

ALAMANCE COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

*Partnering with the community to connect social drivers,
leverage resources, and develop strategies to improve community health*

A Guide for
Community
Partnership

Table of Contents

| | |
|---|----|
| EXECUTIVE SUMMARY | 2 |
| Health Equity Lens | 3 |
| Health Equity Collective | 4 |
| Why a Racial Analysis is Necessary and Transformative? | 4 |
| Capstone Team Recommendations | 4 |
| Overview of CHIP Purpose and Process | 6 |
| INTRODUCTION | 6 |
| How to Use this CHIP | 7 |
| List of Health Priorities | 8 |
| Definitions (in alphabetical order) | 8 |
| Monitoring and Accountability | 10 |
| PRIORITY AREA: Access to Care | 11 |
| PRIORITY AREA: Education | 16 |
| PRIORITY AREA: Economic Issues | 19 |
| Attachment 1: | 21 |
| Hospital & Public Health Requirements related to Implementation Planning | 21 |
| Attachment 2: | 22 |
| North Carolina Institute of Medicine (NCIOM) 2030 Indicators | 22 |
| Attachment 3: | 23 |
| UNC Gillings School of Global Public Health/Healthy Alamance Capstone Team Recommendations Report | 23 |
| Bibliography | 37 |

EXECUTIVE SUMMARY

Following the release of the 2018 Alamance County Community Assessment, the Alamance County Health Department embarked on a process to develop a Community Health Improvement Plan (CHIP). A CHIP is a community-wide, collaborative strategic plan that sets priorities for health improvement and engages partners and organizations to develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of a community and a framework for organizations to use in making that vision a reality.

Alamance County has a long history of collaboration between the health department and the hospital in developing a community assessment. Over the years, agencies have joined the team, allowing for a cross-sectoral approach. The 2018 assessment process is Alamance County's most collaborative process to date, incorporating community residents into all phases of the process. These include conducting seven focus groups among five communities (LGBTQ, Female Head of Household, Occaneechi Band of the Saponi Nation, Parents of Children with Disabilities, and LatinX) in 2018, inviting participants to join the Community Assessment Team, summarizing the themes from the focus groups, planning and executing a community forum.

Key findings - The following themes emerged from the focus groups:

Theme #1: Lack of Trust in Healthcare System

Theme #2: Having to Go Above and Beyond to Access Healthcare

Theme #3: Health and its Connection to Social Well-Being

Theme #4: How Does Infrastructure Play a Role in Health of Communities

Theme #5: Job Stability

To capture the narratives of individuals who have been least well-represented historically, the Community Assessment Team incorporated Community Based Participatory Research (CBPR) tools into the assessment process.

The focus groups represent individuals from five diverse groups across Alamance County. The findings represent the obstacles people face in accessing the resources they need most, and the challenges traditional institutions face in rethinking their solutions to providing care. Five themes emerged from the review of minutes and audio recordings. Each represents an opportunity for residents and organizations to partner together to build trust and recognize the value of bringing discussions of social well-being and nutrition (specific to access) to the patient well and sick visits. They also create opportunities for municipalities and human service agencies to develop strategies for supporting residents as they transition from receiving subsidies and support to being sustainably and successfully employed. Other opportunities include how to use available resources within communities to create better and more satisfying experiences for patients receiving healthcare. These discussions encourage us to rethink how to make healthcare services available in the community easier to access and to share responsibility across multiple organizations to provide the most comprehensive and service-oriented care.

The Alamance County Community Forum was held February 20, 2019, 6-8:00 pm at the Mayco Bigelow Community Center in North Park with 153 people registered to attend. It is estimated 130 attended; including residents, community partners, and an elected official. The forum was developed in collaboration with community residents as part of incorporating the CBPR approach and served as a catalyst for focus group participants to present their findings and move towards a new partnership with the community to develop strategies for addressing health priorities. It was advertised on social media, flyers, through community events, and by email with the intention of having as many members of the community at the table as possible.

The following themes emerged from the tabletop exercises:

- Focus development efforts on urban/rural divide by prioritizing opportunities for people of color to create small business enterprise
- Partner with those most impacted by the issues being discussed
- Create permanent solutions to issues of access; not popup or temporary ones
- Focus on improving education in Alamance County, recognizing that opportunities to create career paths for children whose families cannot afford to send them to college
- Education to the community is needed, demonstrating the value of small business to the broader community for the community to support it
- Residents want organizations and agencies to acknowledge systemic racism and address it in order to improve quality of life
- Hold property owners accountable for conditions of their properties
- Add mixed income housing and intergenerational housing to create community
- To stop isolating people into bubbles by income
- Create specific strategies that address the unique needs of different cultures and ages regarding access to care, education, and economy



Health Equity Lens

Applying a health equity lens to the Community Health Assessment and Community Health Improvement Plan shifts the way institutions make decisions. When this approach is used, it shifts the focus away from the individual and requires a community to consider whether its policies and procedures are equitable and lead to positive health outcomes for everyone. It is public health at its very essence.

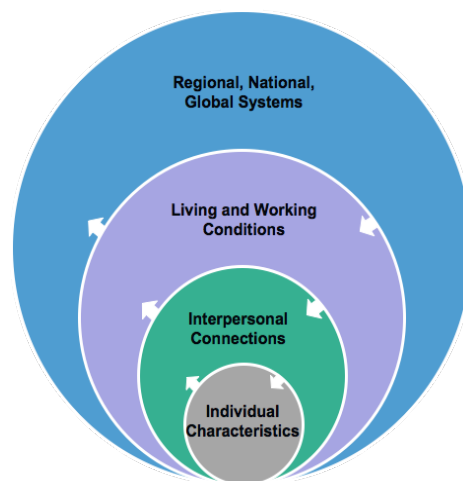
Health Equity Collective

The Healthy Alamance-Elon University Community-Academic Partnership conducted a Photovoice project in April 2019 with members of the Community Assessment Team, focus group participants, additional agencies, businesses, and interested community residents as space and funding allowed. Upon completion of the five photovoice sessions, the group created the Alamance County Health Equity Collective. This collective will determine the best ways to support equity issues, is participating in the development of the Community Health Improvement Plan (CHIP) and creating innovative strategies to better address the community priorities.

Why a Racial Analysis is Necessary and Transformative?

Racial disparities in health outcomes exist for most physical and mental health issues, even when considering other factors like socioeconomic status and access to health insurance. Because race is the primary predictor for health outcomes, it is critical to apply a racial analysis in order to successfully reduce and eliminate disparities gaps. Race is the “social interpretation of our physical appearance in a given place and time” (Jones, 2008). Despite scientific evidence that demonstrates there is no biological or genetic basis for “race,” the impact of racism in our society is real. An analysis of racial health disparities that is “race neutral,” or does not consider the ways that racism impacts outcomes, can result in a widening of disparities gaps. A focus on population health without the consideration of racial inequities can mask progress - overall population health can improve while the racial gaps in health simultaneously worsen. Therefore, it is imperative to document health outcomes based on race, set goals that explicitly aim to reduce racial disparities in addition to improvements in overall health, and to better understand the ways that racism is embedded in our systems, structures, policies, practices, and behaviors so that we can disrupt those pathways to ultimately improve health equity.

Capstone Team Recommendations



The intent of the Capstone project recommendations are to assist the Healthy Alamance - Elon University Public Health community-academic partnership (health equity community partnership) with applying an equity lens generally, and a racial equity specifically, to the revision of the community health improvement plan, making relevant recommendations to task forces and coalitions that focus on public health outcomes in Alamance County.

While the impact of structural and institutional racism has been increasingly identified as an important contributor to health inequities, interventions, programs and policies to address the ways that structural and institutional racism create, reproduce, and maintain health inequities are few. These recommendations support public health efforts in Alamance County so that there is a stronger emphasis on addressing these important contributors to poor health.

The Capstone team engaged in racial equity analysis education, attended related meetings, performed an extensive literature review, conducted 13 interviews, wrote a recommendation report, and presented findings to preceptors and community organizations on November 21, 2019. The 13 interviews featured the perspectives of members of the Alamance Wellness Collaborative (AWC), Alamance Food Collaborative (AFC), Health Equity Collective (HEC), and the Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) team. In these conversations, the team sought out to better understand the state of health and racial equity across the county, as well as, the ways in which challenges can be overcome. Many of the themes present in the interview were reflected in the findings captured in the literature review. Those interview findings were interwoven with the literature review findings to formulate a series of recommendations included in this CHIP.

Recommendations **pg.23:**

1. Facilitators to a Multi-Level Approach
 - a. Recommendation 1.1: Bring in an external facilitator to hold racial equity conversations
 - b. Recommendation 1.2: Break down silos - between groups and within the community
 - c. Recommendation 1.3: Create multi-sector collaboration
2. Individual-level Recommendations:
 - a. Recommendation 2.1: Acknowledge the power that you have as an individual to shape racial equity efforts into the work you do daily
 - b. Recommendation 2.2: Participate in implicit bias training on an ongoing basis
 - c. Recommendation 2.3: Engage in diverse media (e.g., books, podcasts, movies, exhibitions, articles)
3. Built Environment
 - a. Recommendation 3.1: Include and seek out the voices from a broad range of experts, including a variety of professionals and local community members, when conducting built environment assessments
 - b. Recommendation 3.2: Co-locate services
 - c. Recommendation 3.3: Support policy changes that foster more equitable built environment
 - d. Recommendation 3.4: Embed “Health in All Policies” strategies in community development efforts
4. Collaborative-level Approaches

- a. Recommendation 4.1: Track metrics and create standards around the community representativeness of advisory boards, such as coalitions/boards, collaboratives, collectives, and community advisory boards, to shift representation and power
 - b. Recommendation 4.2: Hold ongoing and required racial equity trainings for group members during collaborative meetings (i.e. Racial Equity Institute, other types of trainings, guest speakers)
 - c. Recommendation 4.3: Hold required trainings on health equity frameworks for group members during collaborative meetings
 - d. Recommendation 4.4: Create clearly defined mission statements that center health and racial equity
 - e. Recommendation 4.5: Shift scope of work to address more upstream determinants of health
 - f. Recommendation 4.6: Embed community-based participatory approaches into organizational work
 - g. Recommendation 4.7: Transparently communicate efforts and progress of collaboratives to communities
 - h. Recommendation 4.8: Clarify who is responsible for the work
5. Systems-level Approaches
- a. Recommendation 5.1: Prioritize and measure equity in community health initiatives
 - b. Recommendation 5.2: Create policy change that supports health equity across the county

Overview of CHIP Purpose and Process

A Community Health Improvement Plan (CHIP) is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement. The goal is that with constant and focused effort, a wide range of public health partners and stakeholders engaged in assessment, planning and action will be able to document measured improvements in the selected health priorities in the upcoming years. This CHIP is in no way meant to detail all the health issues in front of Alamance County and its community nor is it able to offer information on all the wonderful programs and initiatives that are taking place here in our community. This CHIP is, however, an action-oriented strategic plan that outlines the priority health issues recognized for Alamance County from the 2018 Community Health Assessment. Its main intention is to provide an overview of how these issues will be addressed in the next three years.

