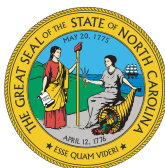


NCDHHS Community and Partner Engagement Guide

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NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

Health Equity Portfolio

Office of Health Equity
Office of Rural Health
Office of People, Culture, and Belonging

This guide is created by the Office of Health Equity to advance and unify the community and partner engagement work of the North Carolina Department of Health and Human Services.

Table of Contents

- Executive Summary 3
- NCDHHS Health Equity Framework 3
 - Work to Adopt and Embed: The 5 Pillars of the Health Equity Framework. . . 4
- Key Terms and Definitions 5
- Work to Adopt and Embed: The Values and Guiding Principles
of Community and Partner Engagement 6
- A Model for Community and Partner Outreach and Engagement. 7
- Equitable Outreach and Engagement: A Continuum 9
 - Community Homework. 10
 - Inclusive Communication 12
 - Listening to Strengthen Community Interactions. 13
 - Collaboration: Partnerships for Community Engagement 14
 - Empowering Communities and Partners 18
- Potential Challenges and Possible Solutions to Community
and Partner Engagement 21
- Our Call to Action Strengthening Community and
Partnership Engagement for Population Health 22
- Appendix A: Examples of NCDHHS, HEP and OHE Mission
and Vision for Community and Partner Engagement. 23
- Appendix B: HEP Community and Partnership Engagement
SMARTIE Goals 2024-2025 24
- Appendix C: Additional Definitions 26
- Appendix D: Prioritizing Community Voices Resources. 27
- Appendix E: Communication Tools and Resources. 27
- Appendix F: Sample Action Planning Template. 29

Executive Summary

The North Carolina Department of Health and Human Services (NCDHHS) is resolutely committed to championing equitable health outcomes for the 10 million North Carolinians it serves. In a groundbreaking move in 2021, NCDHHS established the Health Equity Portfolio (HEP) and appointed its inaugural Chief Health Equity Officer to spearhead this transformative mission. The HEP, comprised of the Office of Rural Health (ORH), the Office of People, Culture, and Belonging (OPCB), the Olmstead Office, and the Office of Health Equity (OHE), introduced a comprehensive **Health Equity Framework (HEF)**. This framework is carefully crafted to elevate the capabilities of organizations, communities, and partners, fostering a landscape of health equity across the entire state. At its essence, health equity embodies our purposeful commitment to ensuring that every individual has an equal opportunity to achieve optimal health, unburdened by obstacles to access and discrimination.

At the heart of this endeavor lies the **NCDHHS Community and Partner Engagement Guide (CPEG, Guide)**, a foundational resource designed to unify NCDHHS’s approach to community engagement. The CPEG serves as a beacon, illuminating evidence-based principles that honor the strength, resilience, history, and lived experiences of communities. By positioning communities at the core of engagement efforts, the guide empowers active collaboration, enabling the elimination of differences in health outcomes. NCDHHS firmly believes that meaningful engagement with individuals who have lived experiences is paramount, especially in policy development. This conviction underscores our mission of working collaboratively with partners to improve the health, safety, and well-being of all North Carolinians. By doing so, we are not only fulfilling our [mission](#) but advancing health access by increasing opportunity and improving outcomes for people who face greater health and situational challenges within NCDHHS and across the state.

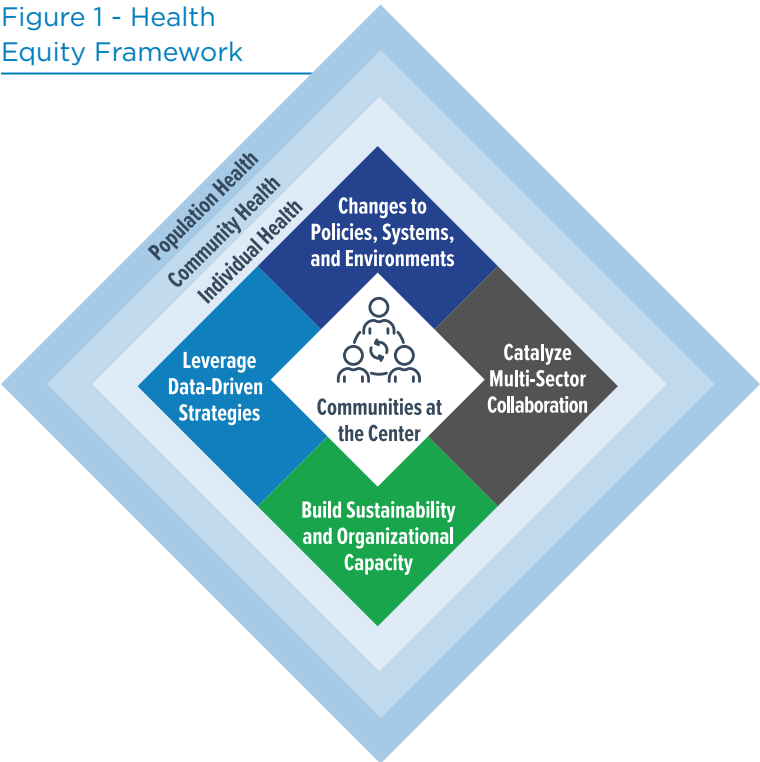
NCDHHS Health Equity Framework

In 2022, the Portfolio created a Health Equity Framework (HEF) intended to catalyze action and put health equity at the center of working with communities across North Carolina. The Health Equity Framework serves as a foundation for developing the Health Equity Community and Partner Engagement Guide.

The Health Equity Framework (see Figure 1) has five pivotal pillars that drive the Department’s equity work.

- **Pillar 1:** *Communities at the Center*
- **Pillar 2:** *Changes to Policies, Systems, and Environments*
- **Pillar 3:** *Leverage Data-Driven Strategies*
- **Pillar 4:** *Catalyze Multi-Sector Collaboration*
- **Pillar 5:** *Build Sustainability and Organizational Capacity*

Figure 1 - Health Equity Framework



Work to Adopt and Embed: The 5 Pillars of the Health Equity Framework

1. The first pillar, **Communities at the Center**, emphasizes the importance of building and nurturing trust through authentic community relationships. To address historical gaps, NCDHHS aims to empower communities that have been historically marginalized by giving them back their rightful power. Integral to this pillar is the embedding of support and partnership with communities in strategy development and execution.
2. The second pillar, **Changes to Policies, Systems, and Environments**, focuses on addressing and eliminating upstream structural drivers that perpetuate health inequities and differences in health outcomes. By tackling these root causes, NCDHHS aims to impact downstream health disparities and cultivate a change-oriented space.
3. In **Leveraging Data-Driven Strategies** through the third pillar, NCDHHS seeks to ensure that all decision-making processes are grounded in data and informed by community voices. Using data, NCDHHS aims to illuminate existing gaps and develop compelling, evidence-based strategies to combat health inequities effectively.
4. To achieve holistic transformation, the fourth pillar, **Catalyze Multi-Sector Collaboration**, encourages the development of robust cross-sector partnerships. Collaborating with various state agencies and partners allows NCDHHS to improve health ecosystems, enhance alignment, foster collaboration, and promote co-creation. This collective effort aims to drive health equity forward across different sectors of society.
5. Finally, the fifth pillar, **Build Sustainability and Organizational Capacity**, underscores the significance of long-term commitment to health equity. By dedicating sustainable funding and providing equity-centered training, NCDHHS seeks to ingrain this commitment within the Department. Additionally, NCDHHS aims to empower communities by expanding their capacity for health equity impact.

