

1. *No community organization, church, etc., has ever reached out to us and our health department has not reached out to them either over the years. What do we do? Just begin calling churches? Seriously, what is our actual first step?*

- *From Jenna Oh at the Washington County Department of Health and Human Services (Oregon) –*

It doesn't hurt to reach out to faith leaders. I have seen personal connections go a long way; I would suggest checking with your team and network to see if someone is connected to any of the organizations and leaders and ask for an introduction. When I first connect with organizations that haven't worked with us, I always share a number of updates and services/resources that might be helpful for them and the community they serve and ask them to contact me for questions to let them know we can keep the communication open. Another idea: we started a newsletter designed for community organizations – we pull together and share out resources (including funding opportunities) that CBOs might be interested; this way, community organizations will start getting a sense of what information and resources are available through the local health department.

- *From Lillie Hall at the South Carolina Department of Health and Environmental Control, Upstate Public Health Region -*

Great question and please know that we understand the frustration. Yes, we have made "cold call introductions" to community partners especially after we conduct windshield surveys and asset maps discern the community leaders and assess the agencies, resources and assets in the communities; this may be your first step as well. Often times, the community does not know that a health department has community staff such as health educators and community health workers that can work "on the ground" in their communities. They may not know or not understand the importance of assessing needs and exposing gaps. Communities tend to be turf-ish and want to have an HD contact to call "their own", so when we introduce ourselves and explain that we want to understand the needs of their community; it piques their interest. These cold call intros are usually initiated with the community leaders and gatekeepers, who then introduce or "share" us with their constituents and partners.

As part of our community engagement strategy, our team members conduct four main tasks: (1) they consistently inject themselves into community meetings and events that may or may not "fit" our scope of work; it always surprises the community group that health department staff took time to attend their meetings; we invite ourselves and justify it by informing the partner that we just want to know more about what is going on in the communities to see if we can partner in some way; we don't always receive a warm welcome, so we break and try again at a later time; (2) they conduct listening sessions in outlying and underserved areas of the county, without an agenda and invite our health director to lead the sessions if she is available; these sessions were a hit while we learned so much about the capacity and will of the smaller areas, and (3) then they stay in constant contact with the community partners by adding them to an email list for

receiving monthly and sometimes weekly announcements on health department services, events and emergencies; our list has grown to more than 400+ partners for the region of eleven counties. (4) When the opportunity arises, we also acknowledge and award the communities for the great work they are doing to affect the health of their communities. For example, this past year, we partnered with the SC Tobacco Collaborative to present Palmetto Smoke Free certifications, to cities and municipalities who passed ordinances and/or smoke-free policies in their communities. We presented them with a very nice certificate and materials to post to share their successes. We took this award announcement to the max by providing press releases for them to share the great news and acknowledged them statewide. All of these tasks are traditional community engagement strategies that most HDs forgot about, but we find them to be valid and viable strategies. I have included a copy of the eligibility for an award.

2. *If a CBO is already engaged with an LHD how can we leverage the relationship to be more impactful in the community? What limitations do CBOs place on themselves because of not knowing what an LHD can assist them with?*

- *From Jenna Oh at the Washington County Department of Health and Human Services (Oregon) –*

CBOs can act as advocates and connection for the LHD. For some community members, community organizations are a trusted voice and main source of information (especially communities that speak another language or rely on oral sharing of information). Without the connection, community members may miss out on timely updates or information. CBOs can be impactful- they can act as an advocate, share with LHD feedback and questions from the community to help shape services and plans or to lift up needs that LHD may not be addressing adequately yet.

- *From Lillie Hall at the South Carolina Department of Health and Environmental Control, Upstate Public Health Region –*

If a CBO is already engaged, we have to make great efforts to keep them engaged in different ways. When they "sign-up" for a partnership with an LHD, generally, it is because they had a set or defined reason to partner (i.e. the LHD partnered with a local STD/HIV CBO because they filled a testing or counseling gap that the LHD did not have capacity to do). In this case, there may be opportunities for the CBO to assist with community events like STD/HIV awareness, World AIDS Day, etc. or help promote other LHD services as needed if they are equipped or receive training and information as a potential referral source. Another way to engage them would be to invite them to be part of a CAB or community advisory board for sharing ideas with the LHD. We established one during the pandemic called the COVID-19 Community Assessment Review and Equity (CARE) Panel. As we demobilize and are no longer using the panels the same way, we are working to change its focus to more of Equity to support our efforts around the SDOHs. These opportunities should answer the question of benefits lost to the CBOs if they are not willing to partner. It's a win/win for both the LHD and the CBO for these types of collaborations. Besides, we are generally serving the same populations. Here is a link to more info on the CARE

panels: <https://scdhec.gov/covid19/covid-19-vaccine/south-carolinas-covid-19-community-assessment-review-equity-care-panels>.

3. When you share data to build trust, do you find that people are discouraged by the data?

- *From Jenna Oh at the Washington County Department of Health and Human Services (Oregon) –*

In our experience, communities that are historically marginalized ask for data about their community's health and find it data helpful to raise awareness about what's going on in their community. More often, the issue is whether the data is designed in a way that resonates with the community's priorities and languages/framework to talk about their people and issues.

- *From Lillie Hall at the South Carolina Department of Health and Environmental Control, Upstate Public Health Region –*

This depends on how the data is presented; it has to be presented in a less intimidating way and blame removed. Our previous data presentation and visualization surely discourage some at times and some became resistant to additional information. Often, it only took one or two persons to establish a wave of resistance to the information and data presented. The Data Walks and the newfound ways to present data changed that dynamic for us. Sometimes we started data presentations with life expectancy maps, social vulnerability index info and materials that supported the SDOHs. These type of data sources tend to invoke empathy and understanding that where you live matters to your health. When people see that it is not necessarily their fault (at least not all their fault), it reduces the chances of the community feeling that they are blamed for circumstances beyond their control. Often times, they have complained about these needs to no avail and frustration mounted that built the walls of resistance noted earlier. Listening to and addressing their "felt" needs BEFORE we invoke documented data like the life expectancy maps, lends itself to our ability to break down barriers and build trust. They return to data updates and annual forums to stay involved. When a community is empowered and feel like they have some control of their health, change happens. I have included a copy of our original data walk process purpose sheet for more information.