INTRODUCTION

A Community Health Improvement Plan, or CHIP, is an action-oriented strategic plan outlining the priority health issues for a defined community, and how these issues will be addressed, including strategies and measures, to ultimately improve the health of the community. CHIPs are created through a community-wide, collaborative action planning process that engages partners and organizations to

develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement. The community health improvement process is interactive and involves continuous monitoring; we plan to release an annual update of this document during a community forum. The next community health assessment will be conducted in 2021.

This CHIP is intended to help focus and solidify each of our key partner agency's commitment to improving the health of the community in specific areas. The goal is that through sustained, focused effort on this overarching framework, a wide range of public health partners and stakeholders engaged in assessment, planning, and action will be able to document measured improvement on these key health issues over the coming years. The next phase will involve broad implementation of the strategies detailed in this CHIP, monitoring/evaluation of the CHIP's disparity information, and partnering to hold an annual community forum and the report out to the community using the State of the County's Health Report (SOTCH). This 2019 CHIP is focused on creating plans within a ten-year timeline.

The goals are specific to addressing disparity and there is a commitment to phased implementation:


2020-2023 *Strategies focus on commitments to an equity approach and evaluation of existing policies and procedures creating barriers to care and quality of life while adopting recommendations that can be implemented in the short-term.*

2023 - 2026 *Strategies will focus on results from reviews and implementation of some recommendations that require more extensive partnership commitments to resources like co-location.*

2026-2029 *Strategies will evaluate the above to address any drift occurring in results, focusing on institutional culture. Priority will be given to trending data for identified disparities, review of lessons learned, and opportunities acquired funding may provide to expand on disparity work.*

How to Use this CHIP

This CHIP is designed to be a broad, strategic framework for community health, and will be a "living" document that will be modified and adjusted as conditions, resources, and external environmental factors change. It has been developed and written in a way that engages multiple voices and multiple perspectives. We are working towards creating a unified effort that helps improve the health and quality of life for all people who live, work, and play in the County. We encourage you to review the priorities and goals, reflect on the suggested strategies, and consider how you can join this call to action: individually, within your organization, and collectively as a community.

To learn more about indicators of health, please refer to the North Carolina Institute of Medicine (NCIOM) Indicator section  pg. 22

List of Health Priorities

Access to Care

Education

Economy

Community health action plans have been developed to address the identified health priorities. Each action plan will include evidence-based strategies that focus on system or policy change, target specific disparate groups and promote individual, family, or community change.

Definitions (in alphabetical order)

- **Community** → a fluid and evolving grouping of people bonded by geographical proximity (or closeness), shared interests, and/or social identity/identities
 - This document pays careful attention to the fluidity of ‘community’ while working to ground itself for clarity and accountability. For the purposes of this CHIP document, the CHIP Team sees Alamance County as a broader community with innumerable, overlapping professional, personal, and familial communities within its current charted boundaries. The Team understands that the term ‘community’ can, and should not be used as a sweeping generalization, and that not all communities within the County have been reached. The Team is committed to collaborating for the creation of space for those who are also interested in bolstering the health equity across the County. The CHIP Team is also committed to ‘naming’ and lifting specific communities for clarity.
- **Community Based Participatory Research (CBPR)** → Community Based Participatory Research (CBPR) is an approach to research that equitably involves community members, practitioners, and academic researchers in all aspects of the process, enabling all partners to contribute their expertise and share responsibility and ownership (Israel, et al., 2010)
- **Equity** → the absence of socially, economically, and/or demographically determined differences among groups
 - Equity can be achieved in relation to any number of things. The CHIP team has shifted its focus to illuminate racial inequities and health inequities across the County.
- **Gentrification** → the displacement of lower income families by higher income families
- **Goal** → a goal is a more concrete way to work towards impacting a priority
 - Goals are a mid-level approaches to contributing to a priority. They can still be rooted in systems change and create a more solid infrastructure for strategic action. Systems, such as the S.M.A.R.T. goal setting approach, create accountability measures that clearly lay out expectations.
 - S. M. A. R. T. Goal = Specific, Measurable, Attainable, Realistic, and Time-bound
- **Indicator** → a way to measure, or assess, change
- **Infant mortality** → the number of babies who pass away before their first birthday
 - Infant mortality rate (IMR) → the number of deaths under one year of age per 1,000 live births
- **LatinX** → a term used to refer to those with Latin American backgrounds; an intersectional term that includes the wide range of gender identities and expressions of those with Latin American backgrounds

- **Maternal mortality** → the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes
- **Medicaid** → a federally supported program that helps those with lower incomes receive health care; the program also supports those who are pregnant, the elderly, young children, and those with disabilities
- **Mixed-income housing** → the composition, or make up, of a housing area or neighborhood based on income; a percentage of a development which would be affordable; with this model, some high, some middle, and some low income families would live in the same neighborhood
- **Mixed-use housing** → housing and commercial properties in proximity (e.g., apartments over a retail location)
- Population health → the condition(s) of an overarching, or broader, community or population; usually on a larger/national scale; does not typically account for unique conditions present in smaller groups
- **Priority** → a higher-level area of focus with the capacity to be further grounded in concrete goals and strategies
 - The CHIP team has selected three broad areas of focus as it relates to health equity. Ideally, these priorities are rooted in systems-level change with ample opportunity for targeted action.
- **Public will-building** → a communication approach that builds **public** support for social change by integrating grassroots outreach methods with traditional mass media tools in a process that connects an issue to the existing, closely held values of individuals and groups.
- **Race** → the “social interpretation of our physical appearance in a given place and time” (Jones, 2008)
- **Racism** → “[A]n organized system premised on the categorization and ranking of social groups into races and devalues, disempowers, and differently allocates desirable societal opportunities and resources to racial groups regarded as inferior” (Williams & Mohammed, 2013)
- **Social drivers** (of health) → systems-level, structural and environmental factors that impact the health of individuals and communities at different levels of a social hierarchy
 - This term is a shift from the more commonly used term “social determinants of health.” The CHIP team understands that though factors like individual health behavior and clinical care access impact the health of a community, there are larger, socially constructed forces that create and perpetuate the disproportionate gaps in the health outcomes of those who have been, and are currently, marginalized. For example, built, or physical environment impacts the health of a community. Attitudes and policies impact the ways in which different communities are positioned to work, play, learn, and live.
- **Stakeholders** → individuals, agencies, governmental entities, and or communities with an interest in a project or goal
 - An equity lens guides us towards an understanding that everyone is an expert in their own way and contributes what they can and are willing to. The CHIP Team understands that all involved in the evolving process of this document and its works are experts in their own right
- **Strategy** → a proactive action, or series of actions, intended to make the goal, and therefore priority, a reality

Strategies can range from building and maintaining relationships, to creating equitable systems, to refining programs that address specific health issues

Monitoring and Accountability

As required by and stated in NC Local Public Health Department Accreditation Benchmark 1, Activity 1.2, “The local health department shall update the community health assessment with an interim “State of the County’s Health” (SOTCH) report (or equivalent) annually. The report shall demonstrate that the local health department is tracking priority issues identified in the community health assessment, identifying emerging issues, and shall identify any new initiatives.” The SOTCH will also include progress made on each CHIP evaluation measure. This document is due to the NC Division of Public Health during the alternate years the Community Health Assessment is not submitted. The health department will collaborate with community partners to collect annual data relative to each year’s respective SOTCH report, and will report this data during the annual community forum.

Additional information about county health data can be found at www.piedmonthhealthcounts.org.

**Alamance County Health Improvement Process
Implementation Plan**

Date Created: 1.10.16

Date Reviewed/Updated: 12.20.19

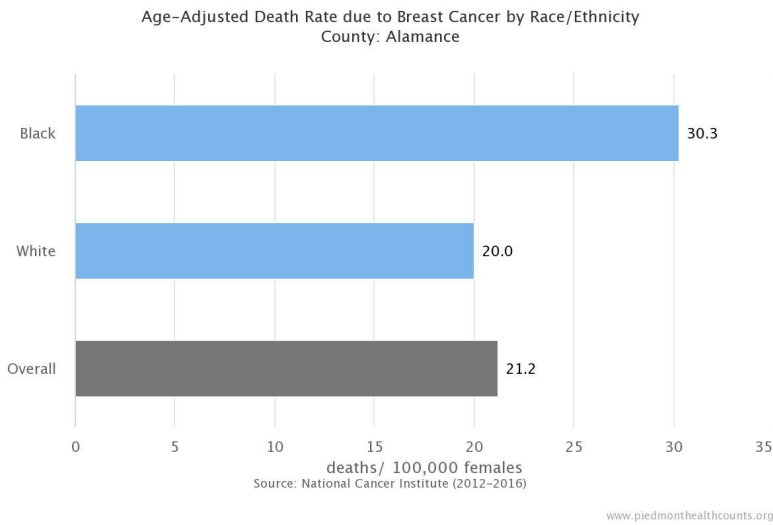
PRIORITY AREA: Access to Care

To learn more about this priority, read [Alamance County Community Health Assessment](#)

GOAL:

Alamance County will identify and address disparities by race, focusing on equitable outcomes to dismantle disparities. Evaluation of policies and practices related to existing services will prioritize access to care being both affordable and welcoming.

Access to care varies based on a variety of social drivers, which are evidenced as disparities. Some of the leading causes of death nationally have some of the widest racial disparities and rates in Alamance County reflect those trends. When considering which of these indicators to start with, the following



were chosen because they are areas of health where disparities exist despite specific interventions and are indicators that both the hospital system and health department are committed to and have recently received funding to address.

Breast Cancer

Breast cancer is a leading cause of cancer death among women in the United States. According to the American Cancer Society, about 1 in 8 women will develop breast cancer

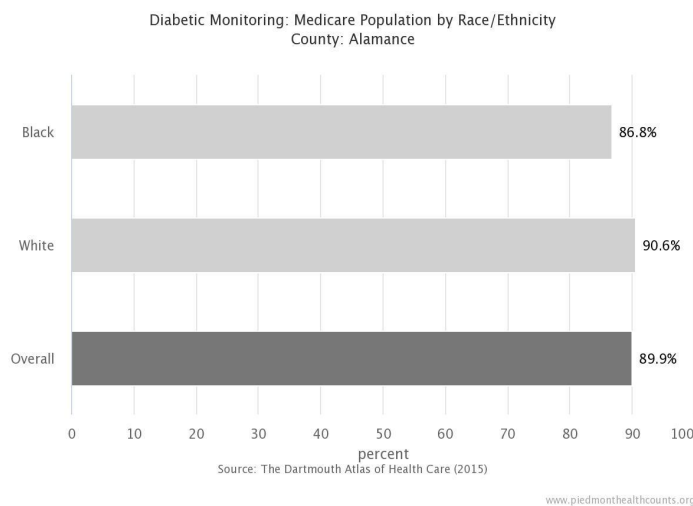
and about 1 in 36 women will die from breast cancer. Breast cancer risk factors include increased age, hereditary factors, obesity, and alcohol use. Since 1990, breast cancer death rates have declined progressively due to advancements in treatment and detection but racial disparities in breast cancer death rates persist. One persisting issue is the lack of racial disparity information that breaks down the Latinx community from the black community. Targeting breast cancer by disparity will allow local healthcare to understand better what this looks like for the Latinx community.