The Health Equity Framework stands on these five pillars as the fundamental principles guiding NCDHHS' pursuit of health equity. By placing communities at the core, striving for policy and system changes, leveraging data-driven strategies, fostering multi-sector collaboration, and investing in sustainability and organizational capacity, NCDHHS aims to provide equitable and inclusive opportunities across all communities in North Carolina.

Note: Please use this NCDHHS Community and Partner Engagement Guide as a companion resource to advance the NCDHHS Health Equity Framework.

Key Terms and Definitions for this Guide

The information below defines key terms that will help you best understand and use this Guide. Having shared language for community and partner engagement ensures NCDHHS has both clarity and precision. Additional definitions may be found in the Appendix.

Community Defined

A **community** is defined as a group of people who have self-identified and/or aligned interests. Communities often share geographies, characteristics, values, beliefs, culture, and/or a sense of belonging. Examples of Community: individuals, families, participants, recipients, North Carolinians, towns and neighborhoods, groups that have been historically marginalized, etc.

Partners Defined

Partners can be defined as organizations or groups that have a self-identified and/or aligned interest. These organizations and groups have varied capacity, infrastructure, and resources to collaborate and take action together. Examples of Partners: Faith-Based Institutions, Non-profit Organizations, Health Care Agencies, Community-Based Organizations, Networks, Coalitions, etc.

Community and Partner Engagement Defined

Community and partner engagement can be defined as a mutual and purposeful exchange of lived experience, acquired skills, and genuine trust among partners and communities working together to achieve a common goal. Community and partner engagement should be both intentional and meaningful.

Community engagement actively involves and empowers communities in the planning, coordination, and decision-making processes as it relates to health outcomes. Community engagement recognizes the importance of local knowledge, shared values, and different viewpoints to develop effective solutions to address differences in health outcomes. Community engagement aims to build trust, foster collaboration, and strengthen the relationship between partner groups and the people they serve. This culturally sensitive approach ensures that community members have a voice in identifying health needs, setting priorities, and designing interventions that are purposeful and sustainable.^{1,2}

Partner engagement involves collaborating with external organizations, agencies, and groups that have a shared interest in goals and advancing health equity. These partners may include governmental agencies, non-profit organizations, health care providers, academic institutions, and community-based organizations. Partner engagement is mutual and requires shared respect between trusted messengers and leaders. It focuses on creating alliances and leveraging resources, expertise, and support from various entities to effectively address health disparities across the state. It involves networking and coordinating efforts to implement comprehensive and impactful health programs and initiatives.

In summary, adopting both community and partner engagement approaches are essential in addressing key challenges and improving the well-being of all communities.

¹ Christopher, S., Watts, V., McCormick, A. K., & Young, S. (2008). Building and maintaining trust in a community-based participatory research partnership. *American journal of public health*, 98(8), 1398-1406. <https://doi.org/10.2105/AJPH.2007.125757>

² Teufel-Shone, N. I., Schwartz, A. L., Hardy, L. J., de Heer, H. D., Williamson, H. J., Dunn, D. J., Polingyumptewa, K., & Chief, C. (2018). Supporting New Community-Based Participatory Research Partnerships. *International Journal of Environmental Research and Public Health*, 16(1). <https://doi-org.ncat.idm.oclc.org/10.3390/ijerph16010044>

Work to Adopt and Embed: The Values and Guiding Principles of Community and Partner Engagement

The following values and guiding principles serve as the foundation for effective community and partner engagement. They capture key principles and approaches important to fostering trust, equity, and positive change within communities. They also help to inform a plan of engagement to better understand what this looks like with the communities we serve and the partners with whom we collaborate. Let's cover each principle to better understand its significance in the context of community and partner engagement.

1. **Transparency, Accountability, Power Sharing:** Open communication and *transparency* is essential for trust-building in marginalized communities. Shared *accountability*, where power, resources, and expertise are combined, facilitates the identification of opportunities, management, and expectations, and the establishment of achievable goals. *Power sharing* in community engagement involves collaborating with diverse partners, including government agencies, health care professionals, community organizations, and the public, to make decisions about public health initiatives and policies. It requires careful attention to group power dynamics and a willingness to adopt non-traditional approaches. By prioritizing power sharing in community and partner engagements, we ensure that the outcomes of these collaborations circle back to the community, preventing them from being inadvertently excluded from the benefits they rightfully deserve.
2. **Capacity Building, Sustainability, Change-Oriented:** *Capacity building* involves enhancing collective knowledge and sharing resources, while *sustainability* entails forming and maintaining partnerships, sharing resources, and collaborating effectively. *Change-oriented* refers to a focus on strategies and actions aimed at bringing about tangible and positive transformations within communities and partnerships. It involves actively working toward meaningful shifts, improvements, or advancements in various aspects, such as social, economic, or health-related factors.
3. **Communication Equity, Health Literacy:** *Communication equity* is a vital engagement tool that prioritizes the voices of the disenfranchised and emphasizes individual and community self-determination. Its primary goal is to provide equitable access to timely, accurate, and culturally appropriate health information and resources for all, regardless of socio-economic, cultural, or linguistic background. *Health literacy* involves understanding and using health information for informed decisions, including written, visual, and data-based content, requiring community engagement approaches accepted by all and involving community members in message development.
4. **Community Readiness, Stewardship, Community Self-Determination:** *Community readiness* refers to the preparedness and willingness of a community to actively engage in and support initiatives and changes. *Stewardship* in community engagement means that responsible and ethical leaders ensure the well-being and sustainable development of the community while respecting its values and interests. *Community self-determination* refers to how the community should always retain ultimate agency and participation in its health. Communities, in co-creation with the partner, should define what success looks like.

5. **Cultural Humility, Cultural Sensitivity, Cultural Competency:** *Cultural humility, sensitivity, and competency* encompass aligned behaviors, attitudes, and policies within systems for effective cross-cultural work. This guide in service delivery authentically engages communities with relevance and responsiveness.
6. **Focus on People and Populations that Have Been Historically Marginalized, Lived Experience, Inclusion, Trust Building:** *Focusing on people and populations that have been historically marginalized* in this context means prioritizing the life experiences, viewpoints, and voices of populations that have been marginalized in community engagement, while actively involving and addressing the needs of communities that tend to not get connected to services and resources more than others for many reasons throughout the entire process. *Inclusion* refers to making sure that every person, regardless of their background, identity, abilities, or needs is considered, treated fairly, and given the same opportunities to access and benefit from services, resources, and programs. *Trust* should be established among partners, the community, and the institution itself, through consistency, accountability, trauma-informed approaches, historical awareness, policy considerations, and respect for community dignity.

