health action
PARTNERSHIP

A Guide to Building Collective Impact Partnerships

About the Health Action Partnership Toolkit

The Health Action Partnership Toolkit provides technical assistance that has been developed from local experiences of a long-term, multi-sector coalition of over 80 agencies. It was developed out of the idea that many community efforts to address health inequities are unsuccessful based on regional divisions, thoughts, resources, traditions and/or other barriers. This resource was designed to assist local communities in building long-term, sustainable collective impact partnerships that foster a local culture of equity and inclusion and improve community health.

It is meant to assist collaborative partnerships in their efforts to:

1) Design a local collective impact partnership

2) Adopt a model of shared decision-making

3) Define metrics for success

4) Incorporate guiding principles for advancing health equity and

5) Craft a community health equity report.

Generous support to create the Health Action Partnership toolkit was provided by **Culture of Health Leaders,** a national program supported by the Robert Wood Johnson Foundation dedicated to creating collaborative solutions that address health inequities and move communities and organizations towards a culture of Health.

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The History of Our Health Action Partnerships

Since 2007, Health Action Partnerships (HAP) have worked through community organizations, neighborhood coalitions and local advocates to support substantial improvement in the health outcomes of Central Alabama residents.

With the support of three anchor organizations: Community Foundation of Greater Birmingham, United Way of Central Alabama, and the Jefferson County Department of Health, a formally defined structure was created, including operational guidelines for achieving the Health Action Partnership's mission of making Central Alabama a healthier place to live, learn, work, and play. Health Action Partnerships are community-based and address the issues recognized as priorities by residents and stakeholders. This partnership model has the unique power to weave together collaborative efforts large and small to drive collective impact.

Our Community Foundation
For a Greater Birmingham

United Way
United Way of Central Alabama, Inc.

JCDH
100 YEARS OF CARING

Our Mission: The Health Action Partnership works with diverse stakeholders to make Central Alabama a healthier place for all residents to live, learn, work, play and achieve their highest possible quality of life.

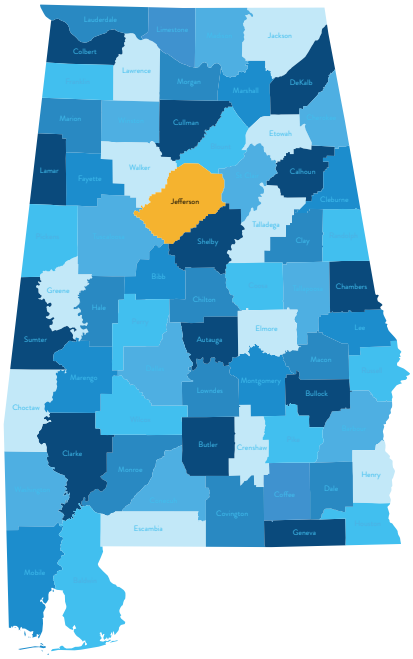
Our Vision: Central Alabama is a healthy, thriving, and connected community, where all residents can achieve their highest possible quality of life, and is recognized as such statewide and nationally.

On the large scale, grants from the Centers for Disease Control and Robert Wood Johnson Foundation totaling more than $13.5 million have helped the Health Action Partnership take major steps toward reducing obesity and tobacco use in the county. On a smaller scale, the Health Action Partnership has helped foster community-based collaborations and mobilized local support to drive community change. Currently, Health Action Partnerships are operating in Jefferson and Walker Counties, and the model is adaptable to work with diverse stakeholders in rural and urban settings.

"This collective impact model has allowed us to secure funding and political support for game changing public health efforts, including smoking ordinances, complete streets policies, increase healthcare access, increased access to healthy, affordable food, and better tools for assessing and intervening on mental health issues affecting students and their families."

- Dr. Monica Baskin
Professor, UAB School of Medicine
Chair, Jefferson County Health Action Partnership

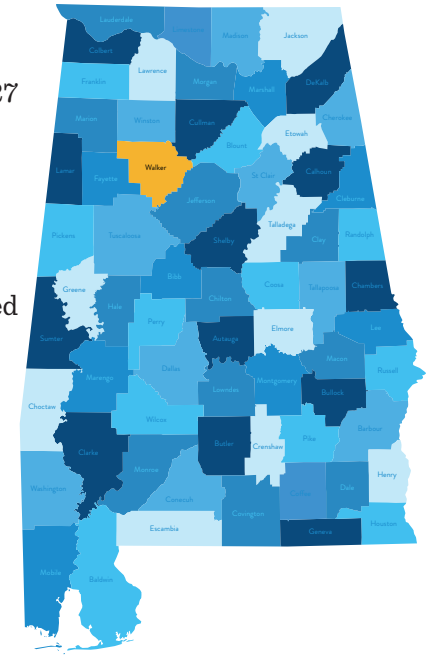
About Jefferson County, Alabama



With over 650,000 residents and 35 independent municipalities, Jefferson is the most populated county in Alabama, and the county seat is Birmingham, Alabama's largest city. The county's overall racial/ethnic population is 52.4% white, 42.5% black and 3.7% Hispanic. According to the 2018 Jefferson County Community Health Equity Report, a 28.9 year difference in life expectancy exists between census tracts experiencing the lowest life expectancies and those with the highest life expectancies. Historical segregation has led to a significant variation in racial concentration, poverty, life expectancy, infant mortality, and healthy food access between suburban census tracks outside of Birmingham and census tracts in Birmingham along the Interstate 20/59 corridor. Specifically, suburban census tracts found higher percentages of white residents, less poverty, longer life expectancy, lower infant mortality, and greater healthy food access.

It is also home to the state's largest single employer, a world class research institution, and the nation's third largest pediatric medical facility in the United States. Despite these and other tremendous resources, our community continues to struggle to achieve optimal health, and, according to the 2020 Robert Wood Johnson Foundation (RWJF) County Health Rankings, Jefferson County is ranked 26 out of 67 counties in Alabama for health outcomes. The lowest rankings are in physical environmental features (65), premature death (34), and social and economic factors (23).

About Walker County, Alabama



According to 2016 Census estimates, the population of Walker County was 64,927 with 74.1% of the population living in rural areas. The county's overall racial/ethnic population is 91.2% white, 6.1% black, and 2.4% Hispanic. Jasper is the largest city in Walker County and the county seat, with an estimated population of 14,137. The median household income in 2016 was $37,025, compared with $44,758 for the state as a whole, and the per capita income was $20,410, compared with $24,736 for the state as a whole.

