Coalition/Core Team Baseline Assessment Summary July 2019

ATSH: Community Partnerships
Themes about systems practice

Coalitions are in early development of systems practice capabilities except for relationship building

- Biggest opportunities are in working across difference, reflective practice, and equity lens
  - Coalitions have awareness of complex systems, half tried 1-2 tools; many of key stakeholders are involved, but need to deepen relationships
  - Most coalitions do not have ways to work across difference; half are gathering feedback for learning
  - Half of coalitions are just beginning to develop multiple level strategies; half are not taking much time out for reflection
  - Coalitions are in the beginning stages of developing equity goals and roles or haven’t discussed it at all
Themes about stakeholders, incl **people with lived experience**

- Biggest opportunities are engaging residents or people with lived experience in leadership or decision-making roles, identifying meeting norms or practices that may cause barriers
  - Strategies for equitable outcomes focus on access points
  - Except for patient and family advocates, few grassroots voices are decisionmakers
  - Large public health/govt agencies hold most of the decisionmaking power
  - More coalitions could identify community touchpoints, e.g., library, food bank, homeless shelters, etc. and race/ethnic groups and include them
  - Residents or people with lived experience are more likely to provide input and less likely to hold leadership or decision-making roles
  - Half of coalitions included people with lived experience in visioning
  - Coalitions could review meeting practices that cause barriers, but some using jargon less
  - Governance does not include mechanisms to ensure inclusion of people with lived experience
Themes about equity and collaboration

- Coalitions have interest in addressing equity and some include voices of lived experience, however there are few structures and processes that center equity
  - Most coalitions do not address equity at scale and have not addressed what marginalizing dominant cultural practices are in place
  - Only one coalition has those most affected by inequity helping with decisions; but most coalitions have community members involved
  - Coalitions discuss impact on affected groups but not with structured processes
  - Coalitions’ core teams have some equity training or diverse representation
  - Most coalitions’ residents/people with lived experience provide input and in one has decision-making power; most don’t have explicit guidance on resident inclusion or decision-making
  - Coalitions don’t address power directly, but some have conversations about biases/fears
Themes about **equity** and collaboration, cont.

- No coalitions train partners/residents in improvement, nor include residents from the beginning of measurement journey
- Coalitions aren’t tracking outcomes related to closing gaps between groups; not directly addressing structural barriers that uphold inequities
- Basic equity goals exist; two coalitions articulate equity policy agendas; coalition staff are addressing inequity in their projects
- Some coalitions have equity implementation plans and processes
  
  *Most questions did not have the reply option of “Not addressed” or NA, so results may overstate coalitions’ work on equity practices.*

● **Recommendation:** Prioritize the equity practices that support and complement mapping and inclusion
  
  ○ **EV2. We Dismantle Dominant Culture Practices That Uphold Inequity Or Marginalization**
  ○ **EV3. We are led by and serve the people most affected by inequities**
  ○ **EC1. Create meaningful and deep engagement with community**
  ○ **EC2. Share leadership and power with residents**
  ○ **EC6. Recognize and eliminate structural barriers that uphold racism, sexism, homophobia, classism, etc.**
Measuring Stigma

A brief review of the literature addressing OUD/SUD stigma (by Rita Hewitt from Santa Cruz & Kristene Cristobal) addresses stigma at three levels: Structural, Public, and Self-stigma.

Collected resources found [here](#).

An exemplar anti-stigma campaign from Indiana’s Family and Social Services Administration, “**Know the O Facts**”

Other resources you’ve found? Let us know!
Next Steps related to evaluation

- Review the detailed summary pdf and reflect on the areas that might be especially helpful as you begin to develop strategies.
- Rachel, Tatiana, and Trish will guide you through the process from sensemaking to identifying leverage points and changes. We’ll ask about these and any concrete goals you may have in the next progress report out Oct 28, due Nov 22.
  - Abbreviated
  - Can choose to complete a shared doc
Project leads with some facilitators, core team members completed the baseline assessment

<table>
<thead>
<tr>
<th>PROJECT LEAD</th>
<th>COALITION</th>
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<tbody>
<tr>
<td>Jermaine Brubaker</td>
<td>RxSafe Del Norte</td>
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<tr>
<td>Rita Hewitt</td>
<td>SafeRx Santa Cruz County</td>
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<tr>
<td>Sarah Salven</td>
<td>San Diego Prescription Drug Abuse Task Force</td>
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<tr>
<td>Mary White</td>
<td>San Benito County Opioid Task Force</td>
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3. Your role in the coalition
4 responses

