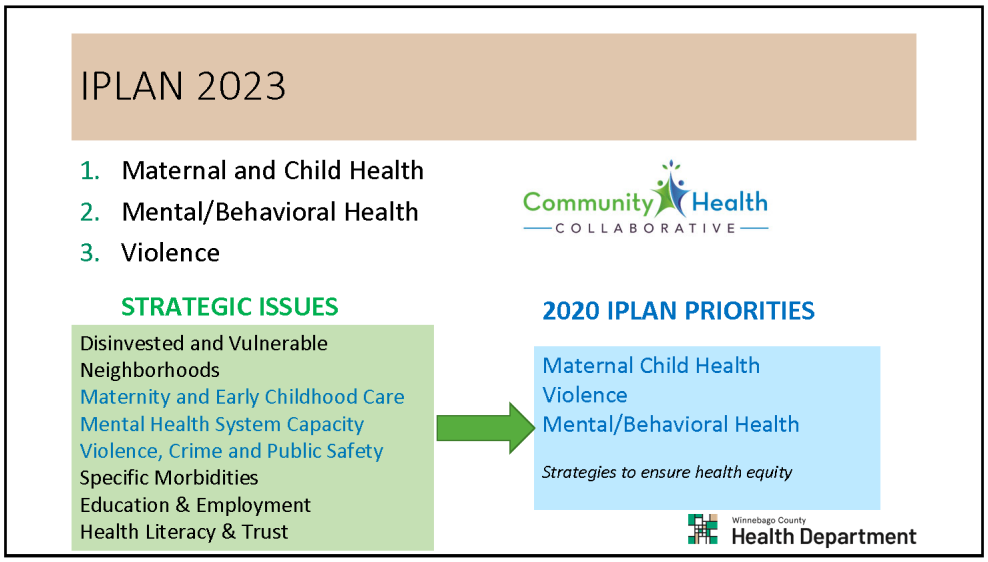
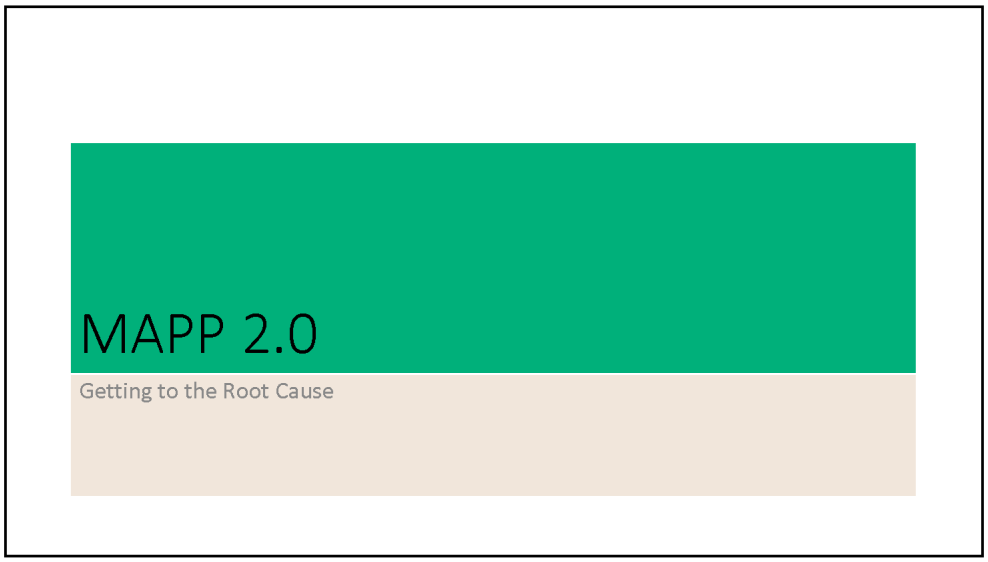

IPLAN 2023
1. Maternal and Child Health
2. Mental/Behavioral Health
3. Violence
Community Health
COLLABORATIVE
STRATEGIC ISSUES
Disinvested and Vulnerable Neighborhoods
Maternity and Early Childhood Care
Mental Health System Capacity
Violence, Crime and Public Safety
Specific Morbidities
Education & Employment
Health Literacy & Trust
2020 IPLAN PRIORITIES
Maternal Child Health
Violence
Mental/Behavioral Health
Strategies to ensure health equity
Winnebago County
Health Department


MAPP 2.0
Getting to the Root Cause

MAPP

- Mobilizing for Action through Planning and Partnerships (MAPP)
- Developed and supported by **NACCHO** (National Association of County and City Health Officials)
- ***Community-driven*** strategic planning process to achieve ***health equity.***
  - Engages broad range of community partners and stakeholders.
  - Focuses on policy, systems, and environmental change.
  - Alignment of community resources.
  - Results → Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP).

Winnebago County Health Department

Key Changes from MAPP 1.0 to MAPP 2.0

MAPP 1.0 Released 2001, periodic updates	**MAPP 2.0** July 2023
Goal: Improve population health	Goal: Achieve health equity
6 Phase process	3 Phase process
4 Assessments • Local Public Health Systems Assessment • Community Health Status Assessment • Community Themes & Strengths Assessment • Forces of Change Assessment	3 Assessments: • Community Partner Assessment • Community Status Assessment • Community Context Assessment
• Resource: Health Equity Supplement	Resource: **Power Primer**

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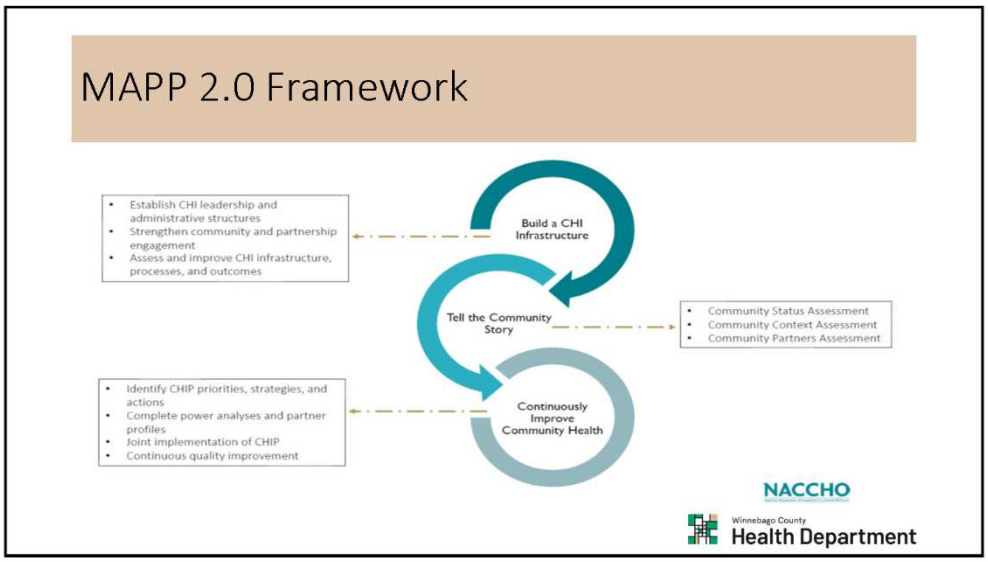
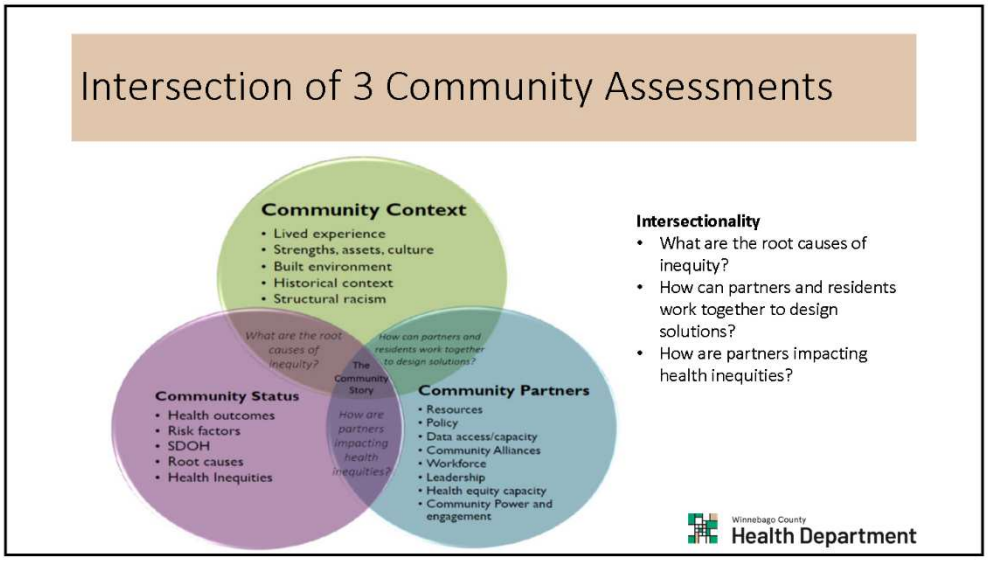
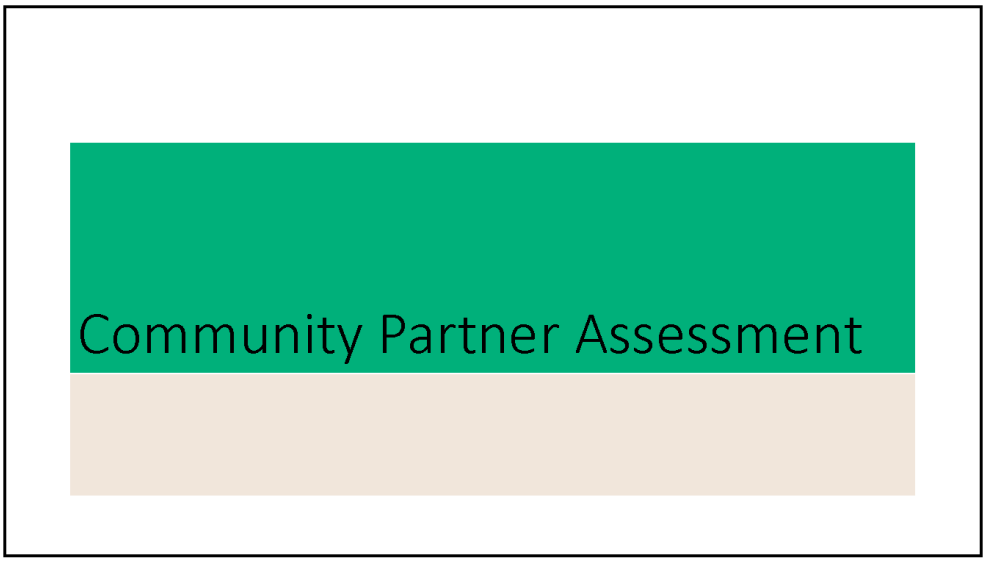