A Model for Community and Partner Outreach and Engagement

Equitable and inclusive community and partner outreach and engagement is critical to the mission of NCDHHS and the Health Equity Portfolio. Community outreach and engagement are integral components of our work. Outreach and engagement are foundational when looking to implement sustainable interventions and improve community and partner-level connections. While outreach looks at how to identify and connect with potential partners and communities, engagement relies on the continuation of genuine and authentic connections, cultivated through collaboration and continued communication.

Community Homework, Communication, Listening, Collaboration, and Empowerment are elements that ensure meaningful engagement with community-based organizations (CBOs), partners, and stakeholders to achieve equity. In the *Meaningful Engagement of People with Lived Experience* report, meaningful engagement focuses on “ensuring that people who are or have been impacted by an issue are involved in developing, implementing, and evaluating the effectiveness of strategies to address such issue”³. Establishing and sustaining meaningful relationships with CBOs, partners, and stakeholders ensures support for communities and

BENEFITS OF EQUITABLE AND INCLUSIVE ENGAGEMENT

1. Ensures equitable health care service delivery across communities
2. Fosters community ownership and resilience
3. Creates spaces for open and inclusive dialogue
4. Encourages tailored innovative and sustainable ideas
5. Drives meaningful outcomes

³ C. Ash and S. Otiende. *Meaningful Engagement of People with Lived Experience: A framework and assessment for increasing lived experience leadership across the spectrum of engagement*. Global Fund to End Modern Slavery and National Survivor Network- Cast, Washington, DC (2023).

underserved populations. It is important to include communities, populations, and individuals impacted by different types of issues throughout the process of planning and developing solutions, implementing change-based strategies, and evaluating the effectiveness and reach of said strategies to ensure that there are significant impacts and sustainable outcomes.

Building a Strong and Inclusive Team: Before engaging with communities and partners, laying a strong foundation within the organization is paramount. Building the right team within the DHHS workforce is crucial. Establishing relationships internally fosters mutual trust and understanding, enabling a cohesive and collaborative environment. It's equally essential to approach these internal connections in an equitable and inclusive manner, ensuring that every team member feels valued and respected. This inclusive atmosphere not only promotes a positive work environment but also prepares the team to engage external partners with the same level of respect and understanding they have for one another, creating a solid basis for effective partnerships and community engagement.

The elements described in the continuum below are critical to learning about the community to improve engagement and establishing, developing, and enhancing partnerships for community engagement.

BENEFITS OF INTERNAL INCLUSIVE EFFORTS THAT SUPPORT COMMUNITY ENGAGEMENT EFFORTS

1. **Enhanced Understanding:** Internal inclusion efforts promote diverse perspectives within the team, leading to a deeper understanding of various community needs and challenges.
2. **Increased Empathy:** Fostering an inclusive workplace cultivates empathy among team members, enabling them to better relate to the experiences and concerns of community members.
3. **Improved Communication:** Inclusive environments encourage open and honest communication, honing interpersonal skills crucial for engaging with diverse community groups effectively.
4. **Creative Problem-Solving:** Diverse teams often generate more innovative and creative solutions, which can be applied to address community issues in unique and effective ways.

Equitable Outreach and Engagement Continuum

Figure 2 - Equitable Outreach and Engagement Continuum



This Continuum is created by the NCDHHS Office of Health Equity.

THIS IS A CONTINUUM

The five community engagement activities listed above are not one-time tasks but ongoing efforts. Each activity is integral and must be revisited throughout the entire engagement process with external partners or communities.

- Community Homework ensures ongoing understanding of community needs;
- Empowerment maintains a sense of inclusivity and agency;
- Collaboration fosters teamwork and shared goals;
- Communication sustains transparency, and;
- Active listening maintains a pulse on evolving community sentiments.

This interactive approach ensures that the engagement remains responsive, adaptable, and truly reflective of the community’s evolving dynamics and aspirations, fostering a relationship built on trust and mutual understanding.

Description of the Continuum and How-To Guide

What is a **Community and Partner Engagement Continuum**? A continuum is a critical first step in how to develop a plan for engagement with partners and communities that aims to give power back to communities. It provides emphasis on the different elements of how to connect and use a bi-directional approach with partners to effectively conduct outreach and maintain engagement. The continuum was designed to show that you can begin at different phases visually. It is important to remember that there is no one-size-fits-all approach. At the very minimum, always start with the key elements described in the continuum for a good foundation and build upon these efforts. Your approach to engagement depends on the

unique needs of the community, population, or partner with whom you're engaging. **This process is not linear.** Within each element of Figure 2 there are examples of activities and attributes (listed below) that are key to understanding how each pillar fits into the process of equitable and inclusive engagement. Adopting this continuum will strengthen and expand your unique way of community and partner engagement for the services and resources you deliver to address the needs impacting the populations and communities you serve.



Community Homework⁴

A critical first step in equitable and inclusive outreach and engagement involves learning about the community. Doing your community homework means it is more than the data collection. It is about demonstrating and treating communities with the same genuine respect, honor and care that you desire for yourself and your family. It is important to make the time to have conversations with them, visit with them, spend time in their space and environment without your survey or assessment tool. This step is critical to building rapport with them before you bring out your assessment tools. Gain their permission to spend time in their community to do various assessment strategies. Doing your homework and assessment of the community helps to gain a deeper understanding of the community's history, demographics, geography, norms and behaviors, and resources to uncover and anticipate the community's unique needs, inform outreach and engagement with the community and partners, and evaluate the impact of outreach efforts. Obtaining agreement from the community whenever possible is crucial for the effectiveness of the assessment. This is essential to establishing trust and developing relationships with the community, community partners, and community-based organizations.

COMMUNITY HOMEWORK GUIDE

- **Understand Community Demographics:** Community demographics change constantly, so avoid making assumptions about a community based on past engagement – what was true before may no longer apply. Understanding population size, distribution, composition, and the processes driving the stability or change in population is crucial in the development and implementation of programs that serve the local community. Demographic analysis must be a prerequisite for the community and partner outreach and engagement planning process. Consider connecting with other NCDHHS Divisions/Offices working in the community to better understand community demographics and how they may have evolved.
- **Complete an Initial Data Scan:** When seeking to learn about a community, use data to identify important demographic information and uncover potential roadblocks that may exist. People of color, members of religious affiliations, LGBTQ+ individuals, people with disabilities, people affected by persistent poverty, and many other communities may face unique challenges and disparities. Also think about the whole person and be mindful of compounding or layered data, meaning one person could represent more than one group listed (e.g., person of color with a disability in a rural area). Pairing disparities data with social and economic demographic data can provide insight into compounding challenges that influence access to care and health outcomes. This leads to better decisions, more appropriate plans, and unique engagement that fits each community. **The HEP Office of Health Equity produces an annual report that can provide disparities data across North Carolina.**

⁴ The Community Homework we describe here is not a "Community Health Needs Assessment" (CHNA) required of charitable hospitals.

- **Be Aware of Community Resources:**

Learning about a community's existing resources is important for informing partnership selection and equitable engagement.