Coal and timber industries continue to be important components of the local economy, but 2018 data from the Alabama State Department of Labor showed the number of jobs statewide in coal mining decreasing each year since 2012, with Walker County's numbers cut in half during the same period. High levels of poverty in the county have led to an increased risk of many chronic conditions, inadequate nutrition, lack of healthcare access, greater academic achievement gaps, and depression. Walker County residents experienced poor physical and mental health days at higher rates than the Alabama average, and this issue is especially significant in a rural community already designated by the U.S. Department of Health and Human Services as Medically Underserved.

The 2020 Robert Wood Johnson Foundation (RWJF) County Health Rankings, Walker County is ranked 62 out of 67 counties in Alabama for health outcomes. The lowest rankings are in premature death (66), quality of life (49), and health behaviors (53). Walker County was home to Alabama's highest opioid prescription rate, according to Drug Enforcement Administration data recently made public by The Washington Post. With an estimated 65,000 residents, Walker County pharmacies received nearly 9 million prescription pain pills per year between 2006-12. The opioid epidemic and its impact on health has taken a tremendous toll on the county, and efforts are underway to build a system of supports to address addiction and recovery needs.

Demographic Characteristics - *Race (2012–2016)*

Race	Jefferson County	Walker County	Alabama	United States
Total Population	659,096	64,927	4,841,164	318,558,162
White	52.4%	91.2%	68.7%	73.3%
Black	42.5%	6.1%	26.5%	12.6%
Asian	1.5%	0.5%	1.3%	5.2%
Multiracial	1.5%	1.8%	1.8%	3.1%
All Other	2.0%	0.4%	1.8%	5.8%

Source: U.S. Census Bureau, American Community Survey, Table DP05, 2012-2016 5 Year Survey

Demographic Characteristics - *Ethnicity (2012–2016)*

Ethnicity	Jefferson County	Walker County	Alabama	United States
Total Population	659,096	64,927	4,841,164	318,558,162
Hispanic or Latino	3.7%	2.4%	4.0%	17.3%
Not Hispanic or Latino	96.3%	97.6%	96.0%	82.7%

Source: U.S. Census Bureau, American Community Survey, Table DP05, 2012-2016 5 Year Survey

Design Your Local Collective Impact Partnership

Collective impact is a theory that large-scale social change can happen more quickly and effectively with cross-sector coordination rather than from isolated interventions by individual organizations. The collective impact process is data driven, encourages collaboration, and requires the commitment of a group of important actors from different sectors to a common agenda aimed at solving a specific social problem at scale.

Our local work has been heavily influenced and guided by FSG and the 2011 article "Collective Impact" in the Stanford Social Innovation Review. In 2012, United Way of Central Alabama launched a regional collective impact approach to solving the most persistent health, education, and financial stability problems in our community. Jefferson County's Health Action Partnership model was a seamless fit for the health-focused work. When the Partnership expanded into neighboring Walker County, it was apparent that a "one-size-fits-all" approach was not the best course of action. The energy and needs of Walker County differ from those of Jefferson County, and the best ways to address health outcomes diverged as well.

The Health Action Partnership model has been adapted to work in large or small geographic footprints from county-wide to the neighborhood level. A first step is to work with a group of potential stakeholders to determine the scope of the collaborative vision and identify the sectors and key individuals that should be engaged. This can include partners that will be considered "backbone" organizations and are willing to commit to a long-term effort, either with thought leadership, time, or financial resources. Any collaborative project needs to include input from the people who will be most affected by the work and have inclusive conversations in the planning stages and throughout execution. This will facilitate an open decision-making process and build trust with a wide group of stakeholders and perspectives as the partnership continues to grow.

For many collective impact partnerships, crafting vision and mission statements can provide a general orientation and quickly communicate the overall purpose of the partnership. While important, mission and vision statements are not a substitute for setting bold community goals and strategic priorities.

Once partners have been engaged, setting bold, upstream goals in close alignment with the mission and vision will add a layer of specificity and focus. The bold goal setting process should be inspiring, motivating, and capture the imaginations of your diverse stakeholders. At the same time, your collaborative goals should be data-driven, retain believability and be achievable. Bold goals will help your collaborative partners have a greater understanding of where you've been, where you are, and where you need to go while being concrete and establishing clear boundaries on the work ahead. Any goal that is unrealistic may result in dismissal from stakeholders or lower the level of engagement with participating partners. It is important that all involved stakeholders are on the same path of understanding and agreeing to goals, and clear parameters are agreed upon for each idea.

> One of the advantages the Jefferson County Health Action Partnership has is that we have a readymade coalition to go after projects. We already have these valued and trusted relationships built and we can jump in and move quickly.

- Drew Langloh
President and CEO, United Way of Central Alabama

The Health Action Partnership Model

Founding Partners Meeting

1. Identify Sectors

- ✓ Education
- Business
- ✓ Government & Public Inst.
- Healthcare
- ✓ Community Organizations

2. Identify Partners within Sectors

✓ Education

- School Board
- Higher Education Admin
- Etc.

Invite Partners & Stakeholders Convening Partnership Meeting

1. Identify Bold Goals

Problem:

Solution:

- ☑ Inspiring
- ☑ Motivating
- ☑ Believable
- ☐ Achievable

2. Identify Leadership

TEAM BUILDING

Innovates Ideates	Plans Clarifies
Analyzes Advises	Implements Completes

Five tenets for successful collective impact initiatives

Common Agenda

All participants share a vision for change that includes a common understanding of the problem and a joint approach to solving the problem through agreed-upon actions.

Shared Measurement

All participants agree on the ways success will be measured and reported, with a short list of common indicators identified and used for learning and improvement.

Mutually Reinforcing Activities

A diverse set of stakeholders, typically across sectors, coordinate a set of activities through a mutually reinforcing plan of action.

Continuous Communication

All participants engage in frequent and structured open communication to build trust, assure mutual objectives, and create common motivation.

Backbone Support

A funded staff position dedicated to the partnership provides ongoing support by guiding the collective impact vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing resources.

Our priority was looking to assess the gaps in care related to infant mortality and maternal and child health. We found a lot of partners working in our area who had never worked together. Our collaboration became the Maternal and Child Health Roundtable. It has allowed patients to access services from other partners that were previously unavailable. We've provided more resources for the uninsured population and made an impact on infant and maternal mortality in the state.

–Dr. Kalilah Brown
Child Health Medical Director, Jefferson County Department of Health
Co-Chair, Healthcare Access Priority Group

The Health Action Partnership is a perfect example of regional cooperation. It's been a great way to rally people around our work in mental health across 35 municipalities in Jefferson County and it's led to our collaboration with Walker County.