MAPP 2.0 Framework
Establish CHI leadership and administrative structures
Strengthen community and partnership engagement
Assess and improve CHI infrastructure, processes, and outcomes
Build a CHI Infrastructure
Tell the Community Story
Community Status Assessment
Community Context Assessment
Community Partners Assessment
Identify CHIP priorities, strategies, and actions
Complete power analyses and partner profiles
Joint implementation of CHIP
Continuous quality improvement
Continuously Improve Community Health
NACCHO
Winnebago County Health Department


Intersection of 3 Community Assessments
Community Context
Lived experience
Strengths, assets, culture
Built environment
Historical context
Structural racism
What are the root causes of inequity?
How can partners and residents work together to design solutions?
The Community Story
How are partners impacting health inequities?
Community Status
Health outcomes
Risk factors
SDOH
Root causes
Health Inequities
Community Partners
Resources
Policy
Data access/capacity
Community Alliances
Workforce
Leadership
Health equity capacity
Community Power and engagement
Intersectionality
What are the root causes of inequity?
How can partners and residents work together to design solutions?
How are partners impacting health inequities?
Winnebago County Health Department



Community Partner Assessment (CPA)

- Five Goals
  1. Interconnectedness
     Describe why community partnerships are critical to community health improvement and how to build or strengthen relationships among community partners.
  2. Addressing health equity
     Identify the specific roles of community partners in engaging communities experiencing health inequities.
  3. Asset mapping
     Assess each partners capabilities, skills, and strengths.
  4. Collective impact
     Document MAPP community partners to summarize collective strengths and opportunities.
  5. Community power building
     Who else needs to be engaged in MAPP?

Winnebago County Health Department

Community Partner Assessment (CPA)

- An assessment process that allows all community partners involved in MAPP to critically look at:
  - their own individual systems, processes and capacities, and
  - their collective capacity as a network to address health inequities.
- Helps identify the range of actions that are currently being taken and could be taken moving forward to address health inequity at the individual to systemic and structural levels.

Winnebago County Health Department

Unpacking Power

Framework for Understanding Power in Public Health

- Personal vs. Collective Power
  - Personal empowerment has limited impact on health inequities.
    - Places burden on the people and communities experiencing inequities
    - Examples: Nutrition education, exercise recommendations, others from your area of practice?
  - Collective power is the capacity of a group to through organization and cooperation
    - Examples: Collaborations working to change laws, protestors gaining awareness of an issue, others from your area of practice?
- Power Over vs. Power With
  - Power over
    - Power is finite, fear-based, blaming, polarizing
  - Power with
    - Power is infinite when shared, accountability driven, leverages connections, responsibility to be in service to others

https://brenebrown.com/resources/brene-brown-on-power-and-leadership/#:~:text=Power%20over%20is%20driven%20by,on%20Empathy%2C%20Unity%20and%20Courage.

Winnebago County Health Department

Why Talk About Power?

- Interplay between *power imbalances* and *structural oppression*
  - Interlocking and interdependent
  - Power imbalances reinforce structural oppression
  - Structural oppression creates power imbalances.

Power imbalances and structural oppression are the root causes of health inequity.

Winnebago County Health Department

Power Primer – WHY?

- Transferring decision making authority over the CHIP requires a deeper exploration of power.
- Achieving health equity must be community driven.
- Foundational to the MAPP 2.0 process.

MAPP 2.0 Fundamental Principles

Equity	Community Power	Inclusion
Trusted Relationships	Strategic Collaboration & Alignment	Data & Community Informed Action
Full Spectrum Actions	Flexible	Continuous

Winnebago County Health Department

What's Your Super Power

Unpacking Power and Privilege

Benefits of Assessing Our Power

- Addresses feelings of powerlessness by identifying what you do have control over.
- Identifies power structures impacting our work in the community and the most effective strategies to make change.
- Increases awareness of the responsibility of having power.
- Improves accountability.
- Identifies ways we can share our power with those who have been structurally blocked.

Winnebago County Health Department

Instructions for Poll Everywhere

Poll Everywhere App

• Download the Poll Everywhere App from your Play Store

• Username: WCHD001

• Click: Join

To change your response

• Click: Clear last response (found at bottom of screen)

Browser

• Type: PollEv.com/WCHD001

into the browser

To change your response

• Click: Clear last response (found at bottom of screen)

Text

• Text: WCHD001 to 22333

To change your response

• Enter your next letter choice. You will receive the following message:

o You can't respond to this poll any more. To clear your answer text CLEAR or UNDO.