Creating a Community Resources and Engagement Partner Inventory is necessary to identify and map existing resources in the community. Valuable community resources may include an individual, hospitals and their staff, institutions of education or worship, public transportation, nonprofit institutions, or community/

social services. Community resources can enhance existing capabilities, minimize barriers to access, and present opportunities to form unique partnerships. Remember to take time to learn about the resources a community has and their values rather than focusing on what the community might lack.

- **Emphasize Community Voices:** Prioritizing community voices is critical for fostering health equity through robust community and partner engagement. By establishing a community advisory board or bringing diverse voices, perspectives, and cultures into existing advisory bodies, such as those detailed in the *Urban Institute's tools and resources for project-based community advisory boards* (see Appendix D), a structured platform is provided to amplify the perspectives of those directly affected. This inclusive approach ensures that the diverse needs, concerns, and insights of the community are recognized and integrated into health initiatives. Harnessing the collective wisdom of community members **not only strengthens the relevance and effectiveness of health programs but also cultivates a sense of ownership and trust among stakeholders, ultimately contributing to more equitable and sustainable health outcomes.**
- **Learn About the Community's History:** To improve engagement, learn about the community's history – particularly in the context of previous responses to outbreaks and pandemics. Many communities, especially underserved ones, have a history of being intentionally or unintentionally forgotten, ignored, misunderstood, underinvested in, or discriminated against. These past events can lead to mistrust of the government and influence the way communities think about and react to future public health concerns. By learning about the community's past and being open to difficult conversations about their experiences, you may begin to address past trauma, commit to stronger engagement, and choose community partners accordingly.

TIPS FOR DEVELOPING A COMMUNITY RESOURCE INVENTORY

- **Be clear on the purpose for collecting the information.**
- **Choose an appropriate method for collecting the information (e.g., Survey, Interviews, Focus Groups, or use of publicly available information.)**

TIPS FOR CONDUCTING COMMUNITY HOMEWORK

- **Be open-minded:** Do not presume you know what the community needs or the challenges it faces.
- **Choose diverse participants for assessments:** Consider the makeup of the community and ensure that the groups involved represent the community fairly. Consider turning to non-traditional leaders, individuals who may not hold official titles but are universally respected and relied upon by the community.



Inclusive Communication

Community and partner outreach and engagement cannot happen without good communication. The intended audience should be top of mind when communicating with the community and community partners. Any communication – verbal or written – should be concise, understandable, and appropriately reflect the community, not just NCDHHS’ priorities. When selecting language, photos, and graphics, consider any sensitivities around culture, race, gender, and other identities. Communication should respect and reflect people’s lived experiences. Unlike traditional communication models where messages are developed in siloes for target audiences, an equity-based model relies on co-developing communications with communities through close partnerships.

While providing accurate and timely information about NCDHHS programs and priorities is always the goal, it is essential to create space for true two-way communication. Two-way communication demands we listen and learn, then tailor our response. It also requires providing information through mechanisms and timelines that work best for the community, not only NCDHHS. This is an example of *meeting people where they are*; in doing so, community-facing employees can build trust and better achieve the agency’s mission.

Be sure to recognize the challenges underserved communities may face. Reach out to the HEP Office of Health Equity before contacting the community to ensure your information is culturally appropriate, aligned, and not duplicative. **Remember: for official communications, you must adhere to existing NCDHHS procedures regarding branding, message creation, development, and distribution and coordinate with the NCDHHS Office of Communication on the best way to communicate.**

GUIDE FOR DEVELOPING INCLUSIVE COMMUNICATION

Inclusive communication should:

- Reflect your knowledge of the community based on your assessment, specifically information received directly from communities
- Be concise, accessible, and reflect the community appropriately
- Reflect individual lived experiences where available
- Recognize the community’s strengths, needs and challenges
- Be shared through platforms that reach the largest audience, strategizing with partners to support communication initiatives/needs



Listening to Strengthen Community Interactions

Listening is the bedrock for community and partner outreach and engagement. Ongoing listening leads to better-connected and better-informed community efforts, improves engagement, and enhances NCDHHS’s value in the community. Every meaningful engagement effort, no matter how big or small, is made better by listening. Actively listening to the communities and community partners can foster cultural awareness, sensitivity, competence, and humility which are the different stages of understanding and engaging with other cultures. Every community has different values, beliefs, cultures, and customs. Culture can define how people see themselves and can influence how they interact with the world. Becoming more aware and informed of other cultures leads to more meaningful interactions.

While cultural humility focuses on self-reflection, self-critique, and acknowledging personal biases, it builds on cultural competence. The CDC National Prevention Information Network (NPIN) defines cultural competence as the **integration and transformation of knowledge** about individuals and groups of people **into specific standards, policies, practices, and attitudes** used in appropriate cultural settings to increase the quality of services, thereby producing **better outcomes**.⁵

CULTURAL AWARENESS	CULTURAL SENSITIVITY	CULTURAL COMPETENCE	CULTURAL HUMILITY
<p><i>Being conscious of similarities and differences between people from different groups.</i></p> <hr/> <p>Considerations for building cultural awareness: Demonstrate self-awareness by exploring your historical roots to understand how culture impacts your life. People see themselves through the lens of gender, race, sexual orientation, socioeconomic status, religion, and other identities. Be cognizant of how others view themselves, how they may perceive you, and how you perceive yourself and others.</p>	<p><i>Being aware of differences, being respectful and accepting of differences.</i></p> <hr/> <p>Considerations for building cultural sensitivity: Because cultures are not monolithic, avoid making assumptions about how someone may think or behave based solely on their appearance or other characteristics. Remember that identities and cultures can be intersectional. Adapt outreach and modify services to fit the different cultures and contexts of the communities you serve.</p>	<p><i>Learning and respecting behaviors and attributes of other cultures.</i></p> <hr/> <p>Considerations for building cultural competence: Be open to learning about different cultures and understand that you do not and cannot fully understand the culture and experiences of all communities you will meet. Listen and ask questions to help your understanding, and approach situations with humility and respect. Reflect on how your experiences with different cultures shapes your perception.</p>	<p><i>Lifelong commitment to self-reflection and maintaining relationships based on mutual trust and respect.</i></p> <hr/> <p>Considerations for building cultural humility: There is no endpoint to being culturally competent. Be committed to lifelong learning and have humility in your interactions with people from within and outside of your community. Engage in continuous self-reflection, check in with your own assumptions, and learn to recognize your blind spots and biases.</p>

⁵ Cultural Competence In Health and Human Services | NPIN (cdc.gov) <https://npin.cdc.gov/pages/cultural-competence#what>



Collaboration: Partnerships for Community Engagement

Building strong partnerships with trusted organizations can make your work easier, more transparent, and representative of community interests and needs. Because of their local insight, community-based organizations can often best pinpoint where strategic engagement efforts will have the greatest impact. Including them in the planning and development of services, communications, and initiatives is an important step toward health equity. It is often more effective to reach communities through trusted messengers. Local partners play key roles in community institutions and may be trusted by the public more than government agencies. Leveraging the expertise and work of these trusted messengers is critical to sustainable community engagement.