The Healthy People 2020 national health target is to reduce the breast cancer death rate to 20.7 deaths per 100,000 females. The above graph indicates Black women are disproportionately affected by breast cancer compared to White women in Alamance County.

Diabetes

Diabetes is a leading cause of death in the United States. According to the Centers for Disease Control and Prevention (CDC), more than 25 million people have diabetes, including both diagnosed and undiagnosed cases. Diabetes disproportionately affects minority populations and the elderly, and its incidence is likely to increase as minority populations grow and the overall U.S. population ages(https://schs.dph.ncdhhs.gov/SCHS/pdf/MinorityHealthReport_Web_2018.pdf).

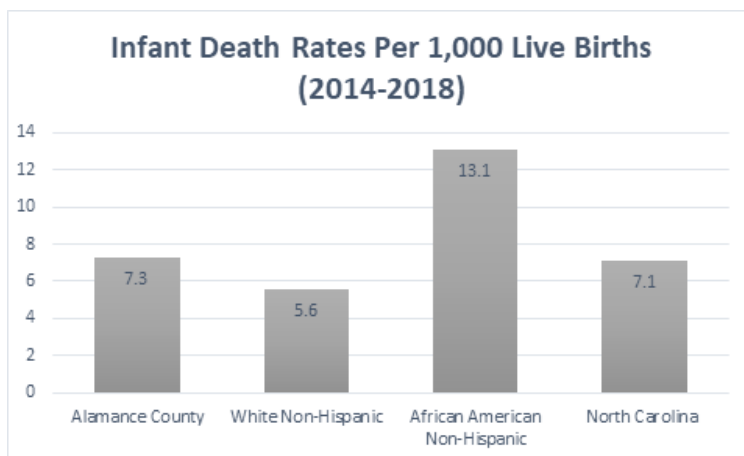
There are different social drivers, such as lack of access to health and healthcare, which act as barriers to HbA1c, a common blood test used to diagnose type 1 and type 2 diabetes. It reflects the average blood sugar level for the past two to three months and be used to monitor how well diabetes is being managed.



In North Carolina, Black and Native American people are greater than 2 times more likely to die from diabetes than their Non-Hispanic White counterparts. This disease can have a harmful effect on most of the organ systems in the human body; it is a frequent cause of end-stage renal disease, non-traumatic lower-extremity amputation, and a leading cause of blindness among working age adults. Those living with diabetes are also at an increased risk for ischemic heart disease, neuropathy, and stroke. In economic terms, the CDC estimates that direct medical expenditures attributable to diabetes is over \$116 billion.

Maternal and Child Health

In 2016, Alamance County was identified as having one of the 25 highest infant mortality rates in the state. Since that time, the county’s overall infant mortality rate has fallen to 7.3 deaths per 1,000 live births, however, the disparity between the number of white infant deaths versus African American deaths continues to persist.



In North Carolina, maternal mortality increased 31% from 2016 to 2018, with a rate of 15.8 deaths per 100,000 live births. This is an issue that also disproportionately affects women of color, with African American women having three times the risk of their White counterparts (American Health Rankings, 2019).

With the support of recurrent funding through NC Department of Health and Human Services, the Alamance County Health Department (ACHD) has strengthened its work in tackling these problems and working toward better birth outcomes by supporting the agency’s Centering Pregnancy program, Reproductive Life Planning Services, 17P, Infant Safe Sleep and Teen Friendly initiatives, as well as the creation of a community volunteer doula program.

As a result, the Alamance County Health Department and many community stakeholders have begun to look at this complex problem on a systems level. One example is the creation of a Community of Providers – representatives from private OB/GYN groups, pediatricians, the local hospital, Federally Qualified Health Center (FQHC), and ACHD – to participate in educational sessions and clinic workflow analyses to increase access to long-term reversible contraceptives (LARC) and reduce teen pregnancies in the county. Additionally, private providers are reporting improved clinic workflow and an excitement to be involved in creating change in their community. There is interest in continuing the work to reduce unintended pregnancies and preterm births.

| OBJECTIVE #1: <i>By 2023, evaluate the utilization rates of specific healthcare services (other than the emergency department) and make recommendations for changes to policies to increase access with a particular focus on Medicaid eligible and single men and women.</i> | | | | |
|--|-------------|------------------------------|---|---|
| BACKGROUND ON STRATEGY – “There are many ways to think of access, and the term access is often used to describe factors or characteristics that influence one's initial contact with or use of services. Anderson and Newman (2005) present a framework of health-care utilization that includes predisposing factors, enabling factors, and magnitude of illness. More recently, Levesque et al. (2013) defined access to health care by presenting five dimensions of accessibility: approachability, acceptability, availability and accommodation, affordability, and appropriateness. They saw access as the opportunity to identify health-care needs; to reach, obtain, or use health-care services; and to have the need for services fulfilled. Access can be seen as a continuum: even if care is available, many factors can affect ease of access to it, for example, the availability of providers who will accept a person's insurance (including Medicaid), ease in making an appointment with a given provider, the ability of a patient to pay for care (even if a patient is insured, due to cost-sharing copayments and deductibles), and the difficulty of arranging transportation to and from healthcare facilities (AHRQ, 2010, MACPAC, 2016).” Source: https://www.ncbi.nlm.nih.gov/books/NBK500097/ Evidence Base: NA Policy Change (Y/N): Yes | | | | |
| Strategy | Target Date | Resources Required | Lead Agency | Anticipated Product or Result |
| Identify and assess healthcare services most utilized by uninsured and underinsured. | Fall 2020 | Review data compiled | Alamance Network for Inclusive Healthcare | Data revealing services least utilized in juxtaposition to disparity data |
| Analyze the impact that Medicaid expansion could have in Alamance County and construct an educational campaign to create awareness. | 2021-2022 | Partners to develop campaign | Alamance Regional/Healthy Alamance | Develop story of how expansion impacts the health of the community |
| Support the expansion of public transit opportunities in Alamance County. | 2021 | | Alamance Network for Inclusive Healthcare | |

OBJECTIVE #2:

By 2023, evaluate utilization of Emergency Department for non-acute health needs, identifying and revising policies and procedures that create barriers to access.

BACKGROUND ON STRATEGY “There are many ways to think of access, and the term access is often used to describe factors or characteristics that influence one's initial contact with or use of services. Anderson and Newman (2005) present a framework of health-care utilization that includes predisposing factors, enabling factors, and magnitude of illness. More recently, Levesque et al. (2013) defined access to health care by presenting five dimensions of accessibility: approachability, acceptability, availability and accommodation, affordability, and appropriateness. They saw access as the opportunity to identify health-care needs; to reach, obtain, or use health-care services; and to have the need for services fulfilled. Access can be seen as a continuum: even if care is available, many factors can affect ease of access to it, for example, the availability of providers who will accept a person's insurance (including Medicaid), ease in making an appointment with a given provider, the ability of a patient to pay for care (even if a patient is insured, due to cost-sharing copayments and deductibles), and the difficulty of arranging transportation to and from healthcare facilities (AHRQ, 2010, MACPAC, 2016).”

Source: <https://www.ncbi.nlm.nih.gov/books/NBK500097/>

Evidence Base: NA

Policy Change (Y/N): Yes

| Strategy | Target Date | Resources Required | Lead Agency | Anticipated Product or Result |
|--|---------------------------------------|--|---|--|
| Complete analysis of Emergency Department utilization for non-acute needs. | 2020 | Data from Cone Health Analytics; personnel to analyze data | Alamance Regional | Deepen understanding of underlying reasons/causes for ED use |
| Incorporate client voice more deeply into design of services for the uninsured | Spring 2020 | | Alamance Network for Inclusive Healthcare | Anticipate more approachable, welcoming, and affordable services |
| Develop prioritizing process for review of services | Fall 2020 | | Health Equity Collective | Partner with clients to prioritize services for review |
| Improve process for appropriate Emergency Department patients to access new diversion center in Alamance County | Ongoing programming – report annually | | Alamance Regional | |
| Support implementation of Strong Minds, Strong Communities, a National Institute of Mental Health and UNCG project to reduce mental health disparities for racial/ethnic and linguistic minorities | | | Alamance Regional | |
| Expand capacity at Open Door Clinic of Burlington | 2021 | Move to new building | Alamance Regional | |
| Patient clinical services will more deeply integrate social needs into patient screening, diagnosis and treatment using NCCARE360 | Ongoing programming-report annually | Integration of NCCARE360 | Alamance Regional | |

OBJECTIVE #3:

By 2023, increase the percentage of persons who receive appropriate evidence-based clinical preventive services with a particular focus on reducing racial disparities for diabetes, breast cancer, and maternal/infant health.

BACKGROUND ON STRATEGY - Support implementation of community-based preventive services and enhance linkages with clinical care OR Reduce barriers to accessing clinical and community preventive services, especially among populations at greatest risk.

Source: [US DHHS](#) Recommendations for Clinical Preventive Services

Evidence Base: Yes

Policy Change (Y/N): Yes

| Strategy | Target Date | Resources Required | Lead Agency | Anticipated Product or Result |
|--|---------------------------------------|--|---|--|
| Centering Pregnancy program | Ongoing programming – report annually | | Alamance County Health Department | Advance Centering model as standard of care |
| Diabetes Prevention Program (DPP) | Ongoing programming – report annually | | NC Minority DPP and Alamance County Health Department | Increased HbA1c screenings and enrollment of minority residents in NC MDPP classes |
| Cancer screenings with known disparities; colorectal, cervical, breast | Ongoing programming – report annually | | Alamance Regional | Increase participation by 10-15% |
| Mammograms and Breast and Cervical Cancer Program (BCCCP) | Ongoing programming – report annually | | Alamance Regional | Increase number of women who receive preventative Breast Cancer screening |
| Oral health screenings for children | Ongoing programming – report annually | | Alamance County Health Department | |
| Linkage to care for mental health (MH) and substance use (SU) disorders | Ongoing programming – report annually | Funding for extensive treatment and recovery options. Collaborative processes to rebuild systems to create a more coordinated system of care. | Alamance County Health Department, along with other County stakeholders | Increase the number of persons with MH/SU disorder who are connected to treatment. Reduce the number of justice-involved persons with MH/SU disorder. Integrate Behavioral services into primary care sites. |
| Increase blood pressure monitoring for those with high blood pressure and pregnant women | Ongoing programming – report annually | | Alamance Regional | |

**Alamance County Health Improvement Process
Implementation Plan**

Date Created: 3.27.16

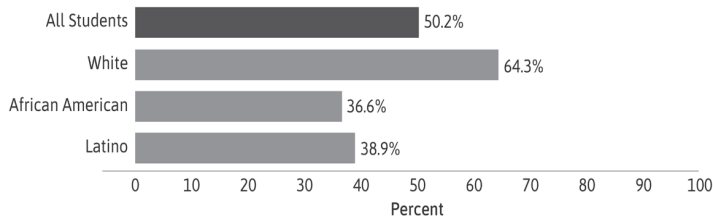
Date Reviewed/Updated: 12.20.19

PRIORITY AREA: Education

To learn more about this priority, read [Alamance County Community Health Assessment](#)

GOAL: Alamance County will engage and align our community to create pathways so that every child has the opportunity to thrive in their education.