• After texting CLEAR or UNDO you will be able enter your preferred response

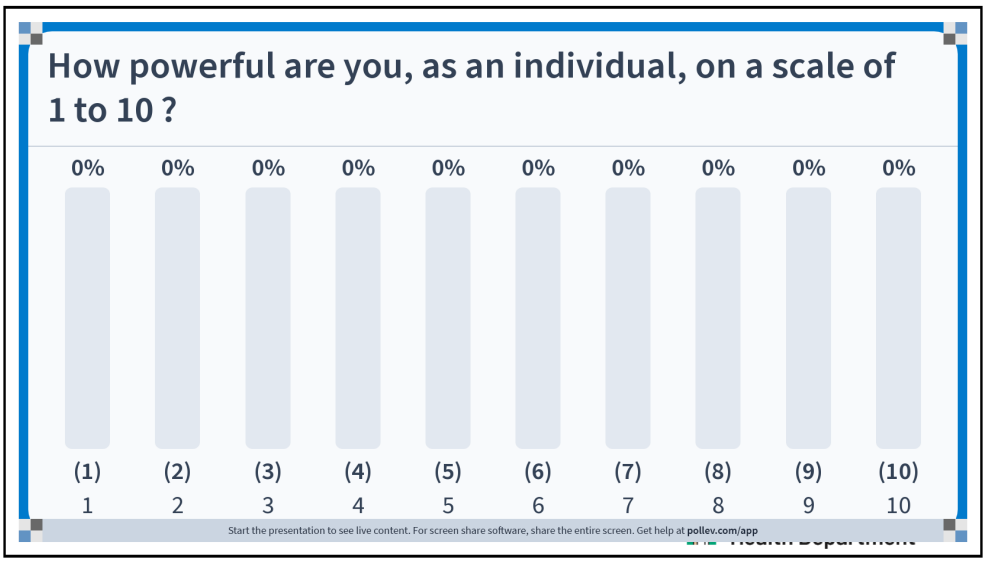
Winnebago County Health Department

Power As An Individual

Individual Power

- Discussion Questions
  - What did you notice about the markers on the scale?
  - How did this activity make you feel?
  - How did you decide to place yourself?
    - Factors
    - Identities
    - Other

Winnebago County Health Department


How powerful are you, as an individual, on a scale of 1 to 10 ?
0%
0%
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0%
(1) 1
(2) 2
(3) 3
(4) 4
(5) 5
(6) 6
(7) 7
(8) 8
(9) 9
(10) 10
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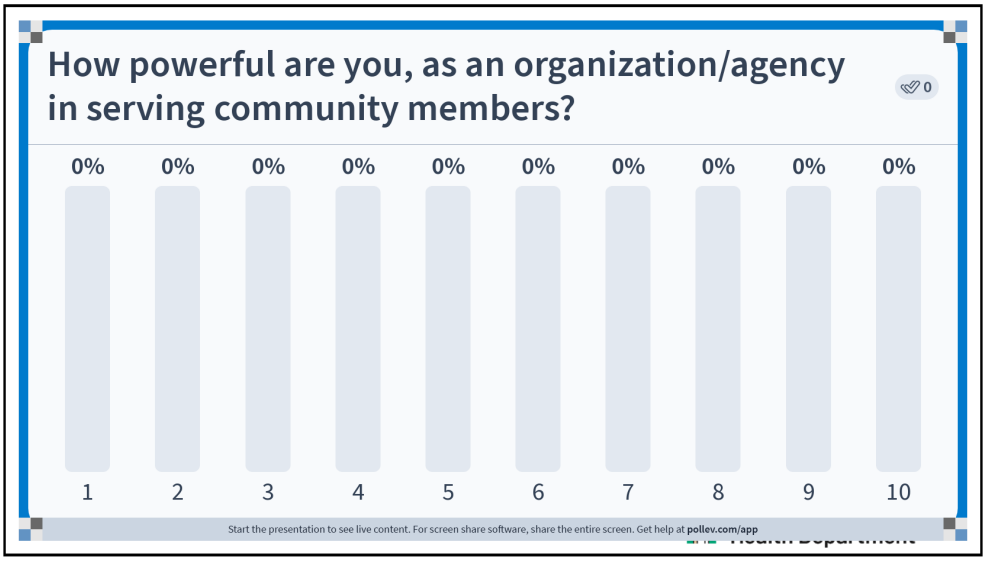
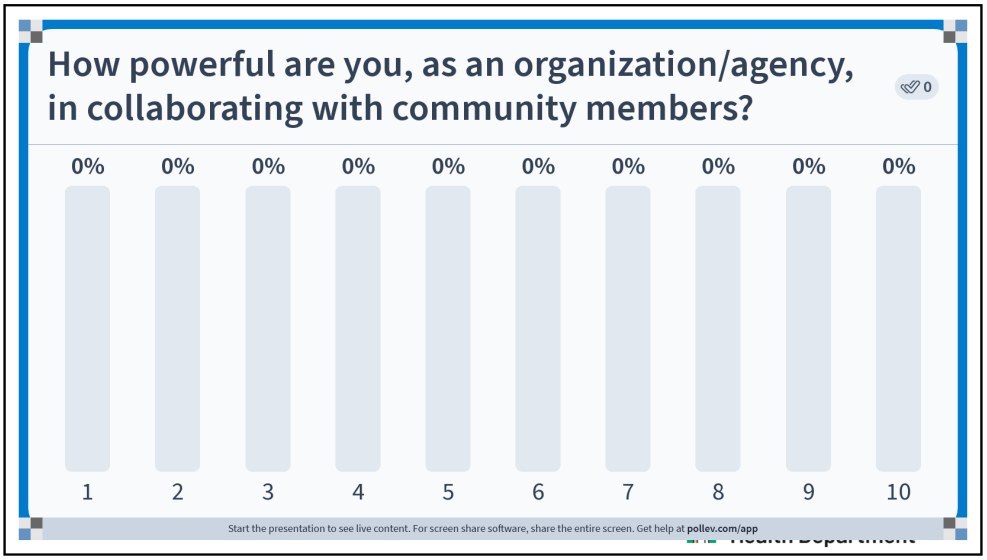
Power As An Organization/Agency


How powerful are you, as an organization/agency in serving community members?
0
0% 0% 0% 0% 0% 0% 0% 0% 0% 0%
1 2 3 4 5 6 7 8 9 10
Start the presentation to see live content. For screen share software, share the entire screen. Get help at pollev.com/app


How powerful are you, as an organization/agency, in collaborating with community members?
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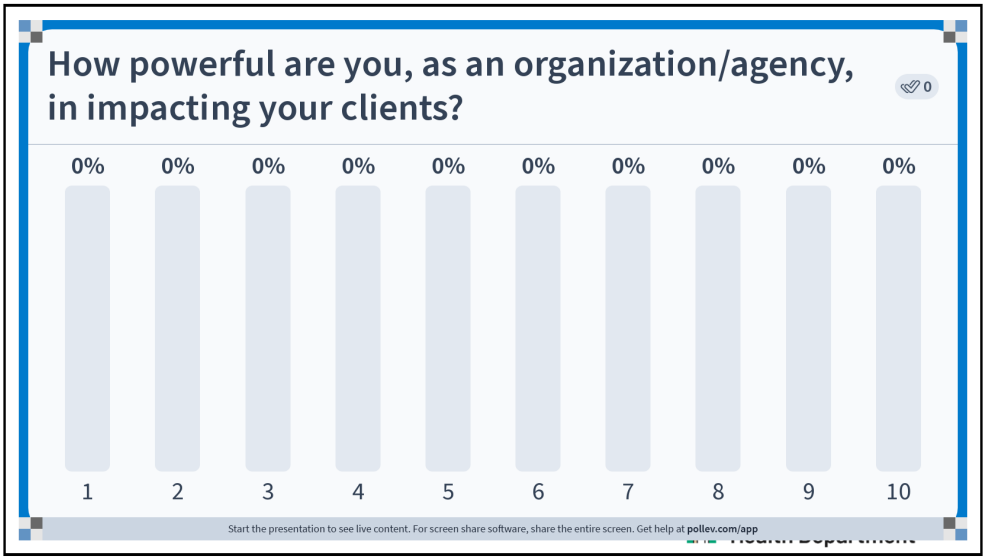
How powerful are you, as an organization/agency, in impacting your clients?
0
0% 0% 0% 0% 0% 0% 0% 0% 0% 0%
1 2 3 4 5 6 7 8 9 10
Start the presentation to see live content. For screen share software, share the entire screen. Get help at pollev.com/app


How effective is your organization/agency, in improving health outcomes?
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0% 0% 0% 0% 0% 0% 0% 0% 0% 0%
1 2 3 4 5 6 7 8 9 10
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Power As An Organization/Agency

Discussion Questions

- Why did you rank your organization/agency where you did?
- Would you change any of your rankings after hearing how others ranked themselves?

Winnebago County Health Department

Forms of Power

Forms of Power

- Positional
  - Comes from organizational authority or position
  - Often overlooked by those with power; rarely forgotten by those without it
- Referred
  - Comes from connection with others
- Expert
  - Comes from wisdom, knowledge, experience, and skills
- Ideological
  - Comes from idea, vision, or analysis
  - Original idea or thought
  - Ideal such as democracy, altruism, etc.