4. Who else from your coalition informed the responses to this assessment?
4 responses
Coalitions’ aspirational goals rated 4s/5s for being explicit & deeply shared amongst coalition members; Reducing deaths is most common goal

4
RxSafe Del Norte
Zero deaths due to opioids in Del Norte County by 2025.

5
SafeRx Santa Cruz County
Have a healthy community, zero deaths from overdoses relating to all substances, and ending stigma and opening dialogue around people with SUD, as treatable condition.

5
San Benito County Opioid Task Force
To eliminate overdose deaths in our community while ensuring all those with OUD receive needed treatment and services to reach recovery.

4
San Diego Prescription Drug Abuse Task Force
To decrease the harms of prescription drugs that we are seeing throughout San Diego County.

- This goal was completed at a visioning session with the coalition.
- Each member comes to coalition meetings with the goal of improving opioid safety and wellness in our community.
- This goal has been the shared concern from the coalition’s inception and the reason why its members are dedicated.
- Treatment Delivery System
  - Harm Reduction
  - Safe Disposal
  - Prevention Education
  - Strategic Partners
Measures tracked towards aspirational goals

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<th>Deaths</th>
<th>Nonfatal overdoses</th>
<th>ER</th>
<th>Opioid Rx/dispensed pills</th>
<th>Bupe Rx</th>
<th>Naloxone</th>
<th>Safe disposal</th>
<th>MAT providers</th>
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<th>Law Enforcement* **</th>
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*Detentions/suspensions due to opioids/drugs, CHKS

**Outreach presentations, guidelines, MAT advisory group attendance

***Arrestees self-report of Rx misuse, Rx prosecutions, pharmacy robberies

Report card
We asked coalitions to self-rate their capability in 7 systems practice areas:

- Seeing and sensing systems
- Relationship building
- Working across difference
- Learning and adapting
- Multiple level strategies
- Reflective practice
- Working with an equity lens

Instructions included:

“Self-ratings of capabilities are best derived from your team discussing and coming to consensus on the score. Candid self-ratings are best so that you can learn and grow the most over the grant period. Since there are no right or wrong answers, and no judgements about where your coalition falls, we suggest you select scores that are conservative, e.g., if you fall between two scores, choose the lower one.

The aim of our systems practice training is to raise awareness in these foundational approaches, not necessarily become experts. Systems practice is an approach that can take some time to learn, practice, and build overtime. We expect most groups to self-rate on the lower end of the scale, especially in the beginning of the grant period.”
Coalitions have awareness of complex systems, half tried 1-2 tools; many of key stakeholders are involved, but need to deepen relationships.
Most coalitions do not have ways to work across difference; half are gathering feedback for learning.
Half of coalitions are just beginning to develop multiple level strategies; half are not taking much time out for reflection.
Coalitions are in the beginning stages of developing equity goals and roles or haven’t discussed it at all.

Coalition capability: Working w/an equity lens

1 = Our coalition has not yet discussed goals for equity or what each of our roles are in relation to equity.
2

3 = Our coalition has an awareness of how each of us has a role in addressing equity and is developing the goals and processes to support equity.
4

5 = Our coalition regularly discusses how each of our cultures, histories, and identities impacts or shapes our challenges and privileges.
Equity, Stakeholders, and Lived Experience

Biggest opportunities are residents or people with lived experience in leadership or decision-making roles, identifying meeting norms or practices that may cause barriers.
Strategies for equitable outcomes focus on access points.

**RxSafe Del Norte**
Strategies centered around people with lived experience in prevention, intervention, harm reduction, treatment, recovery, and maintenance.

**SafeRx Santa Cruz County**
Partnering with Harm Reduction Coalition to develop Syringe Access Program; MAT expansion via DMC-ODS, CA-BRIDGE; increasing MAT, syringe, and mental health services for all.

**San Benito County Opioid Task Force**
MAT in jails & EDs incl homeless; Behavioral Health services expansion via Medi-Cal ODS waiver program.