2018 3rd Grade Reading EOG
Percentage of ABSS Third Graders Performing at Grade Level



The 2018 Alamance Achieves baseline report data shows that significant disparities and achievement exist between white students and students of color within the county. Implementation of strategies to account for these racial gaps and academic achievement should be equity-based educational best practices.

OBJECTIVE #1:

By 2023, increase support for public education through public will-building.

BACKGROUND ON STRATEGY: Education is highly, positively correlated with health outcomes and status. Public will-building support for social change by integrating grassroots outreach methods with traditional mass media tools in a process that connects an issue to the existing, closely held values of individuals and groups.

Alamance Achieves is a Collective Impact model in partnership with Strive Together. Collective Impact has been shown to leverage the resources and expertise of corporate, faith, nonprofit organizations, and corporate leaders by providing them with opportunities to design and implement various projects designed to meet local needs. Project goals are to improve academic achievement, revitalize communities, and initiate systemic educational change by investing in schools and their surrounding communities.

Source: U.S. Department of Education; Alamance Achieves

Evidence Base: Yes

Policy Change (Y/N): Yes, increased funding to support Public Education K-12

| Strategy | Target Date | Resources Required | Lead Agency | Anticipated Product or Result |
|---|-------------|--------------------|-----------------|-------------------------------|
| Develop advocacy campaign focused on investing in early childhood education | 2021 | Frameworks | Impact Alamance | |
| Create Advocacy Committee | 2020 | | Impact Alamance | |

| | | | | |
|---|------|---|---|---|
| Create a Strategic Planning Committee focused on embedding equity into processes | | | Impact Alamance | |
| Create Equity Committee focused on early childhood initiatives | | | Impact Alamance & Alamance Achieves | |
| Establish Parent and Community Engagement Team | 2021 | Participation from: Parents in the community and community partners | Alamance Achieves (as facilitators and conveners) | Creates partnerships and environment of respect and establishes shared goals for academic success through integration of parent and community decision-making |
| Enhanced outreach for low-income households in identified concentrated poverty neighborhoods households | 2021 | | Alamance Achieves | Shared literacy strategies and familiarization with school programs and initiatives. Support parental navigation of school system resources |

| OBJECTIVE #2: By 2018, increase early childhood literacy across the county with a particular focus on areas of concentrated poverty. | | | | |
|--|-------------|--|-------------------|---|
| BACKGROUND ON STRATEGY: Education is highly, positively correlated with health outcomes and status. Early literacy is a leading indicator to educational attainment. Source: Robert Wood Johnson Foundation Evidence Base: <i>Programs like Dolly Parton Imagination Library and Reach Out and Read have national support and strong data collection methods.</i> Policy Change (Y/N): <i>Yes, funding for programs that demonstrate success and creation of a community-wide literacy council.</i> | | | | |
| Strategy | Target Date | Resources Required | Lead Agency | Anticipated Product or Result |
| Form a community Literacy Council | 2018 | Community convening, school system support | Alamance Achieves | Increased promotion of literacy-rich areas within the county and increased education of community as to benefit of increased literacy rates |
| Identify evidence-based strategies that work to improve childhood literacy in Alamance County | 2018 | Research into what is working in our county to | Alamance Achieves | Improved literacy rates will translate to improved kindergarten |

| | | | | |
|---|-----------|---|---|---|
| | | improve literacy and kindergarten readiness | | readiness and educational achievement |
| Launch Early Grade Network at Eastlawn Elementary | 2019-2020 | Participation from: -Community partners -Parents -Teachers | Alamance Achieves and Eastlawn Elementary | Determine best practices for improved third grade reading and literacy scores in Eastlawn and surrounding community |

OBJECTIVE #3:

By 2021, create community-based centers for early childhood development with a particular focus on areas of concentrated poverty.

BACKGROUND ON STRATEGY: Source: *National Association for the Education of Young Children*

Evidence Base: Quality care includes interactive, stimulating, literacy-rich educational environments like Outdoor Learning Environments (OLE) and are correlated with positive childhood educational outcomes

Policy Change (Y/N): *Yes: funding for childcare and support of quality pre-k and OLEs.*

| Strategy | Target Date | Resources Required | Lead Agency | Anticipated Product or Result |
|---|-------------|---|--|---|
| Partner with Alamance Community College and Elon University's School of Education Early Childhood programs to provide teacher practicum experiences | 2021 | Research-based curriculum Culturally responsive pedagogy | Alamance Achieves Elon University Alamance Community College | Teachers would have increased opportunities to teach students of color |
| Create a cohort of Parents as Educators trained by Elon University School of Education Faculty | 2021 | Sustainable community funding for stipends Faculty to train parents Community space to house the initiative | Alamance Achieves Elon University Alamance Community College | The community would have a cohort of parents positioned to improve the educational outcomes for our most vulnerable populations |
| Identify evidenced-based strategies that increase access and affordability of quality childcare | 2020-2021 | Research by numerous community organizations. Funding to support identified projects | Alamance Achieves | |

**Alamance County Health Improvement Process
Implementation Plan**

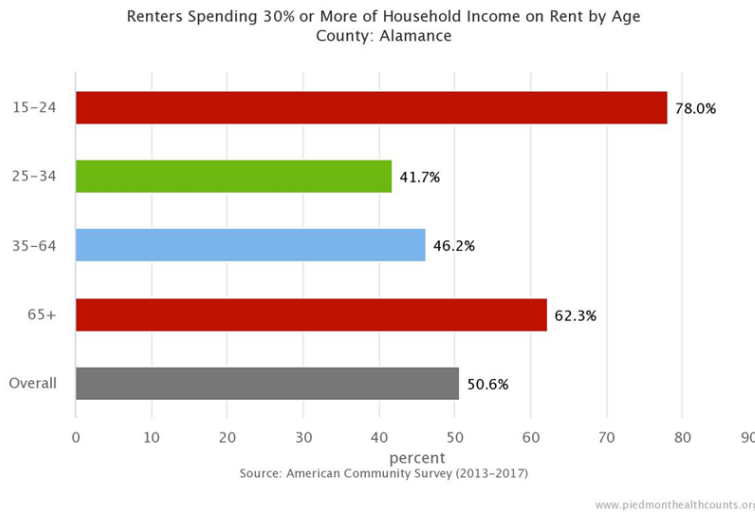
Date Created: 2.19.16

Date Reviewed/Updated: 12.20.19

PRIORITY AREA: Economic Issues

To learn more about this priority, read [Alamance County Community Health Assessment](#)

GOAL: Alamance County will create, support, and evaluate community-oriented policies and programs that address structural barriers to creating a healthy economy within the county to build wealth. Sustainable policies and programs will aim to increase opportunities for quality employment, equitable wages, and safe housing with a particular focus on areas of disparate opportunities.



Previous plans took an approach of getting people into housing. Society is moving towards people renting and owning homes during their lifetimes as appropriate for their needs. Communities who understand this and focus on providing affordable rental options see a decrease in the percentage necessary for individuals and families to spend on housing and transportation.

OBJECTIVE #1:

Decrease the percentage of people spending more than 40% of their income on rental housing and transportation. Expand affordable housing opportunities in higher opportunity areas.

BACKGROUND ON STRATEGY – Housing affordability is a problem that affects mostly low-income individuals and families. People with limited income may have problems paying for basic necessities, such as food, heat, and medical needs. In addition, people with limited incomes may be forced to live in an unsafe environment. 33% of population in Burlington (largest city in county) are renters. A bedroom rental apartment at Fair Market Rate (FMR) (\$695) requires 1.8 full time jobs based on average median income.

Source: Evidence Base: *Analysis of Impediments and Assessment of Fair Housing (Piedmont Triad Region, 2014)*
<http://www.ci.burlington.nc.us/DocumentCenter/View/7201>

Policy Change (Y/N): Yes

| Strategy | Target Date | Lead Agency | Anticipated Product or Result |
|--|-------------|--|---|
| Develop group of partners to focus on increasing affordable mixed-use and mixed-income housing options in Alamance County and higher opportunity areas (with accessible transportation) | 2020 | Alamance Housing Committee | United Way and Healthy Alamance will partner to develop a committee focused specifically on this strategy |
| Expand Rapid Rehousing with a focus on the issues of gentrification | 2021 | Alamance Housing Committee | Reshape strategies to plan accordingly to adapt for growth and reduce displacement |
| Increase job development and training with a focus on creating neighborhood entrepreneurship opportunities | 2022 | Alamance Housing Committee | Require community commitment to targeting strategies for building wealth at the neighborhood level. |
| Consider its role in housing issues during the revision of Alamance Food Collaborative (AFC) Strategic Plan and explore a partnership with above group to create community advisory board (CAB). | 2020 | Healthy Alamance - Alamance Food Collaborative | Develop network for collaborative members to share their expertise with community groups that are focused on social drivers |

OBJECTIVE #2:

Utilize census/zip code data to inform the development of interventions specifically targeting poverty and its effects on health disparities.

BACKGROUND ON STRATEGY – In general, increasing income levels correspond with gains in health and health outcomes – especially at the lower end of the income scale. People in poverty tend to have the worst health outcomes, compared to people at higher income levels. For example, compared to their counterparts, people in poverty are more likely to have chronic illnesses and be in poor or fair health. The newest data (2015) reports that a living wage for Burlington is \$13.37.

Source: Evidence Base: *Census* <http://quickfacts.census.gov/qfd/states/37/37001.html>

Policy Change (Y/N): No, first phase development to understand poverty in county

| Strategy | Target Date | Lead Agency | Anticipated Product or Result |
|--|-------------|------------------|---|
| Develop a map illustrating concentrated poverty tracts and racial demographics of census tracts, and update Income Inequality report from Healthy Alamance 2017 report | Winter 2022 | Healthy Alamance | Utilize report to conduct needs assessment and develop 10-year plan |

Attachment 1:

Hospital & Public Health Requirements related to Implementation Planning

Not-for-profit hospitals have particular requirements related to community health improvement. In terms of an Implementation Strategy, those requirements include:

- ☐ Adopt a written Implementation Strategy to address the community health needs identified during the assessment
- ☐ Describe how the hospital will address the needs
- ☐ Adopt a budget for the provision of services that address the identified needs
- ☐ Describe any planned collaboration to address the needs
- ☐ Execute the implementation strategy

Public health departments are accredited through the North Carolina Local Health Department Accreditation Board. Accreditation is based on the capacity of health departments to perform the three core functions of assessment, assurance, and policy development, as well as the ten essential services detailed in the National Public Health Performance Standards Program:

- Monitor health status and understand health issues facing the community
- Protect people from health problems and health hazards
- Give people information they need to make healthy choices
- Engage the community to identify and solve health problems
- Develop public health policies and plans
- Enforce public health laws and regulations
- Help people receive health services
- Maintain a competent public health workforce
- Evaluate and improve programs and interventions
- Contribute to and apply the evidence base of public health

Attachment 2:

North Carolina Institute of Medicine (NCIOM) 2030 Indicators

| Desired Result | Indicator |
|---|--|
| Decrease the number of people living in poverty | Individuals < 200% Federal Poverty Level (FPL) |
| Increase economic security | Unemployment |
| Dismantle structural racism | Short-term suspensions (per 10 students) |
| | Incarceration rate (per 100,000 population) |
| Improve child well-being | Adverse Childhood Experiences |
| Improve third grade reading proficiency | Third grade reading proficiency |
| Increase physical activity | Access to exercise opportunities |
| Improve access to healthy food | Limited access to healthy food |
| Improve housing quality | Severe housing problems |
| Decrease drug overdose deaths | Drug overdose deaths (per 100,000 population) |
| Decrease tobacco use | Tobacco use |
| Decrease excessive drinking | Excessive drinking |
| Reduce overweight and obesity | Sugar-sweetened beverage consumption |
| Improve sexual health | HIV diagnosis (per 100,000 population) |
| | Teen birth rate (per 1,000 population) T |
| Decrease the uninsured population | Uninsured |
| Increase the primary care workforce | Primary care clinicians (counties at or below 1:1,500 providers to population) |
| Improve birth outcomes | Early prenatal care |

| | |
|--|---------------------------------------|
| Improve access and treatment for mental health needs | Suicide rate (per 100,000 population) |
| Decrease infant mortality | Infant mortality (per 1,000 births) |
| Increase life expectancy | Life expectancy (years) |

Attachment 3:

UNC Gillings School of Global Public Health/Healthy Alamance Capstone Team Recommendations Report

1. Facilitators to a Multi-Level Approach

Recommendation 1.1: Bring in an external facilitator to hold racial equity conversations

External facilitators are useful for mediating racial equity conversations because they represent a neutral, outside perspective. Further, they are more likely to approach group assumptions more critically than an internal facilitator might. A number of key stakeholder interviews indicated that conversations around racial equity were lacking in the Wellness and Food Collaboratives. While conversations around racial equity are difficult, they are necessary in propelling forward the mission and work of each of the collaboratives.