- Chris Nanni
President and CEO, Community Foundation of Greater Birmingham

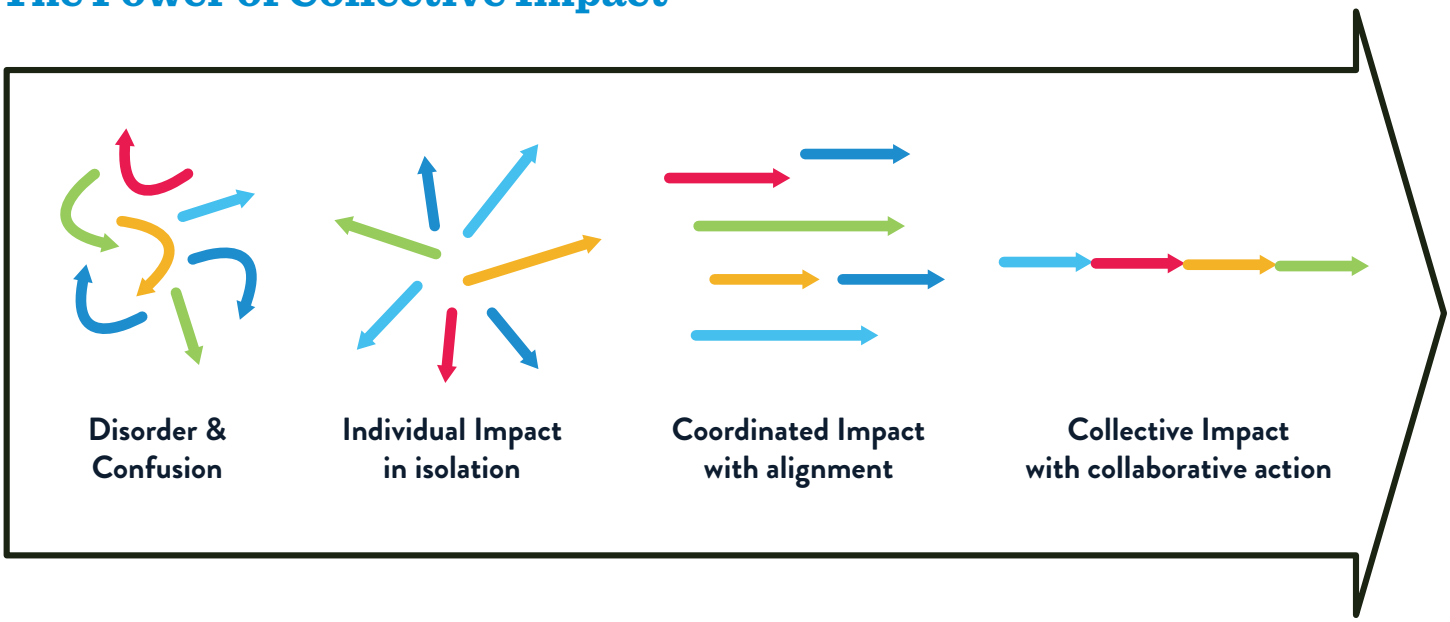
The Health Action Partnership brings together groups or individuals that may have previously been competitors working in the same space. The Partnership has allowed us to collaborate around common goals and make sure that we continue to serve the under-insured and uninsured population.

- **Dr. Darlene Traffanstedt**
Medical Director, Jefferson County Department of Health
Co-Chair, Healthcare Access Priority Group

What I find most beneficial from the Health Action Partnership model is the focus on direction, alignment, and commitment. I can see that working together and being informed about what others are doing motivates everybody and helps us get to some real measurable goals.

–Paul Kennedy
President, Walker Area Community Foundation

The Power of Collective Impact



Adopt a Model of Shared Decision Making

Any successful collaborative must identify diverse partners with experience serving local communities and create meaningful opportunities for them to engage with one another. In order to operate effectively, collaborative work must have an agreed-upon mechanism to make decisions. For our local Health Action Partnerships, Leadership Teams serve as both a governing and supportive body, and many of the members are actively leading issue-focused work. The Leadership Team assesses progress towards goals, promotes the progress of the collaborative work, and ensures functional and ongoing processes for leadership succession.

To be effective, Leadership Teams should consider group size and team diversity when determining the number of available positions to fill. Leadership Teams should be comprised of a Chair, Vice-Chair and members, including one at-large member and, if your community has dedicated anchor organizations, one representative representing each of the anchors. Well-rounded Leadership Teams will include representation from key sectors in the community: education, business, public health, medicine, faith, local government, and neighborhood action. Representation from these sectors should be strongly considered in the formation of the Leadership Team and annual election of new members, but does not have to take the form of designated seats unless the Leadership Team deems such action necessary. Representation from additional sectors in the community or areas of expertise may be included as part of the annual slate of nominees at the discretion of the Leadership Team.

Jefferson County and Walker County, Alabama have created an extra level of commitment through established "Anchor Organizations." Anchor organizations provide additional support in terms of devoted staff time and financial support (when possible) to ensure the long-term success of the partnership. Current anchor organizations in Jefferson County are the Jefferson County Department of Health, the Community Foundation of Greater Birmingham, and the United Way of Central Alabama. A key criterion for anchor organizations is the commitment of staff to Health Action Partnership infrastructure and support. Staff leading these efforts should be strong conveners, communicators, and have the ability to create high-performing teams.

Currently, United Way of Central Alabama provides staffing support for the collective impact work in both Jefferson and Walker Counties as part of its role as an anchor organization. Dedicated staff play a fundamental role in organizing, offering thought leadership and innovative ideas, and connecting organizations with mutually reinforcing objectives. Staff also guide vision and strategies, support aligned activities, establish shared practices, build public will, advance policy, and mobilize funding. Multiple anchor organizations provide support and leadership for cross-sector groups of partners participating in priority groups.

The Health Action Partnership model is flexible and can be used to address one or multiple important issues (or Bold Goals) in committees or priority groups. Priority areas and coordinated priority groups are identified to achieve the greatest community health impact. These priorities inform a yearly Action Agenda or workplan. In order to build momentum, priority areas should not change frequently. Priorities should relate to the community health strategies of the chosen geographic area and be informed by available public health assessments and input from the broader community.

In Central Alabama, the Jefferson County partnership currently operates five priority groups: Transportation, Advancing Health Equity, Improving Food Systems, Improving Mental Health, Health Care Access, and the Walker County partnership operates two: Livable Communities and Behavioral Health. Chairs and Co-chairs lead Priority Groups in planning and

implementing strategies to achieve goals for their priority area. The Chair/Co-Chair facilitates and serves as moderator for Priority Group meetings, coordinating responsibilities among priority group members, promoting collaboration, conflict resolution and decision making. They must be open to diverse opinions and point of views.

Five Rules to Create Lasting Social Changes

1. Build on existing trends and momentum: engage experts to understand the topic at hand and those related to adjacent social issues and the broader society.

2. Pay greater attention to connections and interdependence: look for connections (or lack thereof) through tools such as system mapping and social network analysis.