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Forms of Power

- Obstructive
  - The ability to coerce or block whether implicit, threatened, or demonstrated
- Personal
  - Manifestation of an individual's energy, vision, ability to community, capacity to communicate, capacity to influence, emotional intelligence, psychological savvy, etc.
- Co-powering
  - Origins in the Latinx community
  - Responsibility of individual leaders to mindfully work toward supporting the power of others through modeling, validating, and giving feedback

Winnebago County Health Department

Forms of Power

- Collaborative
  - Ability to join energies in partnership with others including teams, organizations, communities, coalitions, and movements.
- Institutional
  - Economic, legal, and political power directly wielded by institutions apart from the individuals who work there.
- Cultural
  - Norms and conditioning regarding race, class, sexual orientation, gender identification, and age that accrue power and privilege to the dominant group from the perspectives of oppressed peoples.
  - Consciousness of community or culture that serves to empower.

Winnebago County Health Department

Forms of Power

- Structural
  - Power covertly or implicitly exercised through dominant institutions of society.
- Transcendent
  - Comes from connection to something larger than the organization: Creator or Spirit, natural world, ancestral lineage, or the arc of history.

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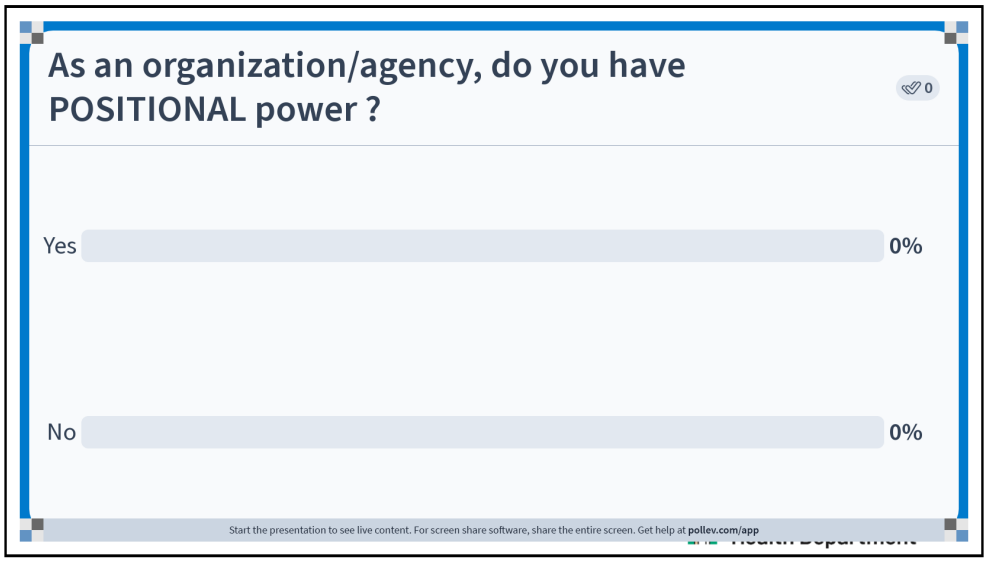
As an organization/agency, do you have POSITIONAL power ?
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Yes
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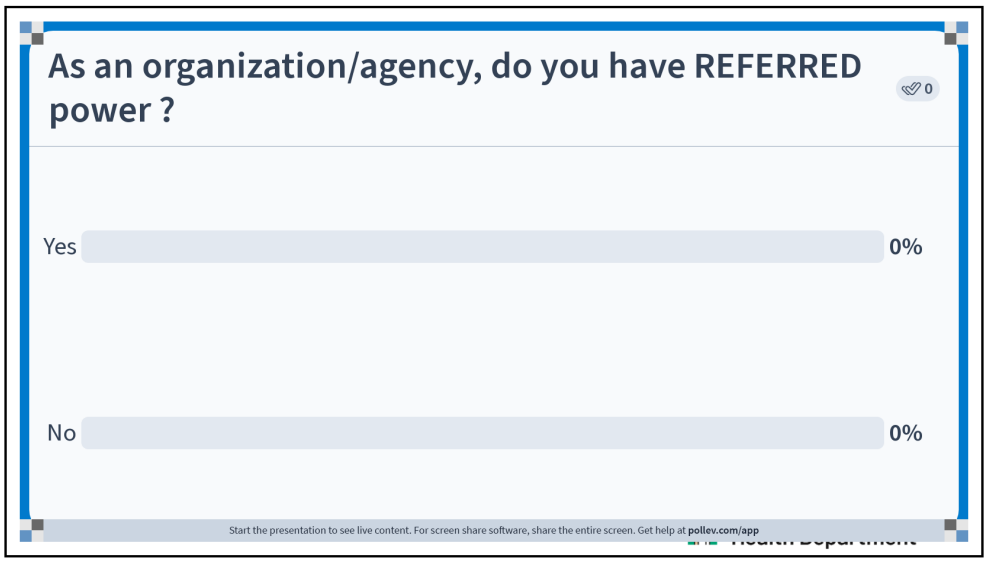
As an organization/agency, do you have REFERRED power ?
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Yes