Case Study Example: Rochester, New York has a history of racially motivated violence. An academic-community partnership utilized Group Model Building as an approach to bring stakeholders/community members from many walks of life together to explore complex issues--specifically leaning on the lived experience of those in the room to create understanding through experiential knowledge of the target community experiencing the issue (Frerichs et al., 2016). The methods used in this study included a 1-day facilitated session with a diverse group of stakeholders, guided by questions inspired by Critical Race Theory (CRT) to cultivate an experiential discussion that could help participants create a causal loop diagram representing the myriad of causal factors that impact such a complex issue as violence, for example. Group Model Building (GMB) is framed in this article as a useful approach for guiding community mobilization and community-based group decision making. Specifically, "GMB may be useful to engage with stakeholders around racism and violence because incomplete mental models and implicit biases due to race likely contribute to the debate that often surrounds discourse on racial disparities in violence." It is noted that during these discussions, guides through group facilitation is needed with issues of racism and unconscious stereotyping surfaces, "in real time." This approach calls for both the methods described, as well as a trained facilitator to guide the discussion at times. The use of CRT also included not just personal narratives, but guided vignettes carefully crafted by the planning

team to help engage participants. The language used to inform how causal loop diagrams are constructed must not be taught in a way that's "talking down" to an individual that conveys a power imbalance. Another model used was "gracious space" that allows for conversation around difficult topics that promotes intentional self-reflection and productive disagreements. "Covenants" were used instead of "ground rules," as "rules" can feel punitive. Further, the researchers note the relationship between these facilitated conversations and an increase in positive neighborhood social support, which in turn promotes racial equity.

Recommendation 1.2: Break down silos - between groups and within the community

Segmentation often creates duplicity of efforts and decreases a group's potential to harness its collective strength to learn from each other and improve racial equity. The segmented nature of the county's many municipalities fosters siloed work between group and impedes collaboration within the community. A key theme among many of the key stakeholder interviews was the disjointed nature of the organizations that participate in the collaborative. When trying to address a systems-level issue like racial equity, organizations must communicate to advocate for shared goals and ideas in the community. Another best practice seen throughout the literature is the engagement of different parts of the community to create change at all levels. Having community members sit on a collaborative is imperative to building trust and relationships needed to engage a larger audience and effect change.

The Food Policy Council framework promotes group cohesion and collaborative empowerment, which emphasizes the importance of the individuals most-affected by the issue assuming leadership in the collaborative (Calancie et al., 2018). In this framework, organizational capacity promotes social capital, which, with the help of a supportive community, creates an effective council that moves the needle on community issues.

Recommendation 1.3: Create multi-sector collaboration

[Multi-sector collaboration](#) is defined as "the partnership that results when government, non-profit, private, and public organizations, community groups, and individual community members come together to solve problems that affect the whole community," and is particularly useful at addressing systems-level change (Community Tool Box, n.d.-c). This approach integrates social purposes with business models to "mobilize the private sector on behalf of a public effort" (National Academies of Sciences, Engineering, and Medicine, 2017). In the literature, researchers cite the importance of multi-sector collaboration and coalition building in affecting health disparity changes on individual, environmental, and policy levels. Specifically, the literature finds that engaging sectors of nonprofit community-based organizations, for-profit businesses, local government organizations, and community residents is essential in multi-sector collaboration. With Healthy Alamance's current collaboratives, Alamance County is in a great place to implement this recommendation; however, we heard in key stakeholder interviews a recognition that these collaboratives should span more sectors and engage with additional organizations in Alamance. Interviewees shared organizations in Alamance that were involved with equity-related work, yet not all these organizations were currently engaged with collaborative work. By addressing the silos mentioned in key stakeholder interviews and Recommendation 1.2, diversifying coalitions and boards as outlined in Recommendation 4.1, and

learning from other cross-sector collaboration successes, Alamance can achieve greater success with this recommendation.

Case Study Example: The collaboration built by Community Health Councils, a non-profit in South Los Angeles, and African Americans Building a Legacy of Health Coalition, a long-standing community coalition in South Los Angeles, to address racial inequities through food policy is an example of a robust, successful cross-sector collaboration (Lewis et al., 2011). While the initial project group involved mostly public health and community service sectors, the collaboration was able to successfully broaden their engagement with other sectors. The development of the project goals, objectives, and workplan involved 44 organizations and 77 individual coalition members, which represented all the key groups mentioned above. This success was attributed to Community Health Councils and African Americans Building a Legacy of Health Coalition’s pre-existing relationships with organizations in the community, which fueled organizational and individual commitment to the project. The project was successfully able to pass local-level policy as a result of this multi-sector collaboration. This case study provides a successful example of an existing collaborative incorporating new partnerships in order to create stronger multi-sector engagement and can serve as inspiration as Alamance implements this recommendation.

2. Individual-level Recommendations

Recommendation 2.1: Acknowledge the power that you have as an individual to shape racial equity efforts into the work you do daily

Through interviews, numerous individuals spoke about the need for efforts to focus towards racial equity within the context of the internal and external work of their collectives and collaboratives. At every level of work, there is an opportunity for the individual to advocate for incorporating a strong racial equity lens into the work being done. Overarching top-level statements are important, but individuals pushing for more focus on racial equity efforts at each step of any process is necessary and needed. Community health advocates, community advisors, lay health workers, ministers, retailers, supermarket and restaurant owners or managers, policy makers, and legislators are effective “change agents” that can leverage their positions as gatekeepers to disseminate various initiatives and garner support from a diverse array of sectors (Liao et al., 2015). Grassroots activism is an often-used strategy that incorporates community collaboration and coalition building (Calancie et al., 2018; Capers, 2018; V. Collie-Akers, Schultz, Carson, Fawcett, & Ronan, 2009).

Case Study Example: A community-based partnership targeting food systems and the built environment improvement within Central Brooklyn’s predominantly low-income, African American and Latino communities outlines its challenges, setbacks and rebirth through a shift in leadership (Capers, 2018). While the work itself was targeting racial inequity improvement, the internal leadership was perceived as a “White-led organization not representative of the community of color it was trying to reach” (Capers, 2018) in addition to having a city-wide organization leading efforts, which conflicted with the desire for community representation from Bedford Stuyvesant itself. To address these concerns, a community-based, minority-led organization stepped in with a strong history of grassroots activism, deep ties to the community and a “45-year track record as a coalition builder and direct service provider

working to holistically improve the quality of life in Central Brooklyn” (Capers, 2018). This resulted in more relevant community-members being brought to the table to make decisions and represent those in the community and those already doing the work that aligned with the food system and built-environment equity work. A number of interviewees representing the Health Equity Collective, Food Collaborative, and Wellness Collaborative acknowledged that powerful, influential county leaders were involved in these collaboratives, recognizing the change-making potential already present in the room. Many also shared, “the makeup of our collectives and organizations need to represent the people we are intending to help if we want to work towards achieving racial equity in Alamance County.” Indeed, this is one way to acknowledge the power that you each have in shaping racial equity efforts into the work you do daily.

Recommendation 2.2: Participate in implicit bias training on an ongoing basis

One important recommendation gleaned from stakeholder interviews was ongoing participation in implicit bias training to establish a common understanding and language that can be used by the collaboratives and collectives.

Case Study Example: The success of the Accountability for Cancer Care through undoing Racism & Equity (ACCURE) study that saw a reduction in racial disparities in cancer treatment completion in Black and White patients in was due in part to the application of a racial equity lens (Cykert et al., 2019). The creation of this racial equity lens stemmed from the requirement that all individuals involved in the study complete a racial equity training through the Racial Equity Institute (REI). Attending this type of training that covers implicit biases we all share demonstrates that providing the space and structure for individuals to cultivate their own understanding of racial equity allows them to apply a meaningful racial equity lens in their work. However, attending one racial equity training is not enough. Continuously attending equity training is crucial to keeping racial equity at the forefront of all public health initiatives that seek to reduce health disparities.

Recommendation 2.3: Engage in diverse media (e.g., books, podcasts, movies, exhibitions, articles, etc.)

One recommendation targeted at individuals is to engage in different types of media and entertainment such as books, podcasts, movies or articles that cover racial equity topics. These are different forms of content that a person can engage with whenever they have free time to advance their personal knowledge and understanding about racism, its history, and racial equity. For example, one could carve out time after work to read books such as *White Fragility* by Robin Deangelo and *Racism: Science and Tools for the Public Health Professional* by Dr. Chandra Ford. Both books discuss racial inequities and provide strategies for how individual can combat them. These books are also available as audiobooks and can be listened to on-the-go while walking or driving.

The Alamance Food Collaborative has done a similar activity, but in a group setting, by holding a book club during meetings. Conducting a book club provides the opportunity to debrief and reflect on these materials with others who may be able to share valuable insights. Another form of media is podcasts such as *1619* and *Seeing White* on Spotify. The 1619 podcast is particularly relevant to Alamance County

because it contains specific episodes on Black farmers in the South, the history of land ownership and the healthcare system. Both podcasts provide important historical context to these large systems that perpetuate racial inequities. The documentary *13th* by Ava Duvernay, available on streaming services such as Netflix, guides the viewer through the history of racial inequality in the U.S., specifically the nation's disproportionate prison population of African Americans. Engaging in these materials on your own, in a group, or both is an excellent way to supplement formalized racial equity training.

3. Built-Environment Approaches

Recommendation 3.1: Include and seek out the voices from a broad range of experts, including a variety of professionals and local community members, when conducting built environment assessments.