3. Employ rigor after the strategy has been developed: redefine evaluation in real-time terms and create beneficial feedback loops for improvement.

4. Be systematic about measuring systems change: measure the set of system and behavior changes that precede population-level outcomes to understand the factors that are combining to achieve the population outcomes at scale.

5. "Be the Change" by building internal adaptive capacity: seek new information, see connections, and make ongoing changes at the individual, the organizational, and the partnership level.

The Summer Feeding Program is a collaborative effort with the goal of providing nutritious meals to kids during summer break when they don't have access to meals they would normally receive during the school year. The Improving Food Systems Priority Group worked together to coordinate efforts so we could centralize administration and logistics under the Community Food Bank of Central Alabama and the Alabama Food Bank Association. Then organizations like the YMCA could do what they do best—provide quality services to local kids. We started serving 1,100 children at 9 sites in 3 counties, and in 3 years we've tripled the number of kids participating and doubled the number of sites. That kind of scale is only possible with a lot of organizations coming together around a common goal.

- Terry Harville, (Right) YMCA of Greater Birmingham, District Vice President for YMCA Youth Centers

- Jon Barnacastle, (Left) Community Food Bank of Central Alabama, Programs Coordinator

Define Metrics for Success

Using a data-driven approach can be a challenge, especially when resources to analyze data are scarce. For a broad community-based initiative, Health Action Partnerships determined that the annual County Health Rankings and Roadmaps (CHRR) data was an ideal fit for our community needs. The CHRR program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. This data source was ideal for a number of reasons: it is released annually, it is reliable, and it provides a year-to-year snapshot of county strengths and areas in need of improvement. It is also offered at no cost and provides evidence-based resources to assist communities in their efforts to improve health.

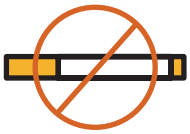
The annual County Health Rankings measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income inequality, and teen births in nearly every county in America. As the Health Action Partnership model expands, the CHRR data allowed consistency for data availability and comparison throughout Alabama. The annual Rankings provide a snapshot of how health is influenced by where we live, learn, work and play. They provide a starting point for change in communities, guidance and tools to understand the data, and strategies that communities can use to move into action.

Once metrics are chosen, it is important to address the feasibility of implementing evidence-based strategies. A feasibility analysis is a great tool to determine the viability of an idea and to determine effective solutions to problems. Checking for this early in the metrics cycle will help your collaborative gain confidence for success and forecast the capacity of partners to execute a strategy. There are five feasible areas to consider for a successful outcome: **Operational, Economic, Legal, Technical, and Scheduling.**

1. Operational feasibility looks at the capacity of the partnership and its ability to successfully complete the proposed project.
2. Economic feasibility determines the financial resources needed to successfully complete the proposed project.
3. Legal feasibility involves assessing whether any aspects of the proposed project conflict with legal requirements.
4. Technical feasibility checks the availability of technology within the given budget and identifies whether other technical resources are available/ needed.
5. Scheduling feasibility is all about the time commitment needed to complete the proposed project.

Whether collaboratives look at programmatic efforts or are more focused on systemic change, the Health Action Partnership model is flexible to accommodate either or both. While more difficult to achieve, systemic change will yield greater results over time and affect more members of the community. Systemic change is a fundamental change in policies, processes, relationships, and power structure to address root causes of social problems.

Examples of systemic change in Central Alabama achieved through the Health Action Partnerships include:



Passage of smoke free policies in many municipalities means that 43 percent of Jefferson County's population now enjoys the health benefits of very strong or comprehensive smoke-free ordinances;

Creating a system of supports for local school systems to address the mental health needs of their students across Jefferson, Blount, St. Clair, and Walker Counties;

Creating a system to deploy and scale federally reimbursable meal assistance throughout Jefferson, Blount, Shelby, and Walker Counties, serving thousands of children, families, and seniors each year;

Creating a system of recreational opportunities in Walker County to encourage physical activity, including a more than 30 mile long blueway for kayaking and canoeing.

One of the main priorities we have is tobacco use, but, as a Health Department, we are limited in what we can do to change policies. The Health Action Partnership brought partners together around advocacy work that influenced many of our local municipalities, including the City of Birmingham, to adopt comprehensive smokefree policies.

- Dr. Mark Wilson
Health Officer, Jefferson County Department of Health

In Walker County, we wanted to provide free, accessible outdoor spaces for recreational activities. Through the Health Action Partnership, we were able to build infrastructure which has also allowed us to develop an outdoor recreation economy. The Walker County Lake project has created access for people to pursue healthy lifestyles and enjoy hiking, canoeing, kayaking, birding, and archery.

- Jenny Brown Short
Community Volunteeer and Chair, Livable Communities Priority Group

Incorporate Guiding Principles for Advancing Health Equity

Health equity results in all people having the opportunity to attain their full health potential. Differences in health status dictated by race, gender, physical abilities, or zip codes causes health inequalities and jeopardize the well-being and prosperity of ALL. For example, in Jefferson County, many neighborhoods bordering Interstate 20/59 are largely minority, have increased poverty and infant mortality, decreased life expectancy, and limited access to healthy foods. (Jefferson County Health Equity Report, 2018).

Advancing health equity for all requires adequate, standardized, and inclusive training to equip community, organizational partners, and political entities with the knowledge and tools to advocate for healthier communities. Using the six guiding principles crafted by the Advancing Health Equity Priority Group of the Jefferson County Health Action Partnership will provide a health equity perspective in a collaborative working environment to promote a healthy community for all.

The Guiding Principles

1. Involve people negatively impacted by health disparities in development, implementation, and evaluation: Program development, implementation, and evaluation should include input from the people who have a greater presence of disease, poorer health outcomes, and/or less access to health care (e.g., racial/ethnic minorities, older adults, lower socioeconomic status, physical or mental disability, geographic location)
2. Ensure objectives target people and communities negatively impacted by health disparities: Program objectives are most effective when they explicitly state that their target population includes people who are negatively impacted by health disparities.
3. Ensure health equity messages are appropriate and widely disseminated: Consider the needs, assets, and priority issues of community members and stakeholders prior to developing messaging to promote shared understanding of health equity goals
4. Value both community and technical expertise: Be sure to respect and incorporate the expertise and perspective of community members as well as the technical expertise provided by health experts
5. Support and build community capacity to act: Build on the capacity of community members by increasing their awareness of health inequities
6. Leverage opportunities to advance health equity: Health equity work is more effective when connected with efforts led by organizations, groups, and/or individuals with complementary goals

The idea in constructing these guiding principles is to help individuals, organizations, and partners understand the impact of health disparities in the local community, comprehend the need to reduce these impacts through collaborations, and discover ways to commit to advancing health equity every day.