INITIAL REFLECTION QUESTIONS FOR NCDHHS EMPLOYEES TO BUILD OR ENHANCE PARTNERSHIPS

- **What are the goals of the partnership?**
 - What is the intended outcome of the engagement? How can collaborative partnerships improve these outcomes?
 - Are these goals mutually beneficial for both NCDHHS and the partner? How will the community benefit from this partnership?
 - Are there existing partnerships I can leverage to build connections?
- **Are there existing networks I can join?**
 - Who else has engaged this community – at NCDHHS, or other state agencies?
 - How do I learn about existing partnerships?
- **What resources can I commit to this partnership?**
 - Investing financial resources adds value to partnership and commitment. But, if such resources are not available what other resources can you offer that show respect for the community's time, expertise, and linkages? Partnership success involves resource sharing.
 - How can I align the resources I have with the goals of the partnership?
 - Can other divisions/offices at NCDHHS provide resources?

IDENTIFYING COMMUNITY PARTNERS

As the state of North Carolina's landscape has changed given the COVID-19 pandemic, engaging community-based organizations to meet local needs and reach underserved communities has become more important than ever. Identifying all partners the division engages with or wishes to engage with is crucial for the success of NCDHHS priorities and goals. Engaging with partners, especially historically marginalized populations (HMPs), will allow divisions/offices to target health equity interventions in a meaningful and productive manner. Additionally, identifying partners allows for more ideas to be shared, strengthens organizational credibility, and increases the success of equity efforts.⁶

SAMPLE PROCESS GUIDE FOR IDENTIFYING PARTNERS

1. **Identify Selection Criteria: Determine the reason for engaging the community and select the geographic area based on your criteria.**
2. **Understand demographic makeup**
3. **Identify Community-Based Organizations**
4. **Build a governance structure for managing the relationships**

⁶ American Hospital Association (AHA) Community Health Improvement, Community Health Assessment Toolkit, www.healthycommunities.org/resources/toolkit/files/step2-identify-engage-stakeholders

COMMUNICATING WITH PARTNERS

Effective community engagement does not begin and end with one interaction. Developing trust, establishing a collaborative relationship with partners, and understanding the unique qualities of a community takes time and commitment. Because of this, the foundation of equitable and inclusive engagement must be set intentionally. Communicating with partners and stakeholders is critical to ensure everyone is aligned on the goals of engagement to address community needs. Be mindful of asking for information that a community or partners have already shared or that could be informed by knowledge and data that already exists at the agency.

DEVELOPING AN ENGAGEMENT PROCESS

When developing an engagement process, work with partners to determine what success looks like before engagement begins by having a clear idea of the outcomes you expect.

Divisions/Offices can consult the HEP Office of Health Equity when considering outreach and engagement with external stakeholders. Be prepared to track outcomes and request feedback from partners to measure the success of the engagement and shape future initiatives. The HEP Health Equity Framework (HEF) which is intended to catalyze action and put health equity at the center of working with communities across North Carolina can be adapted within Divisions/Offices as a strong foundation when developing the engagement process. Building on the HEF, the HEP built a Community and Partner Engagement Framework (CPE Framework) called the **CPE 4 C's: Connecting, Consulting, Collaborating, and Convening** to achieve its community and partner engagement mission and vision.

1. **Connect:** The pillar of *Communities at the Center* forms the foundation for the “connect” component of the CPE framework, emphasizing the significance of building authentic relationships with community partners.
2. **Consult:** The *Changes to Policies, System, and Environment* pillar underpins the “consult” component, recognizing the importance of seeking community input and insights in policy development.
3. **Collaborate:** The *Leverage Data-Driven Strategies* pillar supports the “collaborate” component, as data-driven decision-making fosters collaborative efforts in addressing health disparities.
4. **Convene:** The *Catalyze Multi-Sector Collaboration* and *Build Sustainability and Organizational Capacity* pillars intertwine with the “convene” component, emphasizing inclusive dialogue and fostering partnerships to create sustainable health equity solutions.

This harmonious integration ensures that the CPE guide captures the core values of the Health Equity Framework, driving collective efforts toward a more equitable and inclusive health care landscape in North Carolina.

SAMPLE ENGAGEMENT PROCESS

1. Define the purpose of the engagement
2. Understand community and partner interests, values, and opportunities for engagement
3. Deliver inclusive and respectful engagement
4. Review and interpret engagement feedback, outcomes, and data
5. Apply the outcomes of the engagement to inform the decision-making process
6. Report feedback
7. Evaluate success and share lessons learned

BUILDING AN INVENTORY OF PARTNER ENGAGEMENTS

Sharing information about key partnerships within and across NCDHHS divisions creates greater visibility, tracking, and coordination across the Department. A partner engagement inventory is a vital method to organize these engagements and capture how they connect and amplify work within divisions, and how partners, groups, and constituents can get information on the engagements. Capturing this information helps ensure the sustainability of health equity initiatives and fosters an ongoing commitment to addressing differences in health outcomes. The partner inventory at DHHS is used to track key engagements occurring within various departments. Building an inventory is a strategic move toward a more inclusive and effective approach to public health.

TO IDENTIFY KEY PARTNERSHIPS AND ENGAGEMENTS, CONSIDER ENGAGEMENTS THAT HAVE THE FOLLOWING QUALIFICATIONS:

- *Groups that are your top priorities for engagement:* Clearly define and emphasize engagements that align with NCDHHS and your division's strategic priorities and partners that are essential to your work and groups. This can include community organizations, advocacy groups, and other stakeholders who play a crucial role in shaping program and policy direction.
- *External groups your division engages with regularly (monthly or quarterly) that advise/inform programmatic and policy work as a division:* Prioritize partnerships that involve consistent and meaningful engagement, ensuring that the inventory reflects active collaborations that contribute to program and policy decisions.
- *Engagements that are state or legislatively required.*

TO CONSTRUCT A COMPREHENSIVE PARTNER ENGAGEMENT INVENTORY, CONSIDER THE FOLLOWING BEST PRACTICES:

- Regularly update the inventory: Keep the list dynamic and reflective of the evolving landscape of partnerships. Regular updates ensure that new engagements are incorporated, and outdated information is removed, maintaining the accuracy and relevance of the inventory.
- Use a centralized system or platform for maintaining the inventory: This ensures accessibility for all relevant stakeholders and promotes consistent tracking and coordination.
- Establish communication channels: Facilitate effective communication channels within NCDHHS for sharing information about partner engagements. This can include regular updates, newsletters, or dedicated meetings to enhance collaboration and awareness.

TRACKING AND EVALUATING PARTNERSHIPS

There is no single way to evaluate the success of a partnership. What one individual might view as 'success' might not be how community partners measure effectiveness. **Regularly check in with partners to gauge your progress and working relationship.** You may also consider co-developing an evaluation tool or a continuous improvement plan with your partner to measure effectiveness. Be sure to share feedback with community partners. It is important to provide the space, platform, and opportunity for the community to be heard, valued, and respected. Where possible, ask for recommendations for improvements to monitoring and evaluation. Evaluation should not be thought of as an end to engagement effort, but rather as a way to track progress and continuously improve future efforts.

Use the performance indicators below to understand how partnerships can be improved. Adapt these as appropriate for your partnership or use them as a guide to brainstorm your own. A key step in evaluating partnerships is seeking and being open to feedback, so connect directly with your partner to gauge their perspective on the collaboration.