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As an organization/agency, do you have EXPERT power?
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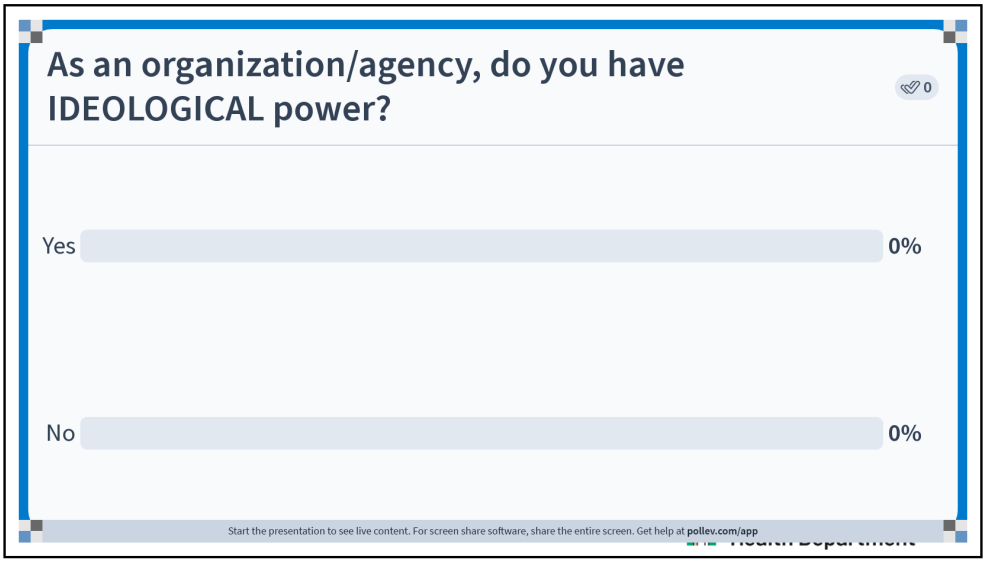
As an organization/agency, do you have IDEOLOGICAL power?
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Yes
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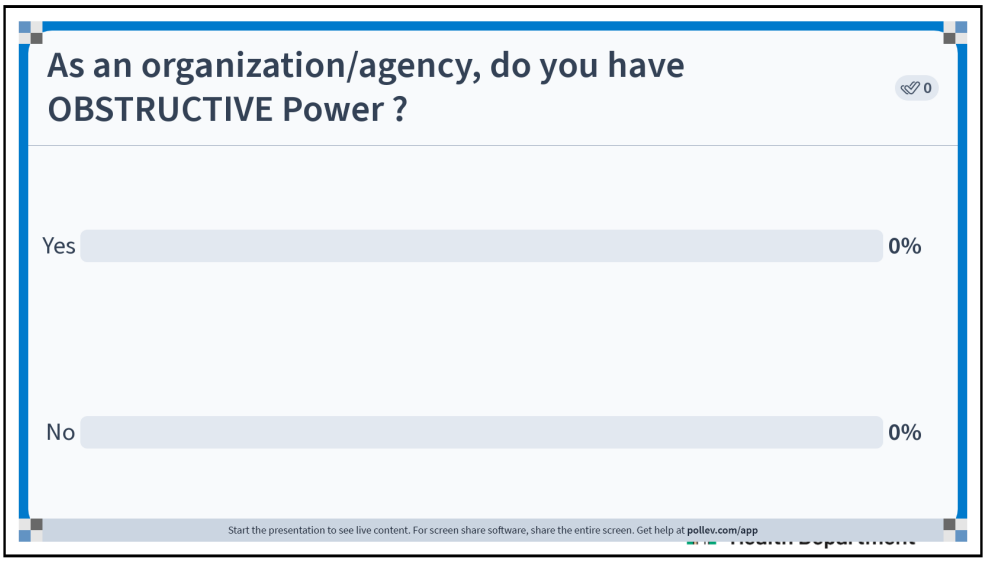
As an organization/agency, do you have OBSTRUCTIVE Power ?
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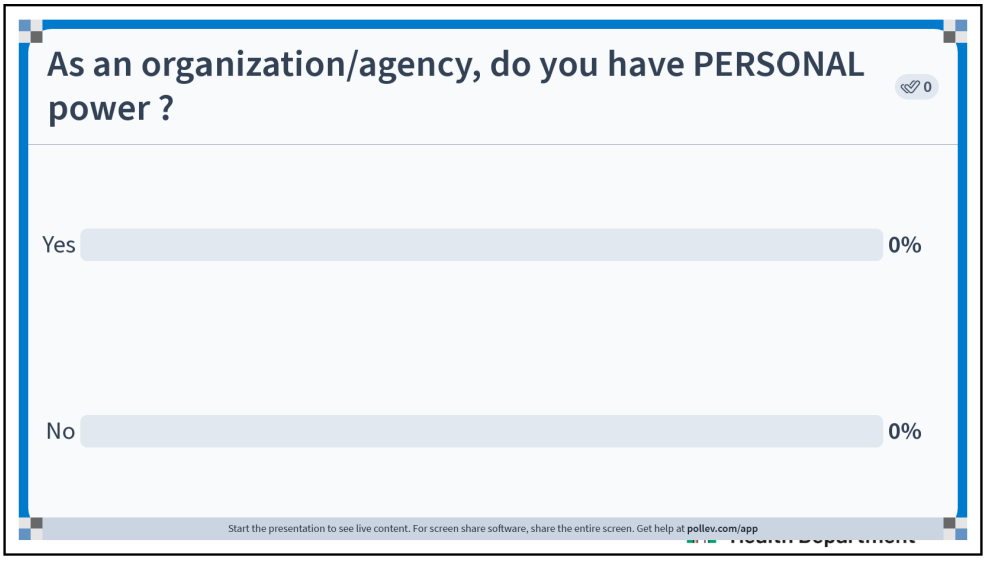
As an organization/agency, do you have PERSONAL power ?
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Yes
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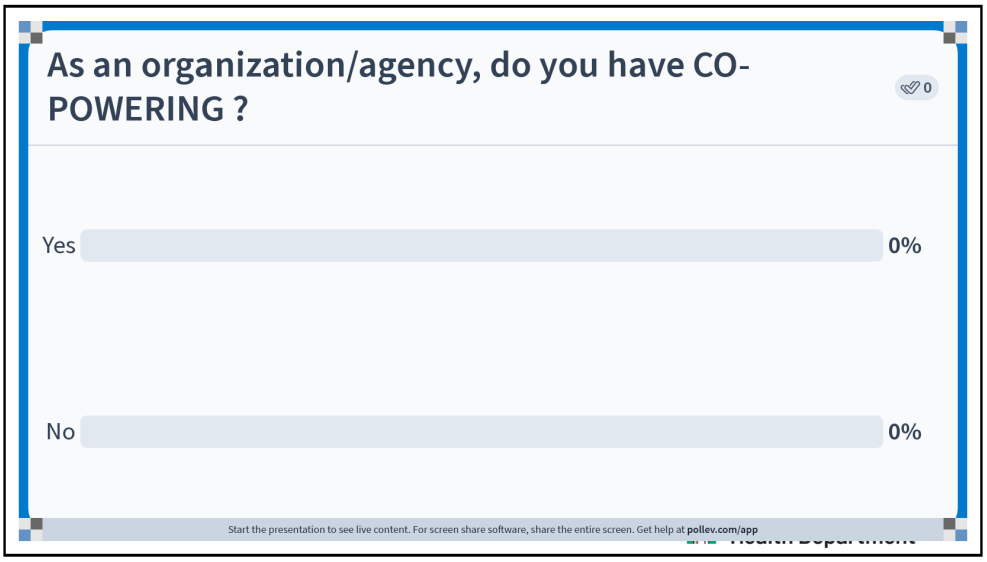
As an organization/agency, do you have CO-POWERING ?
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Yes
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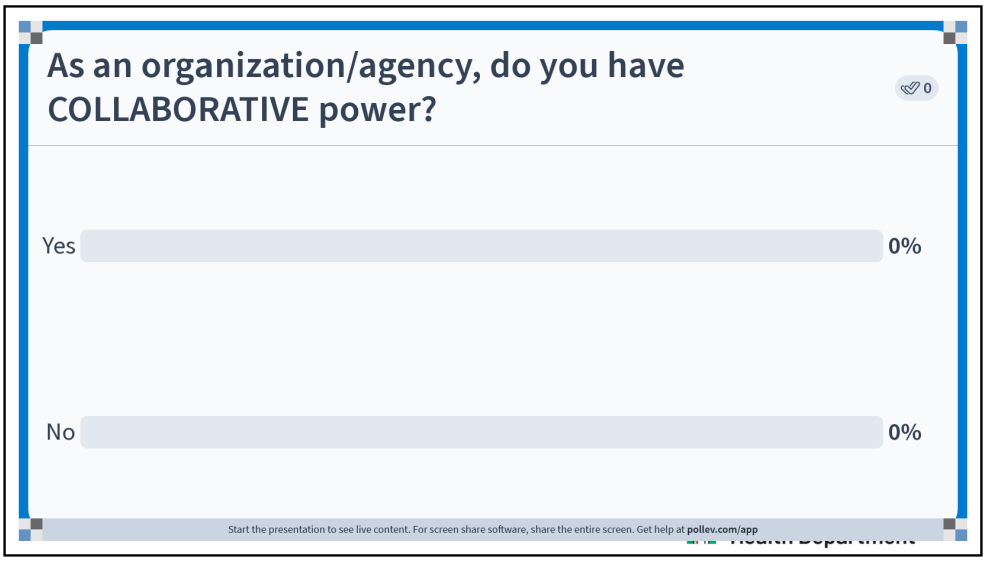
As an organization/agency, do you have COLLABORATIVE power?
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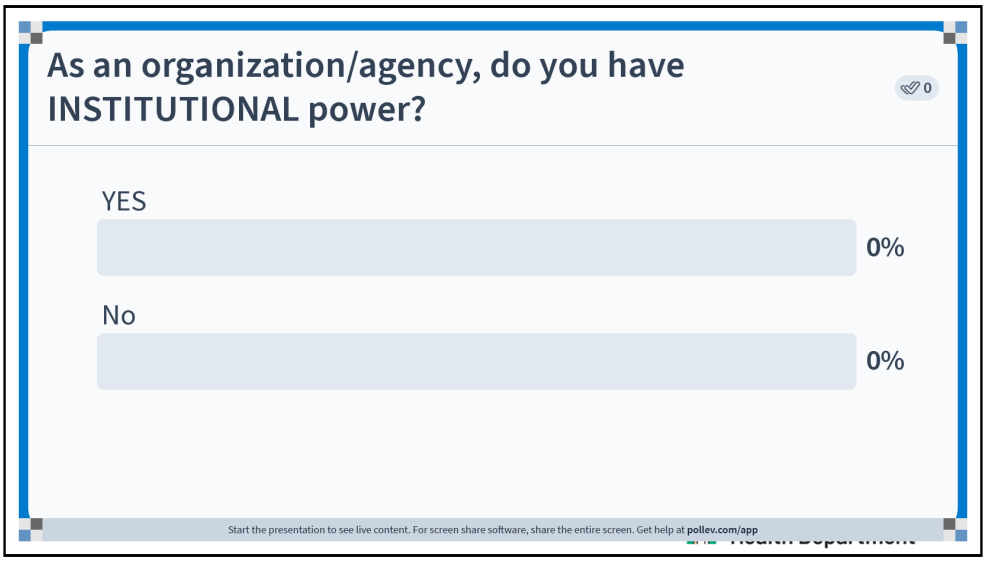
As an organization/agency, do you have INSTITUTIONAL power?
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YES
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As an organization/agency, do you have CULTURAL Power?
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No
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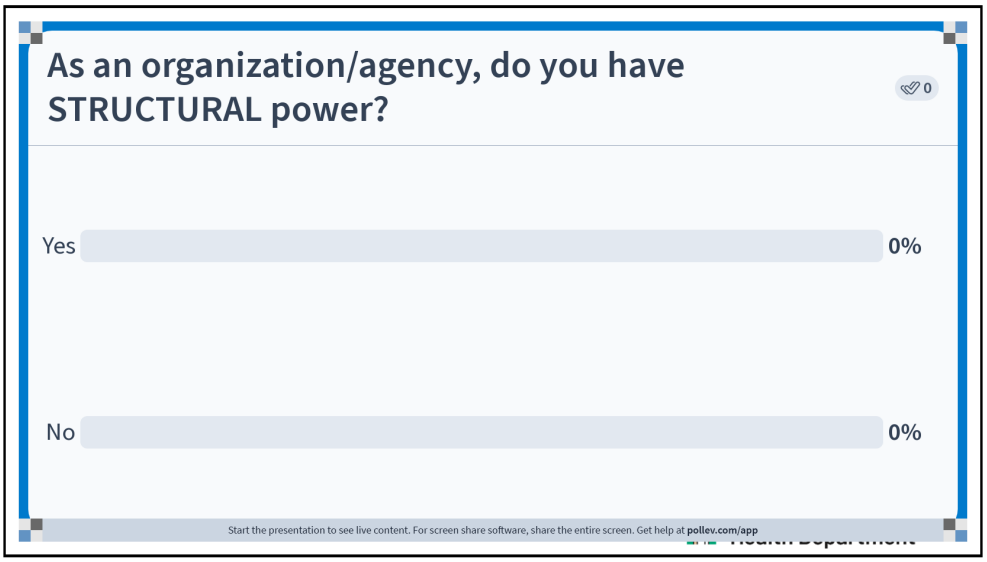
As an organization/agency, do you have STRUCTURAL power?
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Yes
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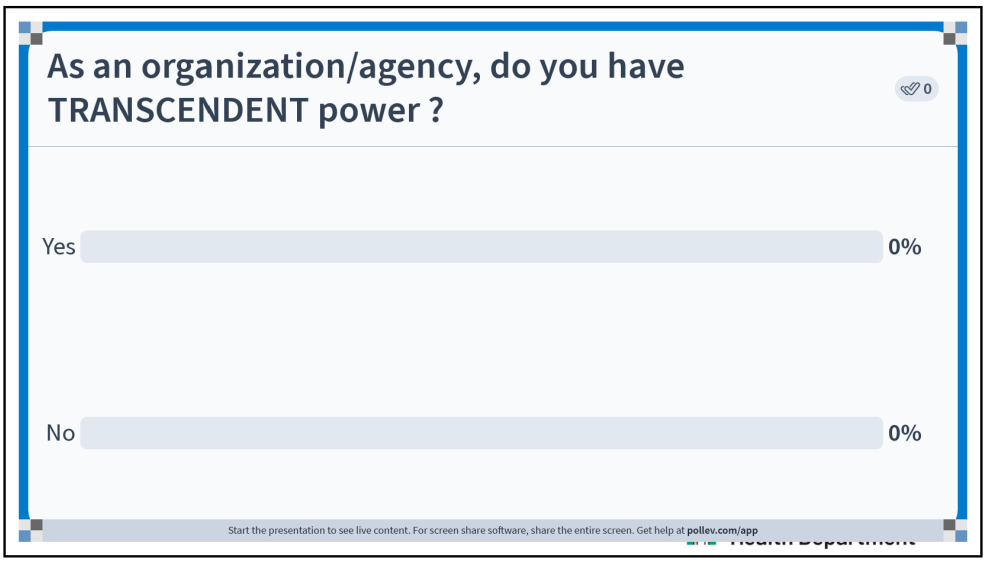
Start the presentation to see live content. For screen share software, share the entire screen. Get help at pollev.com/app