Built environment, or the physical spaces, systems, and interactions that make up our communities, is something that every community member experience daily. These surrounding systems that create our built environment impact our lives and our health; therefore, built environment is considered a social determinants of health (Perdue, Stone, & Gostin, 2003). In turn, social determinants of health greatly impact an increase or decrease in racial health disparities. Urban planners and city developers are not the only experts on built environment. Everyday citizens can speak to their everyday experience in their community and the communities to which they travel to work, learn and play, access healthcare and connect with family and friends. Including these local community experts, as well as a multi-disciplinary group, to weigh in on needs in the assessments and decisions around built environment is essential and productive to meet the needs of and improve equity in all Alamance county communities.

Am and colleagues (2019) describe the organization of an interprofessional group, working across a number of sectors, levels and organizations, whose purpose was to “appraise issues in the local built environment affecting public health, using an interprofessional and intersectoral approach.” Exactly 108 delegates from health professions, management, public health, architecture, and engineering all participated. Grouped into teams, they were assigned specific locations to appraise and provide recommendations based on their assessments. This knowledge-building first step was followed by engagement of local citizens for their input, as well as policymakers to ensure that final recommendations were implemented (Am et al., 2019).

Recommendation 3.2: Co-locate services

The co-location of services refers to the grouping of wrap-around support services in one location. Co-location creates a “one-stop shop” for the community’s most systematically disadvantaged residents to seek community services and retail that help them to achieve health in several domains. Further, co-location benefits the organizations that are housed together by creating a natural environment that facilitates collaboration between sectors to advocate for policy change.

Case Study Example: Dannefer et al. (2019) offer East Harlem, New York’s “Neighborhood Action Centers” as an example of an interdisciplinary location-based service provider serving their community

and targeting the “neighborhood as a unit of change.” The authors cite the co-location of clinical and community-based services, including programs addressing issues such as birth equity, physical activity and nutrition and childhood asthma, and referral systems as a way to both reach underserved individuals and underrepresented communities and strengthen the relationships of partnerships within the neighborhood itself. Alamance County already is doing this in some ways, like with the co-location of the Health Department, Department of Social, and Children’s Dental Clinic. Additionally, the Family Justice Center provides a one-stop shop for victims of family violence and elder abuse. Visitors can speak with a victim advocate, get assistance filing a restraining order, speak with law enforcement, discuss civil and criminal legal issues, and learn about shelters.

Recommendation 3.3: Support policy changes that foster more equitable built environment

Policy changes, particularly zoning policy changes, can support more equitable built environment changes. Collaborative interviewees, especially those connected to the wellness collaborative, discussed built environment changes such as sidewalks and trails in order to improve health equity. The wellness collaborative already does some work with policy, which creates a strong avenue for the wellness collaborative to advocate and support more equitably focused policy change.

Case Study Examples: Community coalitions across the country are working to recommend and inform racial equity focused policy changes. One example of policy advocacy is through an academic-community partnership in Baltimore, where researchers and community organizations are working together through a Community-Advisory Board (CAB) structure to interact with policymakers in order to advocate for local, state, and federal policy changes (Cooper et al., 2016). This policy advocacy has included a range of foci, including advocating for health disparities research funding on a national scale, influencing the Maryland Health Improvement and Health Disparities Reduction Act of 2012, and coordinating cross-sector sessions on how Baltimore can best impact social injustice and meaningfully partner with communities (Cooper et al., 2016). This CAB is unique in that it includes local and state politicians as well as national organizations, which is more feasible given Baltimore’s location compared to Alamance; however, the structure and accomplishments of the academic-community CAB is useful to consider how the influential members of Alamance’s collaboratives can work together to influence more equity-based policy.

Another example of policy change advocacy targeting equity, specifically food access for underserved neighborhoods, is from Philadelphia, PA. Research shows that built-environment affects health, also in ways that include lack of physical access to resources, including healthy food and especially in historically disadvantaged areas (Perdue et al., 2003). In the early 2000s, The Food Trust, a non-profit community-based organization, who was ran farmer’s markets in underserved neighborhoods concluded they would not be able to meet the food needs of their residents year-round, and that no level of healthy nutrition education would change this scenario if there was nowhere to buy healthy food (Giang, Karpyn, Laurison, Hillier, & Perry, 2008). In response, they launched an effective advocacy campaign, including an evidence-based report and dissemination of findings to engage partners and form the larger area of affected communities, in order to highlight the “grocery gap” and bring about

awareness and policy change (Giang et al., 2008). Their work culminated in the nation's first statewide financing program targeting increasing supermarket development in underserved areas, highlighting the ability to change access to healthy food and increase equity through policy change.

Recommendation 3.4: Embed “Health in All Policies” strategies in community development efforts

Health in All Policies (HiAP) is defined as “a collaborative approach that integrates and articulates health considerations into policy-making across sectors, and at all levels, to improve the health of all communities and people” (Association of State and Territorial Health Officials, 2013). The power of the HiAP approach to address racial inequities came up via in-depth interviews, and this approach is already being incorporated in collaborative work in Alamance. We recommend continuing to embrace this approach, with an intentional focus on racial equity.

Case Study Example: The City of Richmond, California has been successful in applying a HiAP approach, specifically in built environment efforts, and can be used as a case study to emphasize the importance and impact of this recommendation (Corburn, Curl, & Arredondo, 2014). Richmond City began this work by building new collaborations, first, by holding participatory planning projects that included residents, community activists, school officials, and other stakeholders in order to ensure that the city incorporated health equity into development strategies. As a result, the city prioritized social determinants of health, directed and prioritized developmental resources to vulnerable communities, and created a “Community Health and Wellness” chapter in the city’s General Plan which outlined seven aspects of healthy community development, including improved access to parks and recreation, healthy food options, medical services, safe public and active transportation options, high-quality affordable housing, economic opportunities, neighborhood safety, environmental quality, and sustainable development, while also calling for government leadership to help build these healthier communities. These aspects were operationalized on neighborhood levels, focusing on neighborhoods of higher need, and actions included paving streets and sidewalks, creating safety improvements, installing new street lighting, creating safe routes to school plans, planting trees, converting tennis courts to sports fields, and reconstructing a playground. The city used a HiAP approach to improve the built environment and community safety, which not only improved health but also increased resident satisfaction (Corburn et al., 2014).

As a result of this pilot, neighborhood-based work, the city worked collaboratively to adopt a HiAP ordinance (Corburn et al., 2014). The HiAP ordinance was drafted through fourteen community workshops over one and a half years that included residents and specifically sought to acknowledge factors that created racial health inequities. In this process, they initially received resistance from city departments who did not want an extra layer of cost and work; however, in the end, a citywide, interdepartmental HiAP leadership group was established and work was linked to the city’s budget, reducing concerns about cost. The group also faced challenges with the lack of outcome and determinant data on a neighborhood level which was needed to help explain this work to the broader community. Like Alamance, Richmond also faced pushback from leaders in the city who opposed the need for and work on equity-based development. They were able to build support and reduce opposition through holding multiple community workshops, listening sessions, trainings, and

informational presentations to City Council. Now, the city is prioritizing health equity and the needs of people of color, a change that can be largely attributed to the HiAP approach (Corburn et al., 2014).

4. Collaborative-level Approaches

Recommendation 4.1: Track metrics and create standards around the community representativeness of advisory boards, such as coalitions/boards, collaboratives, collectives, and community advisory boards, to shift representation and power

Advisory boards, including collectives, collaboratives, and coalitions, are an essential and effective element of work being done towards community improvement, including health equity. However, research shows that assessing and identifying existing and future ideal levels of representativeness within each community being served is effective and can lead to an increase in their impact. In order to reflect the unique missions of their work, specific metrics and goals should be explicitly stated for the groups to meet those goals.

Case Study Example: A coalition built to address health disparities in the Latinx community in Kansas City, Kansas adopted specific metrics of diversity and representativeness. The first step they made was to establish a Community Advisory Board who met bi-monthly in order to better guide the Coalition. In this instance, members of the CAB were either Latino or representing local Latino serving organizations, and it was always made up of at least 80% Latino individuals. This was a metric that was explicitly stated and as community members came and went from the CAB, the 80% metric was upheld. During the 4-year study period, the Coalition/CAB collaboration implemented 64 community/system changes. These changes were aligned with the Coalition's primary goals of healthy nutrition, physical activity, and access to health screenings. As a result, the community/system efforts improved over time, becoming longer in duration and reaching more of the population (V. L. Collie-Akers, Fawcett, & Schultz, 2013).

We can also learn from the aforementioned case study where conflict arose when a white-led organization attempted to lead collaborative work addressing food access in a primarily African-American neighborhood in New York City (Capers, 2018). The racial divide between the lead organization and the community fueled conflict. Ultimately, the lead organization took a step down and created space for a minority-led organization to take over the coalition building work.

This recommendation will look different for every type of group, according to the mission of their work and their target community.

Recommendation 4.2: Hold ongoing and required racial equity trainings for group members during collaborative meetings (i.e. Racial Equity Institute and guest speakers)

From findings found in the literature review and interviews, the Capstone Student Team proposes that all members of the Health Equity Collective, Food Collaborative, and Wellness Collaborative attend ongoing and required racial equity trainings during their regularly scheduled meetings. After all, we, as a society, will never be able to achieve health equity without addressing racial equity (Lee & Navarro, 2018). These trainings are an essential first step that these entities need to be willing to commit to doing

if they truly want to move equity forward in Alamance County to improve health outcomes for all. They will allow members of the three groups to have a shared language when speaking to each other on ways to strive for racial equity in the work they do. For instance, the ACCURE study that was led by the [Greensboro Health Disparities Collaborative](#) – a community, medical, and academic partnership – was able to eliminate racial disparities in cancer treatment completion at a hospital in Greensboro, North Carolina. One of the ways they were able to tackle racial disparities effectively was by requiring all members to attend a racial equity training through the Racial Equity Institute (Cykert et al., 2019).

For one, these racial equity trainings should provide all members with a common understanding of the way racism in this country has structured the ways in which individuals, communities, and institutions think, behave, and act. We, as a country, need to acknowledge the historical and systematic ways in which people of color have been oppressed to create an inherent hierarchy of privilege and advantage for White people (Kohli, Pizarro, & Nevárez, 2017). In addition, by the end of these trainings, members should all understand that racism is still present at the local, state, national, and global level. As a few interviewees put it, “We need to learn that we live in a society that is racist, and the job of equity is to deconstruct and destroy these obstacles that stand in the way.” Second, from the feedback received during the presentation led by the Capstone Student Team to members of the Health Equity Collective, Food Collaborative, and Wellness Collaborative, the student team believes that understanding racism is just one step in racial equity trainings and that knowing how to incorporate a racial equity lens within the institutions we are affiliated with is needed to achieve racial equity. As such, the student team is proposing that a part two training on racial equity could help members delve deeper on this matter (e.g., Phase 2 training through the Racial Equity Institute). This way members of the three groups feel that they have the skills and abilities needed to advance racial equity efforts within the institutions they work under.

Recommendation 4.3: Hold required trainings on health equity frameworks for group members during collaborative meetings

Typically, [frameworks](#) in the behavioral and social sciences are used to show a general representation of relationships between things (Paradies & Stevens, 2005). In fact, many frameworks are used to guide program efforts across systems change, built environment, and food access interventions. For instance, various projects across the country used frameworks, theories, and models to guide their program planning. These frameworks are described in more detail in our literature review. They include the social ecological model, food policy council framework, integrative practice framework, Four I’s for Health Equity framework, place-based approaches, Active Living by Design Community Action Model, and continuous improvement model.