PARTNERSHIP EVALUATION REFLECTION QUESTIONS

- Are you aligned on the purposes and goals of the partnership?
- Is the partnership equitable for all partners involved?
- Are the purpose and goals of the partnership important to the community?
- Has dedicated time been invested in developing and nurturing the partnership?
- Have community members been directly engaged in a number of ways as a result of the partnership?
- Have you and your partners contributed time, information, resources, or any other benefit to the project and to the community?
- Have your partners' time, expertise, and contributions been valued and leveraged?
- In what ways has this been done respectfully?
- Have you performed an after-action review to ensure you have fulfilled commitments to partners and the community and vice versa?
- Does your partner view the partnership as a success? How have you confirmed this? Do you view the partnership as a success? Does the community view the partnership as a success?

IMPORTANCE OF TRACKING ENGAGEMENT OUTCOMES

Tracking engagement outcomes can show the Division/Office what is working well, identify other areas of opportunity, and help staff commit to a culture of continuous learning. Outcomes can be measured through quantitative or qualitative indicators depending on the engagement. For example, tracking the number of meetings, phone calls, or new joiners to a group is one way to determine progress. Over time you may begin to break down the subsets of community engagement for more qualitative metrics. Strive to measure outcomes and track “success” in ways that feel appropriate to your goals.

When reviewing community engagement outcomes, it is important to measure how, not just how many. Numbers alone may not necessarily indicate whether initiatives fulfill community-identified needs or are meaningful and have a positive impact on community members. The question bank below offers some useful indicators for engagement outcomes as a starting point which can be adapted for each community.

QUESTION BANK FOR TRACKING ENGAGEMENT OUTCOMES

The questions below can be used or adapted for process evaluation. They help determine if the initiative's implementation had a positive outcome:

- Were meetings and communications materials in the primary language(s) of a community?
- Were meetings conducted in a location and at a time accessible to community members?
- Was information shared in a culturally accurate and respectful manner that resonated with participants?
- Were community members asked what their priorities are and how they plan to accomplish them?
- Were communications conducted in a culturally sensitive manner (i.e., showing respect for customs, values, beliefs, and preferences in words and actions)?
- Was the information shared reflective of different community needs, capabilities, and capacity?
- Did participants feel encouraged to share feedback?



Empowering Communities and Partners⁷

Empowerment evaluation is a principle that can be adopted by Divisions/ Offices to sustain community and partner engagement efforts. This is an evaluation approach that aims to increase the probability of achieving program success by providing the community and partners with tools for assessing the planning, implementation, and self-evaluation of programs. The aim of empowerment evaluation is to foster community ownership and accountability, increase community knowledge, and build community and partner capacity.

STEPS IN EMPOWERMENT EVALUATION

- **Develop a Mission and Vision** for the evaluation group. This can be done even when a mission and vision statement for the engagement exists.
- **Critically Think:** Brainstorm and prioritize a list of partners to the functioning of the program to evaluate. Recommendation: Identify the 10 most important activities
 - Rate how well the 10 key activities are doing on a scale of 1 – 10. This could provide information on program strengths and weaknesses
- **Plan for the future:** Brainstorm realistic goals and develop strategies to reach them

⁷ Wandersman, A., Alia, K. A., Cook, B., & Ramaswamy, R. (2015). Integrating empowerment evaluation and quality improvement to achieve healthcare improvement outcomes. *BMJ quality & safety*, 24(10), 645–652. <https://doi.org/10.1136/bmjqs-2014-003525>

ENGAGING COMMUNITIES AND PARTNERS IN POLICY DEVELOPMENT

Effective community and partner engagement in policy development is crucial for creating inclusive, well-informed, and sustainable initiatives. Drawing inspiration from successful strategies, here are key considerations and best practices for engaging stakeholders in the policy development process:

1. Identify Appropriate Stakeholders to Involve:
 - a. Begin by building a comprehensive list of external stakeholders early in the process.
 - b. Over-invite to avoid excluding key community members, ensuring diversity in perspectives.
 - c. Personalize invitations and follow up consistently, using direct, person-to-person discussions to address concerns and build rapport.
 - d. Prioritize personalized engagement, recognizing the value of involving stakeholders with lived experiences.
2. Choose a Meeting Structure:
 - a. Tailor invitations to key stakeholders with expertise or interest in the policy topic.
 - b. Consider an open structure for broad community engagement or an invite-only structure for targeted, focused discussions.
 - c. Mitigate the risk of unintentional exclusion in invite-only meetings by actively seeking diverse perspectives and feedback.
 - d. Frame meetings as collaborative efforts, fostering a task force mentality for comprehensive policy development.
3. Determine Meeting Frequency:
 - a. Decide on the number and frequency of meetings, aligning with the time commitment expected from stakeholders.
 - b. Balance the need for regular engagement with the availability and interest of stakeholders.
 - c. Aim for an ideal number of meetings (e.g., four to 10), adjusting based on the pace of decision points and stakeholder preferences.
 - d. Regularly review past content to keep stakeholders informed and engaged.
4. Manage Meeting Logistics:
 - a. Facilitate discussions, record stakeholder opinions, and adjust meetings based on feedback to keep them on track. Incorporate key questions to guide discussions and ensure comprehensive coverage of topics.
 - b. Schedule meetings regularly, using tools like surveys to determine convenient times for stakeholders.
 - c. Choose neutral and central meeting locations with considerations for accessibility and incentives such as free parking or refreshments.
 - d. Maintain regular stakeholder follow-up during the policy development process to keep contributors informed and engaged.

Key Meeting Topics:

1. Provide context and vision to stakeholders, emphasizing how their contributions support broader state goals.
2. Address policy structure, compliance, and recognition, considering the state's sustainability goals and feasibility.
3. Discuss implementation phasing and support, involving stakeholders in decisions about policy rollout and whether to phase it in based on size and scope of the undertaking.
4. Discuss the time needed to achieve goals and stakeholder capacity for policy support.
5. Offer training and workshops to ensure stakeholders are well-informed and supported in understanding and implementing the policy.

By adopting these strategies, NCDHHS can enhance community and partner engagement efforts, ensuring that policies are not only well-informed but also reflective of the diverse needs and perspectives within the community.

COMMUNITY AND PARTNER ENGAGEMENT AS AN ONGOING INITIATIVE

It's crucial to acknowledge that community and partner engagement efforts are continuous and interconnected with internal workforce and service inclusion. NCDHHS staff should utilize this document as a resource to guide their approach, engagement, and strategies. Making workforce inclusion a priority internally translates into genuine and effective external inclusion efforts for communities. Embracing this resource not only keeps communities at the heart of our work but also ensures that our internal culture of inclusion extends outward, enabling us to address health care disparities for North Carolinians effectively. This ongoing commitment will pave the way for a more equitable and inclusive health care landscape in the state, fostering a sense of belonging and understanding for all.