The Advancing Health Equity Group supports all of the priority groups and helps them develop their goals using the Guiding Principles. We've developed training that begins with a one-hour informational presentation and then an in-depth two-day program on diversity, equity, and inclusion.

– Dee Caudel
Chair, Advancing Health Equity Priority Group

The Community Food Bank works with vulnerable populations, and seniors facing food insecurity are amongst the most vulnerable. The Health Action Partnership has allowed us to collaborate with other networks and organizations to create our pilot program that makes healthy food, protein in particular, more accessible to seniors.

- Shalitha McLean
Community Health and Senior Program Manager
Community Food Bank of Central Alabama

The Improving Mental Health priority group brings together expert stakeholders who are working in the mental health field directly with children. When we come together, we get a comprehensive view of the issues, the needs, and the structures we're dealing with, so we can develop a plan that will actually be effective. We meet consistently so we can be deliberate in the process of planning, executing, and adjusting as circumstances change. Since we're not limited by the timeframe of a grant or a time-limited program, we can plan for the long term and find opportunities to actually make a meaningful difference.

– Gus Heard-Hughes
Vice President, Programs, Community Foundation of Greater Birmingham
Chair, Improving Mental Health Priority Group

Craft a Community Health Equity Report

A Community Health Equity Report is designed to inform the public, decision makers, and funders of current health data, highlight areas of persistent disparities and the populations affected by poor outcomes, and showcase ongoing collaborative efforts to improve population health and well-being. In Jefferson County, the first Community Health Equity Report released in 2013 aligned community health within the context of the 50th anniversary of the Civil Rights movement. The five year update was released in 2018 with a focus on community characteristics such as education, poverty, neighborhood segregation, and access to healthy foods. By mapping data at the census-tract level, constituents learn about the social determinants of health having the greatest impact on their community and neighborhood. The report is meant to serve as a snapshot in time and emphasize that neighborhood characteristics such as employment, crime, and transportation have a major impact on the community's health outcomes and life expectancy. Crafting a Community Health Equity Report communicates the message that place matters and the conditions in which people live, learn, work, and play have a profound impact on overall health.

The majority of report data comes from the U.S. Census Bureau's American Community Survey (ACS), an annual survey that provides vital information about growth patterns across the nation. It is the leading source for details about the nation's population and housing information. The ACS reports local data according to census tracts, which are small, relatively permanent, areas within each county. The average census tract has a population of 4,000 people and is restricted to a minimum area of 1,200 people and a maximum of 8,000 people. The geographic boundaries for each tract are determined based on population density, not on local municipal or neighborhood jurisdictions. Therefore, some cities contain many different census tracts, while other areas might have multiple cities within a single census tract.

Identifying questions to include in a local health equity report is the first step to highlighting the health of the population. Examples of initial questions for a geographic area could be:

- What is the racial/ethnic residential segregation?
- What is the distribution of affordable, stable, and good quality housing by census tract?
- What is the distribution of high school graduates by census tract?
- What is the distribution of access to primary care providers?

It is important to include basic demographic data to show the characteristics of the population in your geographic focus. These can include data on age, gender, race, marital status, disability status, and income for community context.

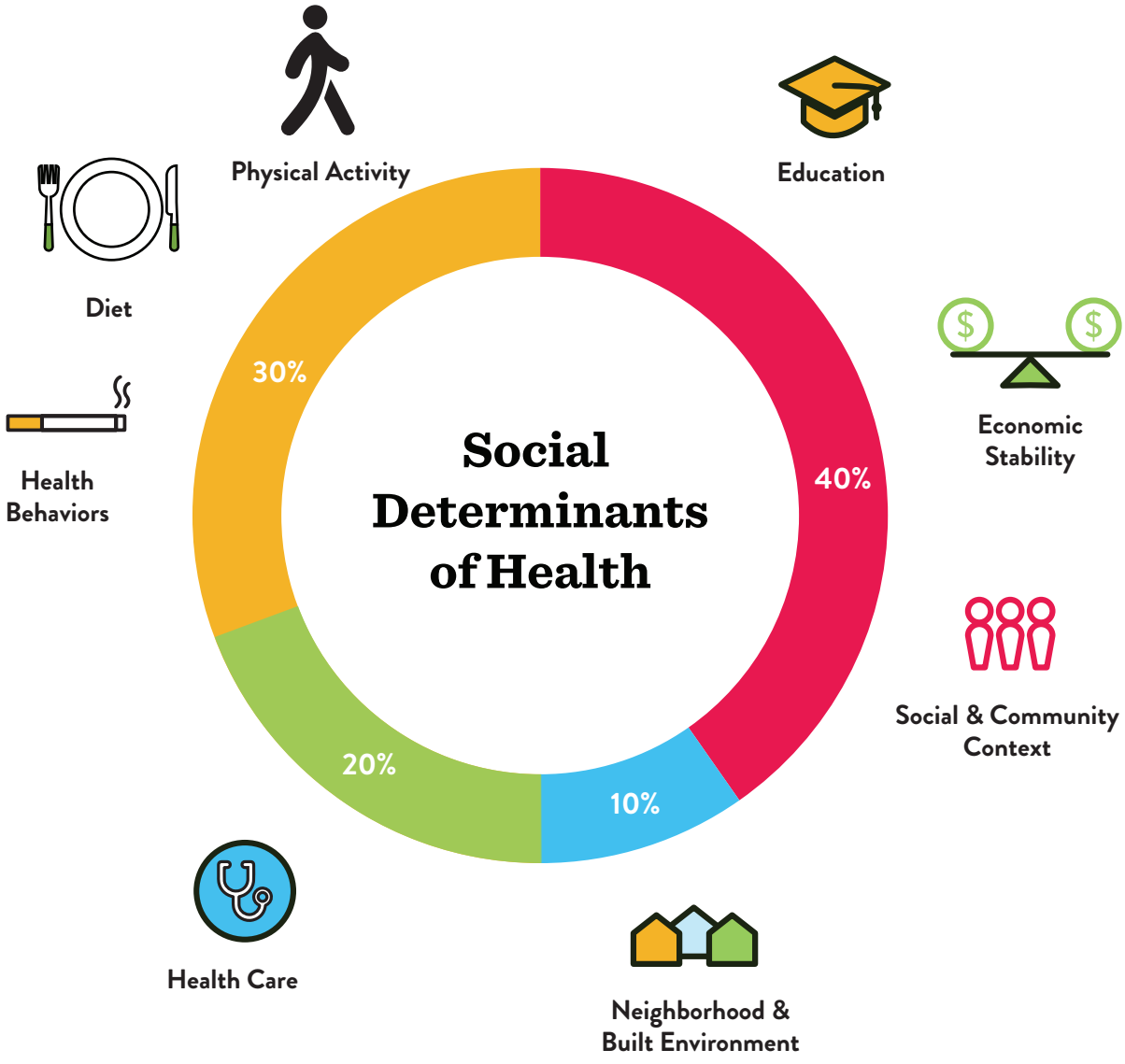
Community characteristics are important to understand because this is where people live, learn, work and play. According to the CDC, social determinants are the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. Understanding that social structures and economic systems includes the social environment, physical environment, health services, and structural and societal factors should all be considered and included in a health equity report. It is also important to acknowledge that social determinants are shaped by the distribution of money, power, and resources throughout the community and the nation.