Case Study Example: In a community-based participatory research (CBPR) project in South Los Angeles, the working team used the social ecological model to ensure that their planning efforts would effectively target racial equity across all levels of their community (Derose et al., 2019). The [social ecological model](#) helps understand the many interactive impacts of personal and environmental factors that influence behaviors (UNICEF, n.d.). The pilot program they developed included education on the individual and interpersonal levels, church policy and environment changes at the living/working

conditions level, and advocacy for policy change at the system-level (Derose et al., 2019). By understanding the social ecological model and other guiding frameworks and models, as well as building the skills to apply these approaches, organizations have been better able to plan and implement successful equity work.

As one can see, there are numerous frameworks used to guide planning and evaluating public health initiatives. As such, after presenting key findings from the literature review and interviews with members of the Health Equity Collective, Food Collaborative, and Wellness Collaborative, we believe it is essential for all entities to attend required trainings on various health equity frameworks. This will be valuable information for collaborative members to know as they continue working to improve health outcomes for all in Alamance County, North Carolina.

Recommendation 4.4: Create clearly defined mission statements that center health and racial equity
[Mission statements](#) are intended to capture the overriding purpose of an organization or group (Community Tool Box, n.d.-b). Typically, it helps answer the question, “What is our organization or group meant to accomplish?” After reviewing several pieces of literature, interviewing various members of the Health Equity Collective, Food Collaborative, and Wellness Collaborative, the Capstone Student Team believes it is crucial for each of these groups to have clearly defined mission statements for their respective entities that put health and racial equity at its core. This means that each of these groups need to understand what each of the terms mean.

For instance, after several interviews conducted, it was clear that some interviewees were using health equity and equality simultaneously, and those two words are not the same. Vital concepts to understand when involved with public health work, indeed, to ensure that resources are directed fairly. Afterall, offering the same resources to all communities in a county could really be not fair and just. Why? There may be certain communities in that county who are well off and some that aren’t, so in that case, it makes more sense to provide additional resources to the communities who are not doing so well and provide less resources to the community that is well off.

When it comes to racial equity, as an outcome, it can be thought of as when the race of an individual does not impact his or her health outcomes (Lee & Navarro, 2018). However, as a process, applying [racial equity](#) implies meaningfully involving people of color in the planning, implementation, and evaluation of institutional policies and practices that impact their lives (Center for Social Inclusion, n.d.). Afterall, systems in this country that intentionally or unintentionally fail people of color, are failing all citizens.

With all this in mind, if the purpose of the Health Equity Collective, Food Collaborative, and Wellness Collaborative is to improve certain health outcomes for residents in Alamance County, health equity and racial equity need to be clearly expressed in their mission statements. **Case Study Example:** Indeed, the Greensboro Health Disparities Collaborative in Greensboro, North Carolina was able to achieve eliminating racial disparities between Black and White patients at hospitals in Greensboro and Pittsburgh, Pennsylvania in 2018 because they knew their purpose when they first became an official

group in 2001. This collaborative is a community, medical, and academic partnership that works to “establish structures and processes that respond to, empower, and facilitate communities in defining and resolving issues related to disparities in health” (Greensboro Health Disparities Collaborative, n.d.). As they proudly emphasize on their website, “We don’t all have degrees in public health, but we all have a desire to improve health outcomes for everyone” (Greensboro Health Disparities Collaborative, n.d.).

Recommendation 4.5: Shift scope of work to address more upstream determinants of health

[Upstream determinants of health](#) are issues that have the power to reduce inequities in our society. The RAND Social Determinants of Health Work Group defines upstream factors as certain social determinants “such as social disadvantage, risk exposure, and social inequities that play a fundamental causal role in poor health outcomes— and thus represent important opportunities for improving health and reducing health disparities.” Community interviews highlight the need to shift the collaboratives’ scopes of work to address upstream determinants. Further, in an intervention in Dallas to identify a new approach to screen, identify, and enroll uninsured minority children in high-risk communities, the combination of a community-based intervention with a more systems-change approach was documented to have clearly measured results in addressing determinants of health disparities like insurance (Flores et al., 2017). In this perspective, efforts targeting “the community” should be multi-faceted and both simultaneously up and downstream to be effective.

Recommendation 4.6: Embed community-based participatory approaches into organizational work

Utilizing and embedding community-based participatory approaches into the work conducted by organizations is seen throughout the literature. Community-based approaches to increase the capacity of community members to work with academic and/or organizational partners, such as Healthy Alamance and their associated collaboratives and collectives. **Case Study Example:** The Community Research Fellows Training program in St. Louis was created to “enhance the capacity” of community members to engage in CBPR that seeks to eliminate racial and ethnic health disparities (Coats, Stafford, Sanders Thompson, Johnson Javois, & Goodman, 2015). Ramos, Fox, Simon, & Horowitz (2013) similarly detailed increasing community participatory capacity, but through grant writing where community members and academic partners were equally involved in the review process. Here, community members who engaged in the review process also recruited and mentored other community members to be reviewers. Unlike the previous two programs, the Model Communities Program increased organizational and community capacity by providing “knowledge, skills, and resources to advance policy, systems, and environmental changes” (Barnett et al., 2014).

While these approaches were in different states and contexts (i.e. rural vs. urban), they share the goal of reducing racial/ethnic health disparities and making impactful change with the collaboratives and collectives with Alamance County. Not only does this approach seek to bring in community members that the collaboratives are serving, but it is a meaningful way to leverage the invaluable assets and networks community members bring to the table. By using a community-based participatory approach, communities, particularly those of color, can have more decision-making power about the programs that are designed for their benefit; which is another way to increase racial equity.

Recommendation 4.7: Transparently communicate efforts and progress of collaboratives to communities

Another recommendation expressed by members of the collaboratives and collectives are communicating efforts to the communities they are supposed to serve, especially communities of color. However, communication between the communities and collaboratives/collectives should be conducted on an ongoing process embedded throughout timelines of all programs and initiatives. This communication can be in-person in the form of town halls or listening sessions where communities are able to hear about the work being done and give feedback in real time, like the structure of the November 21st Healthy Alamance Capstone Student Team presentation. Also, collaboratives should be cognizant of where and when such meetings are held to ensure that these sessions are accessible to community members. Having meetings in collaborative office spaces or at organization headquarters may perpetuate power dynamics that can prevent community members from participating. Regardless of whether it is in person or through a wider broadcasting throughout the county, the communication should be easy to understand and with little to no technical jargon; if jargon is necessary, it is important to explain any and all terms. Transparency about what is being done among collaboratives is essential because it allows communities to hold the collaboratives accountable to their mission of reducing disparities and achieving racial equity.

Recommendation 4.8: Clarify who is responsible for the work

In order to successfully implement action items in any collaboration, it is important to clarify who is responsible for different steps along the way. Key stakeholders acknowledged the importance of sharing responsibilities and the ways in which there has not always been clarity on who is owning the work in Alamance, particularly around equity related tasks. [The Community Toolbox](#) urges collaborations to ask, “What are the roles and responsibilities of each that, taken together, will help make our communities healthier places to live?” (Community Toolbox, n.d.-a). When thinking about sharing responsibilities, it is important to keep in mind which organization or individuals are best suited for the task at hand.

While it is important to clarify who is doing each action step, it is also important in collaborative-based work for there to be collective ownership and responsibility, as demonstrated through the CAB in Baltimore working to address hypertension disparities (Cooper et al., 2016). In this CAB, all members were able to share their expertise, work together using their strengths, while also maintaining co-ownership of the project outputs (Cooper et al., 2016). By both tasking specific parties with action items and maintaining group responsibility, collaboratives in Alamance can stay accountable to the work while also maintaining group co-ownership.

5. Systems-level Approaches

Recommendation 5.1: Prioritize and measure equity in community health initiatives

First, prioritizing racial equity requires differentiating it from the concept of racial equality. This serves to meet historically disadvantaged communities where they are, as a result of systemic racism and disinvestment, to connect to their needs, as opposed to offering a blanket approach to meet “all” needs. Next, Lee & Navarro (2018) call for intentionality around equity by defining it and making it concrete and measurable. In the case of the W.K. Kellogg Foundation’s Food & Fitness Initiative in the Lee & Navarro

article, they brought an outside organization to facilitate these discussions. A fundamental suggestion was for “each community to develop and adopt a working definition of equity that is specific to its needs and context” (Lee & Navarro, 2018). Additionally, this article calls for centering racial equity in the work by determining the specific target or objective for the equity-based work, from the outset of the work itself. An example given features the difference between just setting out to open a grocery store in a community, but setting the target to sell healthy and affordable food in that community grocery store (Lee & Navarro, 2018). Systems-level policy goals are necessary in community initiatives to “remediate inequitable practices of the past and to prevent them from reoccurring” (Lee & Navarro, 2018). This might include comprehensive strategies like increasing business ownership and employment opportunities for target populations. A baseline of how policy is made is important prior to acting in this space. An example of a workshop from an outside facilitator helped participants understand the “interconnectedness of health inequities and racial discrimination as well as the opportunity to approximate the advocacy experience” (Lee & Navarro, 2018). Finally, prioritizing equity in community health initiatives meant leaning heavily into “engaging and involving residents in a manner that was authentic and meaningful.” Specifically, “the principles of equity were made tangible, as people of color and low-income people joined the staff of the partnerships or became members, participating in policy advocacy campaigns” (Lee & Navarro, 2018).

Case Study Example: Another example of this is in the ACCURE study (Cykert et al., 2019). This was a five-year intervention looking at ways to improve racial differences in the quality and completion of treatment for Black and White patients with stages 1 and 2 breast and lung cancer and eliminated racial disparities in cancer treatment completion. CBPR was one strategy used, along with the strong community-academic partnership this study had in place. Their community-academic partnership started early in the process, allowing for extensive time to understand each other and learn how to best work together. Notably, a racial equity lens was used to approach the work, specifically by requiring all individuals involved with this study to complete a racial equity training through the Racial Equity Institute. This allowed the teams to come together and create space to have these conversations about race, systemic racism, and bias throughout history that continue into the present day. Creating shared definitions for these complex concepts and conversations better enabled the study teams to do their work with the community and each other effectively.

Recommendation 5.2: Create policy change that supports health equity across the county

Policy can provide the necessary backbone to ensure that racial equity practices are incorporated in the planning and development of our communities, and it is critical to do policy work to address racial equity. When asked about the importance of policy in racial equity work, key stakeholder interviewees acknowledged the racist underpinnings of policies and acknowledged that policy change was fundamental in addressing racial inequities. This highlights that policy change must take place with a strong racial equity lens; otherwise, we risk perpetuating the racist-informed policies that our communities are founded in. While some collaboratives have already started working in policy change, others have not started working in this space. Even in collaboratives that haven’t started working in policy, interviewees acknowledged that the collaboratives should move in that direction over time. For all collaboratives, a stronger racial equity approach can be applied when considering policy change.