Potential Challenges and Possible Solutions to Community and Partner Engagement

Community and Partner Engagement (CPE) do not come without challenges. The spirit of progressive and successful CPE is to be flexible, open to shifting or building a bridge to connect, or to get over hurdles. Be mindful that CPE is not just a separate service, program, or initiative. It is part of the process for how you operate and should be included in everything that you or your Division/Office does. Be open and intentional about investing in partnerships. This provides the same respect that you would want for your time, subject matter expertise, and linkages. The table below will provide some common challenges that can be developed and possible approaches that could assist.

Potential Challenges and Barriers	Possible Solutions
Perception of Uniformity - Difficulty Recognizing Diversity	Increase awareness about diversity within and among communities. Use data and personal narratives to illustrate these differences. Recognize the diversity of partners, some of whom may also be community members. Implement strategies to ensure inclusive representation and equal participation.
Limited Community Leadership	Provide training and resources to build leadership capacity within the community. Foster mentorship programs and support networks.
Lack of Incentives	Explore non-financial incentives such as recognition, training opportunities, or access to resources that benefit the community.
Trust Barriers	Review and reform existing policies and systems that hinder trust-building. Involve the community in policy discussions and decisions.
Resource Investment	Carefully plan resource allocation and project timelines. Streamline processes and explore cost-effective methods of engagement.
Lack of Leadership Representation	Actively involve community and partner leaders in decision-making processes. Create opportunities for them to take on leadership roles.
Facilitation Challenges	Provide facilitator training that addresses communication, coordination, and power dynamics. Encourage self-awareness and the development of adaptable facilitation skills.
Unclear Roles and Responsibilities	Clearly define roles and responsibilities for different teams and partner groups. Use collaborative tools and agreements to manage expectations and ensure accountability.

It's essential to acknowledge that while these solutions can be effective in many situations, they may not be one-size-fits-all. Communities vary widely, and their needs and preferences differ. Therefore, it's crucial to consider alternative approaches or tailor these solutions to align with the unique characteristics and requirements of specific communities.

Call to Action

Strengthening Community and Partnership Engagement for Population Health

The North Carolina Department of Health and Human Services 2024-2026 Strategic Plan is grounded in the Department's values, driven by equity, rooted in our commitment to whole person care, and responsive to the lessons learned responding to the greatest health crisis in a more than a generation. Community and partner engagement (CPE) work to advance the NCDHHS mission to improve the health, safety, and wellbeing of all North Carolinians.

Community and partner engagement are the core of achieving optimal health outcomes in North Carolina. We can cultivate a healthy ecosystem through meaningful collaboration and shared objectives where everyone is valued and empowered. The North Carolina Department of Health and Human Services (NCDHHS) emphasizes the need for robust community and partner interactions to embed health equity into the fabric of our society. For our partners dedicated to this mission, harnessing the principles of the NCDHHS Community and Partner Engagement Guide to lead with purpose and vision is crucial.

This is a plea for all NCDHHS to pledge and build on this foundation with strategies for whole person care, community-centered response through community and partner engagement approaches. This includes five key areas:

1. **Cultivate Genuine Relationships:** Initiate community dialogues, town hall meetings, and feedback sessions. Engage directly with historically marginalized communities to understand their unique challenges and aspirations. EXAMPLE: Organize monthly community forums to discuss health concerns.
2. **Adopt Evidence-Based Approaches:** Incorporate the strengths, resilience, history, and lived experiences of communities into your strategies. EXAMPLE: Design health campaigns based on real-life narratives of community members.
3. **Promote Transparent Communication:** Ensure all information shared is clear, relevant, and resonates with the community's cultural and linguistic preferences. EXAMPLE: Translate health guidelines into various local languages and distribute them through trusted community channels.
4. **Collaborate Actively:** Engage with a broad spectrum of partners – from faith-based institutions to non-profits and health care agencies. Combine resources and expertise for greater impact. EXAMPLE: Form a health equity coalition with diverse stakeholders to address specific health disparities.
5. **Empower Through Education:** Offer training sessions, workshops, and resources that enhance community and partner understanding of health equity principles. EXAMPLE: Organize bi-annual training programs on cultural sensitivity and health literacy for community leaders and partners.

Let's reshape the way we collaborate, amplifying our communities' voices and harnessing our partners' collective power. By championing community and partner engagement, we're not only striving for health equity but also forging a brighter, healthier future for every North Carolinian. Let's pledge to put this into action and work together to revolutionize the landscape of health equity, ensuring no community is left behind.

Appendix A: Examples of NCDHHS, HEP and OHE Mission and Vision for Community and Partner Engagement

NC Department of Health and Human Services (NCDHHS): Mission and Vision

Mission: In collaboration with our partners, the North Carolina Department of Health and Human Services provides essential services to improve the health, safety, and wellbeing of all North Carolinians.

Vision: Advancing innovative solutions that foster independence, improve health, and promote well-being for all North Carolinians.

Health Equity Portfolio: Mission, Vision, and Goal

Mission: Embedding equity through trust, collaboration, innovation, and quality service delivery.

Vision: Foster fair and just opportunities for all people of North Carolina to achieve their healthiest outcomes.

The Health Equity Portfolio uses the **4 C's: Connecting, Consulting, Collaborating, and Convening** to achieve its mission and vision.

1. **Connect:** The pillar of Communities at the Center forms the foundation for the “connect” component of the CPE framework, emphasizing the significance of building authentic relationships with community partners.
2. **Consult:** The Changes to Policies, System, and Environment pillar underpins the “consult” component, recognizing the importance of seeking community input and insights in policy development.
3. **Collaborate:** The Leverage Data-Driven Strategies pillar supports the “collaborate” component, as data-driven decision-making fosters collaborative efforts in addressing health disparities.
4. **Convene:** The Catalyze Multi-Sector Collaboration and Build Sustainability and Organizational Capacity pillars intertwine with the “convene” component, emphasizing inclusive dialogue and fostering partnerships to create sustainable health equity solutions.

This harmonious integration ensures that the CPE Guide captures the core values of the Health Equity Framework, driving collective efforts toward a more equitable and inclusive health care landscape in North Carolina.

Office of Health Equity: Mission and Vision

Mission: Promote and advocate for the elimination of disparities and improve health equity in North Carolina, especially in populations that have been historically marginalized. OHE assists in leading an agency-wide strategy that aims to integrate health equity into all that we do from a Departmental level.

Vision: All North Carolinians have the opportunity to attain the most optimal level of health possible, regardless of race/ethnicity, disability, sexuality and gender identity, socioeconomic status, or other differences.

HEP and OHE adopt and embed the NCDHHS values, driven by equity, rooted in our commitment to whole person care in all that we do. Community and partner engagement (CPE) works to advance the NCDHHS mission to improve the health, safety, and wellbeing of all North Carolinians.

Community and partner engagement is an operational practice embedded in all of OHE's foundations to advance our mission and vision. OHE works to equip and empower communities and partners to be full participants in, and have agency over, their own health outcomes.