As an organization/agency, do you have TRANSCENDENT power ?
0
Yes
0%
No
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Start the presentation to see live content. For screen share software, share the entire screen. Get help at pollev.com/app

Identifying Our Collective Powers

- What forms of power do we have as community partner agencies?
- Where do we have the most consensus about our power?
- Where do we have less consensus about our power?
- On powers that we have a high consensus…
  - How can we work to share these powers with residents/community members?

Winnebago County Health Department

Power Up to Power With!

Your Role in MAPP 2.0/IPLAN

- Complete the Community Partner Assessment (CPA) for your organization/agency.
- Engage the community to complete the Community Context Assessment (CCA).
- Encourage focus group participation.

Power is infinite when shared…

SHARE YOUR POWERS!

Winnebago County Health Department

WCHD
Winnebago County Health Department

Serving Our Whole Community

Cynthia Hall, MPH
Patrick Ngum, MPH
Sandra Martell RN, DNP

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Winncohealth

Attachment C: Sample Email to Community Partners to complete Community Partner Assessment

Dear Community Partner,

Please take a short survey to sharing your experiences and challenges relevant to health in our community.

Our community is fortunate to have energized and engaged partners who are willing to work together to address health disparities and achieve health equity. Your participation in this survey is important in helping to build a safer, stronger, healthier community for all.

Click here to complete the Community Partner Assessment Survey

Thank you for being our **SUPER HEROES!** 

Dear Community Partner (spell out their name or say Hello),

Thank you for partnering with the Winnebago County Health Department to provide services for.....(make this personal – what do they do for your clients!).

Our community is fortunate to have energized and engaged partners who are willing to share their powers to address health disparities and achieve health equity. The next step in sharing your powers is to **click here to complete the Community Partner Assessment** by December 15.

Thank you for being our **SUPER HEROES!** 

(Our apologies if this is a duplicate request. Please complete only one survey.)

Attachment D: Examples of Forms of Power

Winnebago County Health Department

Examples of Forms of Power

Form of Power	Description	Examples
Positional	Comes from organizational authority or position - often overlooked by people with the power, rarely forgotten by those without it.	- A leadership structure at WCHD - Provide guidance for the community and staff
Referred	Comes from connections to others (e.g. a staff member without formal positional power but who has known the ED for years.	- Networking with other community organizations/individuals with referrals - We receive referrals because of relationships we have established in the community - Referrals from Swedish American, Crusader, providers in the community
Expert	Comes from wisdom, knowledge, experience & skills (e.g. someone who is widely respected because of their skills as an organizer.	- The community looks to WCHD for guidance on key public health concerns. - Collaborating with other community agencies/organizations who have expert knowledge on key services needed by community residence.
Ideological	Comes from an idea, vision, or analysis... it can be the original idea of an individual, an ideal such as “democracy" or "liberation, or a developed ideology.	- Winnebago County Health department Board of Health, Leadership and the community help provide our vision for the community - The community assessment helps us form the vision for the community - WCHD working with community partners on a shared vision of health equity.
Obstructive	Stems from the ability to coerce or block whether implicit, threatened, or demonstrated. Those without other sources of power may depend on it. Many activists are experts in its use.	- If an employee has idea to share with upper management and it is not given any consideration - When requesting funding (keeping people safe) Harm Reduction - Resistance to policy change, demonstrating/protesting. This can apply to mask requirements and other COVID related issues, as well as opposition to a women’s health clinic that offers abortions.
Personal	The manifestation of an individual's energy, vision, ability to communicate, capacity to influence, emotional intelligence, psychological savvy, etc.	- Influencers, spokesperson, employee milestones – personal recognition, personal connections
Co-powering	A term from the Latinx community that articulates the responsibility of individual leaders to mindfully work toward supporting the personal power of others through modeling, validating, and giving feedback	- Role model in the community that can point people in the right direction, provide resources to help people better themselves - Support group leaders, Sponsors