We've already discussed many recommendations that support policy change, such as multi-sector collaboration, using HiAP approaches, and advocating for policy change; however, collaboratives themselves can create policy change in the community as well. The aforementioned collaboration in South Los Angeles used a multi-sector coalition in order to enact local built environment policy change to improve food access inequities between racial groups (Lewis et al., 2011). Together, they were able to secure funding and successfully pass two local policy changes in a primarily African-American area of Los Angeles with limited access to quality, healthy foods (Lewis et al., 2011). The first policy change created an incentive package for food retailers to develop in South Los Angeles and other communities deemed "vulnerable," which led to two new grocery stores being built in a food desert neighborhood within four years. The second was an Interim Control Ordinance which prevented new fast food restaurants from opening in three specific community planning areas of South Los Angeles (Lewis et al., 2011). Together, these policies created time and space for the city to improve equitable access to healthy food while reducing inequitable exposure to fast food.

Recommendations- Glossary of Terms

[Multi-sector collaboration](#) is defined as "the partnership that results when government, non-profit, private, and public organizations, community groups, and individual community members come together to solve problems that affect the whole community," and is particularly useful at addressing systems-level change (Community Tool Box, n.d.-c).

[Community-Advisory Boards \(CAB\)](#) are groups of representative individuals who are recruited from communities to engage with members of an organization or institution on equity-focused quality improvement efforts targeting the communities or populations from which they represent (Solving Disparities, n.d.).

[Health in All Policies \(HiAP\)](#) is defined as "a collaborative approach that integrates and articulates health considerations into policy-making across sectors, and at all levels, to improve the health of all communities and people" (Association of State and Territorial Health Officials, 2013)

[Upstream determinants of health](#) are defined as certain social determinants of health "such as social disadvantage, risk exposure, and social inequities that play a fundamental causal role in poor health outcomes— and thus represent important opportunities for improving health and reducing health disparities."

[Racial equity](#) implies meaningfully involving people of color in the planning, implementation, and evaluation of institutional policies and practices that impact their lives (Center for Social Inclusion, n.d.). As an outcome, it can be thought of as when the race of an individual does not impact his or her health outcomes (Lee & Navarro, 2018).

[Social Ecological Model](#) is a theory-based framework that helps understand the many interactive impacts of personal and environmental factors that influence behaviors (UNICEF, n.d.)

Bibliography

- Am, C., Godinho, M. A., Murthy, S., Manapure, N. H., Ramadevi, N., Kinjawadekar, A., ... Vinod Bhat, H. (2019). The built environment and health: fostering interprofessional collaboration for better policy recommendations. *Journal of Interprofessional Care*, 1–4.
<https://doi.org/10.1080/13561820.2019.1650009>
- Association of State and Territorial Health Officials. (2013). *Health in all Policies: Strategies to Promote Innovative Leadership*.
- Barnett, G. L. M., Dombrowski, R. D., Welter, C. R., Mason, M., Geraci, M. V., Gilmet, K. A., ... Kapadia, D. A. (2014). Model communities: a vital strategy to implementing policy and environmental change for active living and addressing health equity in Suburban Cook County, Illinois. *American Journal of Health Promotion*, 28(3 Suppl), S122-4. <https://doi.org/10.4278/ajhp.28.3s.S122>
- Calancie, L., Allen, N. E., Ng, S. W., Weiner, B. J., Ward, D. S., Ware, W. B., & Ammerman, A. S. (2018). Evaluating food policy councils using structural equation modeling. *American Journal of Community Psychology*, 61(1–2), 251–264. <https://doi.org/10.1002/ajcp.12207>
- Capers, T. (2018). Working Together to Improve Community-Level Health: The Evolution of the New York City Food & Fitness Partnership. *Health Promotion Practice*, 19(1_suppl), 57S-62S.
<https://doi.org/10.1177/1524839918788844>
- Center for Social Inclusion. (n.d.). What Is Racial Equity? . Retrieved December 6, 2019, from <https://www.centerforsocialinclusion.org/our-work/what-is-racial-equity/>
- Coats, J. V., Stafford, J. D., Sanders Thompson, V., Johnson Javois, B., & Goodman, M. S. (2015). Increasing research literacy: the community research fellows training program. *Journal of Empirical Research on Human Research Ethics : JERHRE*, 10(1), 3–12. <https://doi.org/10.1177/1556264614561959>
- Collie-Akers, V. L., Fawcett, S. B., & Schultz, J. A. (2013). Measuring progress of collaborative action in a community health effort. *Revista Panamericana de Salud Publica = Pan American Journal of Public Health*, 34(6), 422–428.
- Collie-Akers, V., Schultz, J. A., Carson, V., Fawcett, S. B., & Ronan, M. (2009). Evaluating mobilization strategies with

- neighborhood and faith organizations to reduce risk for health disparities. *Health Promotion Practice*, 10(2 Suppl), 118S-127S. <https://doi.org/10.1177/1524839908331271>
- Community Tool Box. (n.d.-a). Chapter 1. Our Model for Community Change and Improvement | Section 7. Working Together for Healthier Communities: A Framework for Collaboration Among Community Partnerships, Support Organizations, and Funders | Main Section . Retrieved December 5, 2019, from <https://ctb.ku.edu/en/table-of-contents/overview/model-for-community-change-and-improvement/framework-for-collaboration/main>
- Community Tool Box. (n.d.-b). Chapter 8. Developing a Strategic Plan | Section 2. Proclaiming Your Dream: Developing Vision and Mission Statements | Main Section . Retrieved December 6, 2019, from <https://ctb.ku.edu/en/table-of-contents/structure/strategic-planning/vision-mission-statements/main>
- Community Tool Box. (n.d.-c). Chapter 24. Improving Services | Section 4. Developing Multisector Collaborations | Main Section . Retrieved December 2, 2019, from <https://ctb.ku.edu/en/table-of-contents/implement/improving-services/multisector-collaboration/main>
- Cooper, L. A., Purnell, T. S., Ibe, C. A., Halbert, J. P., Bone, L. R., Carson, K. A., ... Levine, D. M. (2016). Reaching for Health Equity and Social Justice in Baltimore: The Evolution of an Academic-Community Partnership and Conceptual Framework to Address Hypertension Disparities. *Ethnicity & Disease*, 26(3), 369–378. <https://doi.org/10.18865/ed.26.3.369>
- Corburn, J., Curl, S., & Arredondo, G. (2014). A health-in-all-policies approach addresses many of Richmond, California’s place-based hazards, stressors. *Health Affairs (Project Hope)*, 33(11), 1905–1913. <https://doi.org/10.1377/hlthaff.2014.0652>
- Cykert, S., Eng, E., Manning, M. A., Robertson, L. B., Heron, D. E., Jones, N. S., ... Gizlice, Z. (2019). A Multi-faceted Intervention Aimed at Black-White Disparities in the Treatment of Early Stage Cancers: The ACCURE Pragmatic Quality Improvement trial. *Journal of the National Medical Association*. <https://doi.org/10.1016/j.jnma.2019.03.001>
- Dannefer, R., Wong, B. C., John, P., Gutierrez, J., Brown-Dudley, L., Freeman, K., ... Maybank, K. A. (2019). The Neighborhood as a Unit of Change for Health: Early Findings from the East Harlem Neighborhood Health Action Center. *Journal of Community Health*. <https://doi.org/10.1007/s10900-019-00712-y>

- Derose, K. P., Williams, M. V., Branch, C. A., Flórez, K. R., Hawes-Dawson, J., Mata, M. A., ... Wong, E. C. (2019). A Community-Partnered Approach to Developing Church-Based Interventions to Reduce Health Disparities Among African-Americans and Latinos. *Journal of Racial and Ethnic Health Disparities*, 6(2), 254–264. <https://doi.org/10.1007/s40615-018-0520-z>
- Flores, G., Walker, C., Lin, H., Lee, M., Fierro, M., Henry, M., ... Massey, K. (2017). An Innovative Methodological Approach to Building Successful Community Partnerships for Improving Insurance Coverage, Health, and Health Care in High-Risk Communities. *Progress in Community Health Partnerships : Research, Education, and Action*, 11(2), 203–213. <https://doi.org/10.1353/cpr.2017.0025>
- Frerichs, L., Lich, K. H., Funchess, M., Burrell, M., Cerulli, C., Bedell, P., & White, A. M. (2016). Applying critical race theory to group model building methods to address community violence. *Progress in Community Health Partnerships : Research, Education, and Action*, 10(3), 443–459. <https://doi.org/10.1353/cpr.2016.0051>
- Giang, T., Karpyn, A., Laurison, H. B., Hillier, A., & Perry, R. D. (2008). Closing the grocery gap in underserved communities: the creation of the Pennsylvania Fresh Food Financing Initiative. *Journal of Public Health Management and Practice : JPHMP*, 14(3), 272–279. <https://doi.org/10.1097/01.PHH.0000316486.57512.bf>
- Greensboro Health Disparities Collaborative. (n.d.). GHDC - Greensboro Health Disparities Collaborative. Retrieved December 6, 2019, from <https://greensborohealth.org/index.html>
- Kohli, R., Pizarro, M., & Nevárez, A. (2017). The “new racism” of K–12 schools: centering critical research on racism. *Review of Research in Education*, 41(1), 182–202. <https://doi.org/10.3102/0091732X16686949>
- Lee, M. M., & Navarro, A. (2018). Prioritizing racial equity: how efforts to advance racial equity helped shape the W.K. Kellogg food & fitness initiative. *Health Promotion Practice*, 19(1_suppl), 24S-33S. <https://doi.org/10.1177/1524839918783970>
- Lewis, L. B., Galloway-Gilliam, L., Flynn, G., Nomachi, J., Keener, L. C., & Sloane, D. C. (2011). Transforming the urban food desert from the grassroots up: a model for community change. *Family & Community Health*, 34 Suppl 1, S92–S101. <https://doi.org/10.1097/FCH.0b013e318202a87f>
- Liao, Y., Siegel, P. Z., Zhou, H., Grimm, K., Njai, R., Kent, C., & Giles, W. (2015). Reduced Disparity in Vegetable Consumption in 16 Disadvantaged Black Communities: A Successful 5-Year Community-Based

Participatory Intervention. *Journal of Racial and Ethnic Health Disparities*, 2(2), 211–218.

<https://doi.org/10.1007/s40615-014-0065-8>

National Academies of Sciences, Engineering, and Medicine. (2017). *Communities in action: Pathways to health equity*. (A. Baciu, Y. Negussie, A. Geller, & J. N. Weinstein, Eds.). Washington, DC: National Academies Press. <https://doi.org/10.17226/24624>

Perdue, W. C., Stone, L. A., & Gostin, L. O. (2003). The built environment and its relationship to the public's health: the legal framework. *American Journal of Public Health*, 93(9), 1390–1394.
<https://doi.org/10.2105/ajph.93.9.1390>

Ramos, M. A., Fox, A., Simon, E. P., & Horowitz, C. R. (2013). A community-academic partnership to address racial/ethnic health disparities through grant-making. *Public Health Reports (Washington, D.C. : 1974)*, 128 Suppl 3, 61–67.

Solving Disparities. (n.d.). Tips for Developing a Community Advisory Board.

UNICEF. (n.d.). MODULE 1: What is the Social Ecological Model (SEM), Communication for Development (C4D)?