When developing a health equity report, identifying key stakeholders in the assessment and development process are essential to achieve good results. It is important to include individuals and organizations that have a deeper un-

derstanding of the community and a strong connection with the population they serve. A community health equity report team should be versatile, including experienced graphic designers, mapping experts, epidemiologists, writing and research personnel, and others that will help bring the report to life. In Jefferson County, key partners in crafting the local report were University of Alabama at Birmingham, United Way of Central Alabama, Jefferson County Department of Health, Regional Planning Commission of Greater Birmingham, Lakeshore Foundation, Community Foundation of Greater Birmingham, and the Community Food Bank of Central Alabama.

Conclusion

For more information about starting your own Health Action Partnership, contact healthaction@uwca.org. Or visit our website: healthactionpartnership.org.



Appendix: Example of Articles of Collaboration

Article I: Name

The name of this collaboration shall be the Health Action Partnership ("HAP").

Article II: Mission, Vision and Guiding Values

A. Mission

The HAP works with diverse stakeholders to make Jefferson County a healthier place for all residents to live, learn, work, play, and achieve their highest possible quality of life.

B. Vision

Jefferson County is a healthy, thriving, and connected community where all residents can achieve their highest possible quality of life, and is recognized as such statewide and nationally.

C. Guiding Values

Equity and Justice – HAP recognizes the profound health disparities in health experienced by residents of Jefferson County as a result of race, ethnicity, sex, sexual identity, sexual orientation, age, disability, socioeconomic status, and geographic location. Our work seeks to eliminate those disparities through collaborative efforts that address the policies, systems, and environmental conditions that perpetuate inequities. The following Advancing Health Equity Guiding Principles will be used as a guide for all decision making:

1. Involve people negatively impacted by health disparities in development, implementation, and evaluation
2. Ensure objectives target people and communities negatively impacted by health disparities
3. Ensure health equity messages are appropriate and widely disseminated
4. Value both community and technical expertise
5. Support and build community capacity to act
6. Leverage opportunities to advance health equity

Collaboration – HAP believes that we can achieve greater improvements in community health through a commitment to collaboration. We commit to sharing both the responsibility and recognition for our collaborative work.

Value of Diverse Perspectives – Each HAP member contributes unique perspectives, cultural beliefs, and real-life experiences for promoting health and preventing disease. Our work will honor those perspectives and strive for consensus among stakeholders.

Willingness to Have Candid Dialogue – Whether among the Leadership Team, Priority Groups, or within the membership as a whole, the HAP believes candor and genuine listening provide opportunities to better understand one another and improve our work. While we may not always agree, open and respectful dialogue that moves us towards our shared vision will strengthen our partnership.

Learn From Failure and Celebrate Success – HAP has learned from what has worked well and what has not worked well; failure has given us the opportunity to examine our assumptions and change our approach when needed. We will strive to continually monitor and evaluate our progress, share lessons learned and to celebrate the hard work and commitment shown by each member.

Article III: Function

In support of the above mission and vision, the function of the Health Action Partnership (HAP) shall be to:

1. Develop and review annually an Action Agenda to advance the mission of the HAP and address critical community health needs, to include priorities, goals, objectives and tactics;

2. Support collaborative action locally and statewide to advance the Action Agenda through well-supported, action-oriented participating Priority Groups;

3. Educate and build public support in the broader community through effective communication and education;

4. Grow the capacity of Health Action Partners to meet the vision through opportunities for learning, sharing of effective policies/practices and access to available funding, and

5. Leverage the HAP to carry out strategies promoting community health and wellbeing.

Article IV: Priorities

Priorities are identified for the HAP to achieve the greatest public health impact. These priorities inform the Action Agenda and, to sustain progress, should change infrequently. The Leadership Team and current anchor organizations may revise the priorities per Article VI, Section G. Priorities should relate to community health strategies in Jefferson County as informed by public health assessment and input from the broader Jefferson County community. While the HAP may support additional community health efforts, the priorities shall take precedent for support resources and strategic action.

The priorities and associated goals are selected to sustain and leverage the HAP's accomplishments to date and align with the current Jefferson County Community Health Improvement Plan.

Article V: Partnership

A. Partnership and Eligibility

The HAP shall be comprised of public and private organizations interested in and committed to the mission and vision of the HAP, hereinafter referred to as HAP Partners. HAP Partners may be involved with the HAP in the following ways:

Representation, upon election, to the Health Action Partnership Leadership Team;

Membership on Priority Groups working to achieve HAP goals guided by the Action Agenda;

Participation on special task groups that may be formed to focus on specific actions, and

General participation in HAP events, meetings and collaborative efforts.

There are no term limits for HAP Partners, who may resign or withdraw from the HAP at any time by providing written notification to one or more of the anchor organizations.

Clear and consistent communication among HAP Partners is a HAP operating principle with the intention that partners are informed of current HAP work and have the opportunity to participate in HAP activities and planning.

B. New Partners

New organizations may join the HAP at any time. New organizations may be recruited for participation in the HAP or join through their own interest. Leadership Team members, anchor organizations or other HAP Partners may recommend appropriate roles for new HAP Partners, such as membership in a Priority Group.

C. Partnership Meetings

The HAP shall convene at least one time per year, serving as an Annual Meeting. The Annual Meeting shall serve to inform HAP Partners of progress toward implementing the HAP Action Agenda, to review and/or provide input on the Action Agenda, and to address emerging issues pertinent to the mission of the HAP. HAP meetings shall be led by the Leadership Team Chair or the Chair's designee.

Article VI: Leadership Team

A. Composition

The HAP Leadership Team shall consist of no fewer than 13 members and no greater than 25 members; effective group size and team diversity should be considered in determining the number of available positions filled. It shall be comprised of Chair, Vice-Chair and general Leadership Team members including one at-large member and one representative from each of the anchor organizations (see Article VII). The HAP Leadership Team will include representation from key sectors in the community: education, business, public health, medicine, faith, local government, and neighborhood action. Representation from these

sectors shall be a strong consideration in the formation of the Leadership Team and annual election of new members, but will not take the form of designated seats unless the Leadership Team deems such action necessary. Representation from additional sectors in the community or areas of expertise may be included as part of the annual slate of HAP Leadership Team nominees at the discretion of the Leadership Team.