Appendix B: HEP Community and Partnership Engagement SMARTIE Goals 2024-2025

SMARTIE Goals can be defined as 'Strategic, Measurable, Ambitious/Achievable, Realistic, Time-Bound, Inclusive, and Equitable Goals' that produce better outcomes for populations and communities that have been historically marginalized and help to address health disparities. Incorporating an 'inclusivity and equity' component to existing SMART goals reinforces the agency's commitment to advancing equity and ensures goals are grounded by actionable steps to move forward.⁸

HEP 2024-2025 Broad Priorities:

1. Olmstead/TCL
2. Operations
3. Engagement
4. Sustainability
5. Operationalize Governance Model and Frameworks

⁸ The Management Center. (2021). SMARTIE goals worksheet. Retrieved from: www.managementcenter.org/resources/smartie-goals-worksheet/#:~:text=SMARTIE%20stands%20for%20Strategic%2C%20Measurable,bound%2C%20Inclusive%2C%20and%20Equitable.

HEP Priority Goals Related to Community and Partner Engagement

1. **Olmstead:** Engage disability-related population groups to better serve individuals with disabilities and caregivers; ensure communities and partners inform and participate in the implementation of the Olmstead Plan by June 2024.
2. **Operations:** Develop tools and strategies for tracking, evaluating, and improving community and partner engagement.
3. **Engagement:** Drive policy and facilitate system change by supporting best-practice standards of engagement to eliminate health disparities for HMPs.
4. **Sustainability:** Identify long-lasting resources, funds, and collaboration opportunities across NCDHHS focused on community and partner engagement.
5. **Operationalize Governance Model:** Launch HEAT (internal NCDHHS group, Health Equity Champions) Groups to operationalize the HEP Governance Model by January 2024. HEAT groups include 1) Health Equity Champions and 2) External Community Advisory Council, and Subject Matter Expert (SME) Network.
6. **Operationalize Frameworks:** The HEAT (the internal NCDHHS group, Health Equity Champions) will promote the adoption of the HEF and the CPEF into NCDHHS plans by May 2024.
 - a. HEP to train all Health Equity Champion members on the HEF and CPEF (“Train the Trainer”).
 - b. HEP/Capstone Team to conduct a landscape analysis/inventory of CPE across NCDHHS.
 - c. HEAT to develop policy directives on how to leverage communities and partners for the reduction of health disparities.
7. **Medicaid Expansion:** Provide leadership, coordination, and consultative support throughout the implementation of Medicaid Expansion by engaging primary care, behavioral, and social service providers; new and existing beneficiaries; and HMPs (such as rural, indigenous, Latinx, and other priority populations) by June 2024.

Appendix C: Additional Definitions

Health Equity Portfolio – HMP Definition (Revised Spring 2020)

REVISED DEFINITION of Historically Marginalized Population:

Populations that have been Historically Marginalized (HMP) include the following:

- **Denied and/or have received limited access** to survival services and resources such as health care, housing, food, education, transportation and more...
- **Based on their race, ethnicity, work-status, immigration status, socioeconomic status, geographical location, religion, language, sexual orientation, sex, gender identity, age, and ability**
- **Vulnerable** to systemic, durable, persistent racism, ableism, discrimination, and other forms of oppression
- **Disadvantaged by power relationships** across economic, political, and cultural dimensions
- **Continue to experience adverse health outcomes** as a result of historical injustices and inequitable access
- **Recognize compound disparities and how they can cause additional difficulties** (being part of multiple populations at the same time)
- **Documented that marginalization leads to adverse outcomes and complex barriers to overcome in the past, present, and future.**
- **Terms are constantly shifting**, and this definition may expand to include other individual, communities, and groups.
- As an example, **some of the groups that fall within this definition and that have been the focus of the NCDHHS equity strategy** are listed below. Many additional groups and sub-groups that meet this definition could also be listed. It is important to be inclusive in identifying groups that meet this definition that may be the focus of your work:
 - African Americans/Black
 - Latinx/Hispanic
 - American Indian
 - Alaskan Native
 - Asian
 - Refugees/Immigrants
 - People with disabilities
 - LGBTQ+
 - Rural
 - Unhoused
 - Farmworkers, meatpacking, front-line workers, low-wage workers
 - Individuals with disabilities

Appendix D: Prioritizing Community Voices Resources

The resources listed provide additional strategies, guidance, and best-practices when prioritizing community voices within community and partner engagement efforts.

- The Urban Institute – [Community-Engaged Methods](#) provides tools and resources for project-based community advisory boards. It serves as a community voice and power sharing guidebook.
- The Robert Wood Johnson Foundation’s “Community Voices in Health” program can be found at rwjf.org for dedicated sections or articles addressing community engagement and voices in health care.
- The Agency for Healthcare Research and Quality’s “Patient-Centeredness, Diversity, and Stakeholder Engagement” initiative is available at ahrq.gov/pcor/strategic-framework/stakeholder-engagement.html. Look for sections or articles that highlight the importance of community voices in health care decision-making.

Appendix E: Communication Tools and Resources

Communication Equity

The resources below provide information about how to make presentations and other communications more inclusive for those who may be visually impaired, hard of hearing, or otherwise disabled.

- [Communication Equity Tips](#)
- [Advancing Equity Through Language, Communication, and Physical Access \(LCPA\)](#)
- [Hearing Loss Communication Guide for individuals and providers](#)

Communication Tips for Effective Facilitation of Meetings

The resources listed provide communication equity best practices facilitating effective meetings from a variety of organizations for unique perspectives.

- [Engaging Emergent Strategies in Facilitating Multi-Stakeholder Health Equity Collaboration](#)
- [Practice Facilitator’s Guide to Running Effective Meetings](#)
- [Facilitating Community Engagement](#)

Communication Engagement Best Practices

The resources listed below are examples of community engagement at work and of incorporating health equity into all procedures.

- [HMP Provider Engagement Toolkit by Dr. Rhonda Stephens](#) focuses on embedding health equity into organizational structure long term.
- [Providing Access for Everyone Accessibility Document](#) provides guidance on ensuring COVID-19 testing and treatment sites are ADA-compliant.
- [Tips to Print, Customize and Share WeCanDoThis Campaign Content](#) provides tips for printing and sharing documents
- [COVID-19 Social Media Toolkit](#) provides social media tips for communicating public health initiatives
- [Health Equity Guiding Principles for Inclusive Communication | Gateway to Health Communication | CDC](#) provides language and health equity lens guidance
- [Public Health Campaigns | Research Prevention | ODP \(nih.gov\)](#) provides best-practice NIH public health campaigns from a variety of health promotion programs

Communicable Disease Response Resources

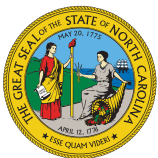
This section lists resources about communicable diseases that contain information regarding public health strategy, communications, and best practices.

- [Mpox Communications Toolkit](#)
- [Promoting COVID-19 Vaccine Equity in NC](#)

Appendix F: Sample Action Planning Template

- **FY 2023-24 Annual Goal 2: For your goal answer: What vision are you working to achieve?**
- **Measure of Effectiveness/Measurable Objective: For this answer: What problem are you working to address here, who are you touching with it and when can you get this done?**
- **Target audience for objective: Let's prioritize! Based on the data, who should be reached to address the problem and achieve what you set out to do?**

Strategies/Activities Planned to Achieve Objective	Process	Data/ Resources Needed	Team Members Responsible	Partners Internal/ External	Timeline	What's Your Proof? Products/ Outputs



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