Winnebago County Health Department

Examples of Forms of Power

Form of Power	Description	Examples
Collaborative	Our ability to join our energies in partnership with others in pairs, teams, organizations, communities, coalitions, and movements.	- Farmer's Market - Two or more organizations coming together to support each other and the community - IGrow – home visiting referrals to 6 other HV agencies - Catholic Charities and Rock Valley – Refugee Program - Mission of Mercy – Free Dental Services - Youth care – insurance for any child in the state in Foster Care - DCFS, LSSI, and 8 other foster care agencies - Other health departments in the state - Week of the Young Child
Institutional	Economic, legal and political power directly wielded by institutions -whether a corporation, police department, or your own organization. It exists apart	- Different organizations/institutions can be influenced by outside factors - To maintain accreditation - Certain trainings must be completed through an approved organization - WIC Program must abide by federal guidelines - Family Planning must follow CDC Guidelines must follow evidenced based research - Mandated DCFS Reporters - HealthWorks must follow DCFS and YouthCare Policies
Cultural	The cultural norms and conditioning regarding race, class, sexual orientation, gender identification and age that accrue power and privilege to the dominant E group…. from the perspective of appressed peoples is also a consciousness of community or culture that serves to empower	- Health Equity - Grants with a focus on specific populations: Family Planning, Refugee, people living with HIV, programs with income guidelines
Structural	Power covertly or implicitly exercised through the dominant institutions of society (e.g. resistance to alternative medicine from the AMA and insurance providers or racism expressed and maintained through structures like red-lining by lending institutions)	- The vaccine guidelines from CDC - Political, corporations, religious institutions - Working with community partners to address establish/review policies.
Transcendent	Comes from our connection to something larger than ourselves: to the Creator or Spirit, the natural world, our ancestral lineage, or the act history.	- Based on human interpretation – people have different spiritual beliefs - We are made of individuals and transcendent power is real for some provides support, guidance, reassurance, and perspective

Attachment E: Forms of Power

Forms of Power

Positional

Organizational authority or position - often overlooked by people with the power, rarely forgotten by those without it.

Co-Powering

The responsibility of individual leaders to mindfully work toward supporting the personal power of others through modeling, validating, and giving feedback

Referred

Connections to others (e.g. a staff member without formal positional power but who has known the Executive Director for years.)

Collaborative

Our ability to join our energies in partnership with others in pairs, teams, organizations, communities, coalitions, and movements.

Experts

Wisdom, knowledge, experience & skills (e.g. someone who is widely respected because of their skills as an organizer.)

Institutional

Economic, legal and political power directly held by institutions. It exists apart from the individuals who work there at any one time. (eg. brand, membership, skills, etc.)

Ideological

From an idea, vision, or analysis. Can be from an original idea of an individual or of an ideal such as “democracy" or "liberation, or a developed ideology.

Cultural

The cultural norms and conditioning regarding race, class, sexual orientation, gender, and age that accrue power and privilege for the dominant group from the perspective of oppressed groups and is also a consciousness of community.

Obstructive

Ability to coerce or block which may be implied, threatened, or demonstrated. Those without other power may depend on it. Many activists use. (eg. Protests, spreading misinformation like with vaccines)

Structural

Power covertly or implicitly exercised through the dominant institutions of society (e.g. insurance providers influence on medical care or lending institutions maintaining racism by red-lining)

Personal

Manifestation of an individual's energy, vision, ability to communicate, capacity to influence, emotional intelligence, psychological savvy, etc.

Trancendent

Comes from our connection to something larger than ourselves: to the Creator or Spirit, the natural world, our ancestral lineage, or history.

Winnebago County Health Department

Partner Power

Rev.11/28/2023

Appendix F: Community Partner Assessment Survey Questions

Community Partner Assessment Survey (CPA) Survey Questions

Thank you for participating in the Mobilizing for Action through Planning and Partnerships (MAPP) Community Partner Assessment Survey (CPA), which helps to identify how we will improve our community's health together. Your organization plays a vital role in our Local Public Health System, which extends beyond healthcare. Survey responses will be summarized to help identify strengths and opportunities for collective health improvement in our community.

Things to Know

This survey should take 10-15 minutes. Your responses will be combined and summarized with all other responses. *Please submit only one completed survey per organization.*

Did you attend the Community Partner Workshop on November 29, 2023?

- ○ Yes
- ○ No

What did you like best about the Community Partner Workshop?

_____

Please list any area(s) for improvement regarding the Community Partner Workshop.

_____

Please list any suggestions for future Community Partner Workshops.

_____

About Your Organization

This section asks about your organization name, type, interest in participating in the Mobilizing for Action through Planning and Partnerships (MAPP), populations served and topic or focus areas.

What is the full name of your organization?

_____

Which best describes your position or role in your organization? (Select all that apply)

- ☐ Administrative staff
- ☐ Front line staff
- ☐ Supervisor (not senior management)
- ☐ Senior management level/unit or program lead
- ☐ Leadership team
- ☐ Community member
- ☐ Community leader
- ☐ Other: _____

Has your organization ever participated in a Community Health Improvement process?

- ○ Yes
- ○ No
- ○ Unsure

Which of the following best describe(s) your organization? (Check all that apply)

- ☐ Hospital Associated Healthcare System
- ☐ Federally Qualified Health Center
- ☐ Private clinic
- ☐ Public clinic
- ☐ Emergency response
- ☐ Schools/education (PK–12)
- ☐ College/university
- ☐ Library
- ☐ Non-profit organization

- [ ] Grassroots community organizing group/organization
- [ ] Tenants' association
- [ ] Social service provider
- [ ] Housing provider
- [ ] Mental health provider
- [ ] Neighborhood association
- [ ] Foundation/philanthropy
- [ ] For-profit organization/private business
- [ ] Faith-based organization
- [ ] Center for Independent Living
- [ ] Long term care
- [ ] County health department
- [ ] State health department
- [ ] Other city government agency
- [ ] Other county government agency
- [ ] Other state government agency
- [ ] Other: _____

What are your organization's top three interests in participating in the Community Health Improvement process?

- [ ] Deliver programs effectively and efficiently and avoid duplicating efforts
- [ ] Pool resources
- [ ] Increase communication among groups
- [ ] Break down stereotypes
- [ ] Build networks and relationships
- [ ] Revitalize groups that are trying to do too much alone
- [ ] Engage community groups that are working independently on similar issues
- [ ] Plan and launch community-wide initiatives
- [ ] Develop and use political power to advocate for services or other benefits for the community
- [ ] Improve communication from communities to government decision-makers
- [ ] Improve communication from government to communities
- [ ] Create long-term, sustainable social change
- [ ] Obtain or provide services for your clients
- [ ] Gain access to data
- [ ] Improve public relations
- [ ] Other: _____

Demographics and Characteristics of Clients/Members Served/Engaged by Your Organization

Does your organization focus on a specific racial or ethnic population?

- ○ Yes
- ○ No
- ○ Unsure

What racial/ethnic populations does your organization work with? (Check all that apply)

- ☐ Black/African American
- ☐ African
- ☐ Native American/Indigenous/Alaska Native
- ☐ Latinx/Hispanic
- ☐ Asian
- ☐ Asian American
- ☐ Pacific Islander/Native Hawaiian
- ☐ Middle Eastern/North African
- ☐ White/European
- ☐ Other: _____

Does your organization work with immigrants, refugees, asylum seekers, and/or other populations who speak English as a second language?

- ○ Yes
- ○ No
- ○ Unsure

What populations do you serve?

_____

Does your organization offer services tailored to transgender, nonbinary, and other members of the LGBTQIA+ community?

- ○ Yes—we provide services tailored to the transgender, nonbinary, and other LGBTQIA+ community
- ○ Somewhat—we provide other services and transgender, nonbinary, and other LGBTQIA+ individuals could use those services
- ○ No—services are not available to transgender, nonbinary, and other LGBTQIA+ populations
- ○ Unsure

Does your organization offer services designed for people with disabilities?