The elected members of the HAP Leadership Team (and appointed members for the first team) shall have full voting rights.

The Priority Group Chairs elected by the Priority Group shall serve as ex-officio members of the Leadership Team without vote except in the event that the elected Priority Group Chair is also elected by the Leadership Team to serve as a member of the Leadership Team; in this situation, the Priority Group chair shall have voting rights on the Leadership Team.

B. Roles & Expectations

The Leadership Team shall serve as both a governing and supportive body that will:

Annually assess progress toward goals and review the HAP Action Agenda, ensuring input from the HAP partners and Priority Groups and alignment of the HAP Action Agenda with the HAP mission and vision;

Revise the HAP Action Agenda, based upon annual assessment and/or other changes in community assessment and needs;

Support HAP Priority Groups to achieve objectives indicated in the HAP Action Agenda;

Promote the HAP Action Agenda and related work in the broader community;

Ensure functional and ongoing processes for leadership succession;

Review and revise HAP priorities, goals and Priority Groups as needed, and

Act as the governing body of the HAP.

Leadership Team members are expected to:

Attend, in-person, Leadership Team meetings be held at least four times each year (additional meetings may be called as needed);

Serve as proactive advocates for the HAP Action Agenda, particularly within each member's area of influence;

Contribute to a specific Priority Group (see Article VIII) or other special task group, and

Actively engage and represent his or her HAP Partner organization.

C. Terms and Qualifications

New members of the Leadership Team shall be elected to serve a three year term. Leadership Team members shall not serve more than two consecutive terms. All Leadership Team Officers shall be elected to a two year term, and may not serve more than two consecutive terms in the same office. Each active anchor organization shall have an appointed member on the Leadership Team.

D. Elections

The Chair of the Leadership Team shall invite Leadership Team members to nominate individuals to serve in any available officer positions and vacant positions on the Leadership Team when: 1) a vacancy in seated positions exists and/or 2) the maximum number of Leadership Team members has not been achieved and a majority of Leadership Team members approve the addition of a member position to the Leadership Team. HAP Partners may also suggest new Leadership Team members at any time by providing the name and contact information of the individual to the Leadership Team Chair in writing.

A Nominating Committee established by the Chair of the Leadership Team and comprised of the Immediate Past Chair (current Chair for first Leadership Team) and four additional Leadership Team members shall review the nominations and develop the slate for election. The slate of nominees for the HAP Leadership Team members and officers shall be presented to the Leadership Team by the Nominating Committee at least fifteen (15) days in advance of the intended vote. The Leadership Team members shall vote on the slate, which shall pass by simple majority of the Leadership Team (as described in Article VI, Section G; all references to Leadership Team voting refer to that section). The exceptions to this election process shall be: 1) an at-large Leadership Team member elected by the HAP Partners at the HAP annual meeting, when the position is vacant, and 2) the Leadership Team member appointed by each anchor organization. The appointment of Leadership Team members representing anchor organizations shall be subject to approval by a simple majority of the Leadership Team.

The first HAP Leadership Team shall be appointed by the outgoing Communities Putting Prevention to Work (CPPW) Leadership Team and the anchor organizations.

E. Vacancies

A vacancy in the Leadership Team Chair position shall be filled by the existing Vice-Chair for the remainder of the term. A vacancy in the Vice-Chair position shall be filled for the remainder of the term by a Leadership Team member upon receiving a nomination from and the majority vote of the Leadership Team. A vacancy in the at-large Leadership Team member position shall be filled for the remainder of the term by recommendation of the HAP Leadership Team Chair, informed by the four Priority Groups, and upon simple majority vote of the Leadership Team.

F. Meetings

Notice of HAP Leadership Team meetings shall be provided to each Leadership Team Member at least two weeks in advance of each meeting and a meeting agenda shall be provided seven days in advance.

G. Leadership Team Action/Quorum Requirement

A simple majority of Leadership Team members shall constitute a quorum for the transaction of business, including elections. The Leadership Team will, as relevant, assess the health equity impact of all motions through a Leadership Team discussion prior to a vote. The discussion is to be facilitated by the current chair. Leadership Team decisions should be made with the intent to purposefully implement the Advancing Health Equity Guiding Principles listed in Article II, Section C, Equity and Justice.

Motions will be passed with a simple majority vote of the quorum. Electronic action may be taken upon the assent of a simple majority of team members on the item of interest. Notification of anticipated actions will be provided to the Leadership Team prior to Leadership Team meetings.

The addition, deletion or revision of HAP priority goals and/or Priority Groups shall require a simple majority vote by the Leadership Team and approval by all current anchor organizations.

H. Officers' Responsibilities

a. Chair: The Leadership Team Chair shall be the principal officer of the HAP and preside over HAP and Leadership Team Meetings. To be eligible for the chair position, the Leadership Team member must have served on the Leadership Team for at least one year (first Leadership Team Chair excepted).

b. Vice-Chair: The Vice-Chair shall carry out the powers, duties and responsibilities of the Chair in his or her absence. The Vice-Chair shall assume the position of Chair after the two year term of the existing Chair has terminated. To be eligible for the Vice-Chair position, the Leadership Team member must have served on the Leadership Team for at least one year (first Leadership Team Vice-Chair excepted).

c. Immediate Past Chair: After completion of the two year term as Chair, the previous Chair shall assume the post of Immediate Past Chair, serving as an appointed member of the HAP Leadership Team and Chair of the Nominating Committee. The Immediate Past Chair shall additionally serve in an advisory role to the seated Chair and Vice-Chair.

Article VII: Anchor Organizations

A. Roles and Expectations

Anchor organizations have made an extra level of commitment to ensure the long-term success of the HAP and shall each have a representative on the HAP Leadership Team. Current anchor organizations are the Jefferson County Department of Health, the Community Foundation of Greater Birmingham, and the United Way of Central Alabama. Additional anchor organizations may be added by a simple majority vote of the Leadership Team. A key criterion for anchor organizations is the commitment of staff for HAP infrastructure support purposes. Coverage of the roles listed here will be made by mutual agreement among the anchor organizations and may be adjusted as needed.

1. Collective Anchor Organization Roles:

Facilitate clear communication within the HAP and with the broader community;

Assist/coordinate the identification of funding opportunities and leveraging of private/public partnerships;

Serve as a point of contact for Leadership Team Members;

Assist in organizing and coordinating the Leadership Team;

Help promote sufficient diversity, engagement and effective utilization of Leadership Team members;

Facilitate administrative support for Priority Groups and special task groups;

Review and provide feedback on priorities and Priority Groups when they are revised and approved by the Leadership Team;

Assist/coordinate the special events, the HAP Annual Meeting and community outreach events.