- ○ Yes—we provide services designed for people with disabilities
- ○ Somewhat—we are wheelchair accessible and compliant with the American Disabilities Act but are not specifically designed to serve people with disabilities
- ○ No—our organization is not specifically designed to serve people with disabilities
- ○ Unsure

Does your organization work with other populations or groups that are not addressed in the previous questions?

- ○ Yes
- ○ No
- ○ Unsure

Please list these groups:

What languages do staff at your organization speak? (Check all that apply)

- ☐ English
- ☐ Spanish
- ☐ Chinese (Mandarin, Cantonese, Hokkien, etc.)
- ☐ Tagalog (Filipino)
- ☐ Vietnamese
- ☐ French and French Creole
- ☐ Arabic
- ☐ American Sign language
- ☐ Other: _____

☐ Are there things we should know about your organization or community you serve that we haven't asked in the previous questions? *Optional*

How much does your organization focus on the following social determinates of health: Primary focus represents the main focus or capacity of the organization Secondary focus means we can address this aspect internally but it is not the primary focus Refer (We do not have internal capacity to address this and we refer to other organizations) We do not address this topic Unsure

	Primary Focus	Secondary Focus	Refer Out	Topic is not addressed	Unsure
Economic Stability	○	○	○	○	○
Education Access and Services	○	○	○	○	○
Healthcare Access and Quality	○	○	○	○	○
Neighborhood and Built Environment	○	○	○	○	○
Social and Community Context	○	○	○	○	○

What programs and services does your organization provide for the community? (Check all that apply)

- [ ] Arts and culture
- [ ] Business and for-profit organization
- [ ] Criminal legal system
- [ ] Disability/independent living
- [ ] Early childhood development/childcare
- [ ] Education
- [ ] Community economic development
- [ ] Economic security
- [ ] Environmental justice/climate change (conservation)

- [ ] A Faith Community
- [ ] Family well-being
- [ ] Financial institutions (e.g., banks, credit unions)
- [ ] Food access and affordability (e.g., food bank)
- [ ] Food service/restaurant
- [ ] Gender anti-discrimination/equity
- [ ] Government accountability
- [ ] Healthcare access/utilization
- [ ] Housing
- [ ] Human services

- [ ] Immigration
- [ ] Jobs/labor conditions/wages and income support
- [ ] Land use planning/development
- [ ] LGBTQIA+ anti-discrimination/equity
- [ ] Parks, recreation, and open space
- [ ] Public health
- [ ] Public safety/violence prevention
- [ ] Racial justice
- [ ] Seniors/elder care
- [ ] Transportation
- [ ] Utilities
- [ ] Veterans' issues
- [ ] Youth development and leadership
- [ ] Other: _____

Organizational Commitment to Equity

If your organization has a shared definition of equity or health equity, please enter it below.

_____

We have at least one person in our organization dedicated to addressing diversity, equity, and inclusion internally and externally in our community.

- ○ Yes
- ○ No
- ○ Unsure

What are the barriers you have encountered while working on equity/health equity for your organization?

- ☐ Community resistance
- ☐ Staff resistance
- ☐ Staff shortages
- ☐ ⊗No barriers

Organizational Accountability

In 1–2 sentences, describe the people impacted by the work of your organization. *Optional*

_____

To whom is your organization accountable? This could be who has power over your organization's decision-making—for example, city government agencies may be accountable to the mayor or city council; a business

may be accountable to its shareholders; and an organizing group may be accountable to its members. (Check all that apply)

- [ ] Mayor, governor, or other elected executive official
- [ ] City council, board of supervisors/commissioners, or other elected legislative officials
- [ ] State government

- [ ] Federal government
- [ ] Foundation
- [ ] Community members
- [ ] Members of the organization/association
- [ ] Customers/clients
- [ ] Board of directors/trustees
- [ ] Internal and External Advisory Board
- [ ] Shareholders
- [ ] Voters
- [ ] Voting members
- [ ] National/parent organization
- [ ] Other government agencies
- [ ] Other: _____

Organizational Capacities as Part of the Public Health System

Does your organization regularly engage in the following activities? (Check all that apply)

☐ **Assessment**: My organization conducts assessments of living and working conditions and community needs and assets.

☐ **Investigation of Hazards:** My organization investigates, diagnoses, and addresses health problems and hazards affecting the population.

☐ **Communication and Education**: My organization works to communicate effectively to inform and educate people about health or well-being, factors that influence well-being, and how to improve it.

☐ **Community Engagement and Partnerships**: My organization works to strengthen, support, and mobilize communities and partnerships to improve health and well-being.

☐ **Policies, Plans, Laws:** My organization works to create, champion, and apply policies, plans, and laws that impact health and well-being.

☐ **Legal and Regulatory Authority**: My organization has legal or regulatory authority to protect health and well-being and uses legal and regulatory actions to improve and protect the public's health and well-being.

☐ **Access to Care:** My organization provides healthcare and social services to individuals or works to ensure equitable access and an effective system of care and services.

☐ **Workforce**: My organization supports workforce development and can help build and support a diverse, skilled workforce.

☐ **Evaluation and Research:** My organization conducts evaluation, research, and continuous quality improvement and can help improve or innovate functions.

☐ **Organizational Infrastructure**: My organization is helping build and maintain a strong organizational infrastructure for health and well-being.

☐ Other _____

☐ ⊗**Unsure**

Capacity to Support Community Health Improvement The following questions ask about your organization's experience collecting data, engaging community members, advocating for policy change, and communicating with the public.

Data Access and Systems

Does your organization collect data?

- ○ Yes
- ○ No
- ○ Unsure

Does your organization conduct assessments (e.g., of basic needs, community health, neighborhood, other)?

- ○ Yes
- ○ No
- ○ Unsure

How does your organization collect data? (Check all that apply)

- ☐ Surveys
- ☐ Focus groups
- ☐ Interviews
- ☐ Feedback forms
- ☐ Photovoice or other participatory research

- [ ] Notes from community meetings
- [ ] Videos
- [ ] Secondary data sources
- [ ] Electronic health records
- [ ] Data tracking systems
- [ ] Other: _____
- [ ] ⊗None of the above/we don't collect data

Does your organization analyze data with a health equity lens?

- ○ Yes
- ○ No
- ○ Unsure

Community Engagement Practices

Which of the following methods of community engagement does your organization use regularly? (Check all that apply):

- [ ] Customer/patient satisfaction surveys
- [ ] Fact sheets
- [ ] Open houses
- [ ] Presentations
- [ ] Billboards
- [ ] Videos
- [ ] Public comment
- [ ] Focus groups
- [ ] Community forums/events
- [ ] Surveys
- [ ] Community organizing
- [ ] Advocacy
- [ ] House meetings
- [ ] Interactive workshops
- [ ] Polling

- [ ] Memorandums of understanding (MOUs) with community-based organizations
- [ ] Citizen advisory committees
- [ ] Open planning forums with citizen polling
- [ ] Community-driven planning
- [ ] Consensus building
- [ ] Participatory action research
- [ ] Participatory budgeting
- [ ] Social media
- [ ] Other: _____
- [ ] ⊗We do not do community engagement

Policy, Advocacy, and Communications

Does your organization engage in external policy or advocacy work?

- ○ Yes
- ○ No

Does your organization regularly engage in external communication?

- ○ Yes
- ○ No
- ○ Unsure

What methods does your organization use to communicate? (Check all that apply)

- ☐ Internal newsletters to staff
- ☐ External newsletters to members/the public
- ☐ Ongoing and active relationships with local journalists and earned media organizations
- ☐ Social media outreach (e.g., on Facebook, Twitter, Instagram)
- ☐ Ethnicity-specific outreach in non-English language
- ☐ Press releases/press conferences
- ☐ Data dashboard
- ☐ Meet internally to discuss narrative and messaging to the public
- ☐ Other: _____

Our organization uses an equity lens that we use for our external communications and engagement work.

- ○ Strongly agree
- ○ Somewhat agree
- ○ Somewhat disagree
- ○ Strongly disagree
- ○ Unsure

Please add any questions, comments, or suggestions about the Winnebago County Health Department MAPP process and our how we can work together to improve community health: *Optional*

_____

Winnebago County
Health Department

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