Facilitate new HAP Partners' orientation to the history, purpose, structure and priorities of the HAP;

Link the HAP to relevant research, best practices and technical assistance resources, and

Assist with evaluation planning and implementation as a component of the HAP Action Agenda.

B. Leadership Team Positions

Each anchor organization shall recommend its representative for the Health Action Partnership Leadership Team when those positions are vacant or up for re-appointment, as provided for in Article VI.

Article VIII: Priority Groups

A. Purpose and Definitions

HAP Goal Groups were formed in 2007 based on the Mobilizing for Action through Planning and Partnerships (MAPP) assessment and the resulting report, *Our Community Roadmap to Health*. Goal Groups (now called Priority Groups) determine and carry out specific strategies to achieve the HAP's priorities through the HAP Action Agenda.

The HAP Leadership Team shall determine which Priority Groups shall participate in the HAP based on current activity and focus of the HAP work. Priority Groups that address the HAP's current priorities and goals shall exist, but Priority Groups may also be established for additional HAP goals. The Priority Groups may be changed per the process described in Article VI, Section G. The first HAP Priority Groups prior to appointment of the first HAP Leadership Team shall be established (in terms of priority focus, not members) by the anchor organizations, informed by input from HAP members and the outgoing CPPW Leadership Team through a member survey and meetings.

Priority Groups will, as relevant, assess the health equity impact of all motions, especially as they are related to the passage of annual Action Agendas, prior to a vote through a discussion, to be facilitated by the current chair. Priority Groups are required to report annually on their efforts to purposefully implement the Advancing Health Equity Guiding Principles listed in Article II, Section C, Equity and Justice.

B. Priority Group Chairs and Vice-Chairs

1. Roles and Expectations

Each participating Priority Group shall elect a Priority Group Chair and may elect a Priority Group Vice-Chair. Priority Group Chairs shall lead their Priority Groups in planning and implementing strategies (to include objectives, tactics and metrics) to achieve designated goals for their priority area. The Action Agenda is approved by the HAP Leadership Team per Article III, but Priority Groups shall have the flexibility to implement strategies as needed. Priority Groups may recommend a revision to strategies in the Action Agenda, for consideration by the Leadership Team at its next meeting provided the required advance notice is provided. Priority Groups shall ensure reporting on implementation progress and pertinent activities to the HAP Leadership Team at the two Health Action Partnership Meetings each year designated for receiving such reports. Anchor organization staff shall be provided the semi-annual Priority Group reports at least two weeks prior to the designated HAP Leadership Team meetings. Priority Group Chairs shall serve as ex-officio, non-voting members of the HAP Leadership Team and participate in the HAP Annual Meeting. The organization or agency each Priority Group Chair represents shall commit adequate time for its representative to fulfill the Priority Group Chair function, with due consideration to other commitments and the voluntary nature of the position. The Priority Group Vice-Chair shall assume the duties of the Priority Group Chair in the Chair's absence.

2. Terms & Qualifications

Priority Group Chairs (or Co-Chairs) and Vice-Chairs shall be elected by the respective Priority Group members to a two year term. Priority Group Chairs and Vice-Chairs may serve no more than two consecutive terms as chair of the same Priority Group. The succession of the Vice-Chair to the Chair position is not automatic; rather the position of chair must be elected at the time of vacancy.

3. Appointments

Priority Group Chairs (or Co-Chairs) and Vice-Chairs are appointed by the respective Priority Group backbone-support organization. If the backbone-support organization elects not to appoint a chair from within its organization, the Priority Group chair shall be nominated and elected by a simple majority of the Priority Group members in attendance at the meeting where the vote is taken. The HAP Leadership Team shall be notified of Priority Group Chair (or Co-Chair) and Vice-Chair elections at the next Leadership Team meeting.

4. Vacancies

Priority Group Chair and Vice-Chair vacancies shall be filled by a special nomination and election at the next scheduled meeting of the Priority Group, At least two weeks' advance notification of the special election is provided to Priority Group members. In the event that two week's notice of the special election cannot be achieved or the Priority Group is unable to identify and select a chair, the HAP Leadership Team Chair may appoint a temporary Priority Group Chair until the election of a Priority Group Chair, with appropriate guidance from the Priority Group members.

C. Notice & Meetings

Priority Groups shall meet at least quarterly, though they may meet more frequently at the discretion of the Priority Group Chair and members. Priority Group Chairs shall set and facilitate meetings; next meeting dates shall be set at the previous Priority Group meeting or within a reasonable time frame thereafter. Priority Group meetings are open to all HAP Partners who are not Priority Group members unless otherwise specified.

Article IX: Amendments and Approval

A. Amendments

Any HAP member may propose amendment to these Articles of Collaboration by submitting the change in writing to the HAP Leadership Team Chair at least 30 days prior to a Leadership Team meeting. A majority vote of approval by the HAP Leadership Team and approval by the current anchor organizations is required for each amendment as described above.

B. Approval

These Articles of Collaboration shall become effective upon approval by the HAP Leadership Team and the current anchor organizations in accordance with provisions contained in section VI G.

Article X: Relationship of the Parties/Binding Affect of Articles:

These Articles of Collaboration serve as an agreement among the participants in this consortium which is not formally incorporated as a legal entity, by which they establish their relative mission, vision, goals and responsibilities. The parties to this collaboration are each an independent member, agency or entity and the relationship between the parties hereto does not constitute a partnership, joint venture, agency, or relationship of any kind recognized under Titles 10, 10A, or 11 of the Code of Alabama 1975 or any other state or federal law regarding business entities. No party to these Articles of Collaboration has the authority to make any statements, representations or commitments of any kind, or to take any action that will be binding on any other party. No third party is intended, or will be deemed, to be a formal beneficiary of any provision of these Articles of Collaboration. Each party will be separately responsible for compliance with all federal, state, local and/or municipal ordinances, regulations and laws.

Nothing in these Articles of Collaboration shall be interpreted as limiting, superseding, or otherwise affecting any governmental entities' normal operations or decisions in carrying out its statutory or regulatory duties. These Articles of Collaboration do not limit or restrict the parties from participating in similar activities or arrangements with other entities. These Articles of Collaboration do not create any legally enforceable rights, nor are they to be construed as obligating funds, services or assets. These Articles of Collaboration do not themselves authorize the expenditure or reimbursement of any funds, nor do they serve to obligate the parties to expend appropriations.

These Articles of Collaboration were approved by the Health Action Partnership Leadership Team on March 14, 2019 as witnessed by the signature of the Chair of the Health Action Partnership Leadership Team.

health action PARTNERSHIP

For more information about starting your own Health Action Partnership, contact healthaction@uwca.org. Or visit our website: healthactionpartnership.org.