**San Diego Prescription Drug Abuse Task Force**
Plan for system mapping with underserved populations.
Stakeholders who were *most* likely decision-makers

100%
- County public health and/or county health care delivery system,
- County Alcohol and other drug dept

75%
- Pharmacists, Methadone clinics, Patient and family advocates,
- Medical examiner

50%
- Community clinics, Health plans/Medi-Cal plans, Hospitals,
- Emergency physician groups, Other Addiction treatment/harm reduction, Law enforcement, Corrections, Education/schools

*Percent of coalitions reporting a stakeholder’s involvement as a 4 or 5 using a 1-5 scale, 1=informed, 3=gives input, 5=decision-maker
Stakeholders who were *least* likely decision-makers

100% Hospital association

75% Medical association, Medical groups and IPAs, Politicians and supervisors

50% Hospitals, Urgent Care, Urgent care or retail clinics

*Percent of coalitions reporting a stakeholder’s involvement as a 1, 2, or 3 using a 1-5 scale, 1=informed, 3=gives input, 5=decision-maker*
Stakeholders not involved in the coalitions

50% 75%

Of coalitions did not include...

- Hospital association
- Urgent Care
- Retail clinics
- Dentists
- DEA
- Local Native American Tribes
- First responders
- Recovery community
- Other community: Library, Food Bank, Homeless shelter, Integrated Waste Management,
- Interest groups: Whole Person Care, Oral Health Advisory Group, Pharmacy Work Group, Safe Kids
Residents or people with lived experience are more likely to provide input and less likely to hold leadership or decision-making roles in the coalitions.

We can learn from the coalitions where they are leading a workgroup or are a Board member or another leadership role. (San Benito, San Diego)
Half of coalitions included people with lived experience in visioning

**Framework**

People with lived experience were involved in the creation of the Vision and/or Common Agenda for our initiative

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<td>2= Planning</td>
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<td>3= Started/Needs Improvement</td>
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<td>4= Implementing</td>
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<td>5= Performing/Done consistently</td>
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Some strategies and also concerns

- Outreach at schools and to parents
- Invitation to participate through media
- Founders and members include people with lived experience
- We do acknowledge some discomfort with sharing the leadership role, and meaningful engagement around decision-making.
- Some community members aren’t ready to fully participate due to the sensitive nature of this topic.
- Testimony from those with lived experience at coalition meetings and Naloxone trainings.
Most coalitions have some community representation but not in leadership roles

**Leadership & Structure**

Our group has members who represent the community impacted by the issue

2

1

0

1= None/Not at all 2= Planning 3= Started/Needs Improvement 4= Implementing 5= Performing/Done consistently

**Leadership & Structure**

Our group has established a policy that people with lived experience are in leadership roles

2

1

0

1= None/Not at all 2= Planning 3= Started/Needs Improvement 4= Implementing 5= Performing/Done consistently
Coalitions could review meeting practices that cause barriers, but some using jargon less

**Inclusive Meeting Norm/ Practices**

Our group refrains from using “jargon” or language that alienates or distances people with lived experience

**Inclusive Meeting Norm/ Practices**

Our group reviews meeting practices to ensure they don’t cause barriers to people with lived experience.
Utilizing formal and informal ways to obtain community partner feedback

- Seek input during and after meetings; standing agenda item includes feedback/report out from each member; seek input/feedback during school presentations (particularly parent presentations) and have done so through small group break outs after main presentation; many 1:1 conversations with community leaders such as government officials and agency directors; also representation on other coalitions such as Wellness Coalition and Oral Health Advisory Group.
- We have a planning retreat every year with the Executive Committee where we reflect on the past year and review suggested objectives/goals for the upcoming year from our general members. This allows us to identify the needs of coalition members and then decide on several goals/objectives to focus on throughout the year based on the identified needs expressed at the general meeting.
- 1:1 conversations and informal discussions
- Currently facilitators have one on one conversations with community stakeholders.
Governance does not include mechanisms to ensure inclusion of people with lived experience

- We do not have a formally documented governance, however, we have a set structure that we initially established and have since followed: Co-Leads are from Public Health Services (Health Officer and one other) (public health is lead agency for grants, support, etc.); Core Team of 5 members from varying agencies/organizations; large overall membership; and two sub-work groups (MAT work group and Education work group).
- We have an executive committee that provides the guidance and planning for each year. The executive committee represents many sectors including law enforcement, treatment, DEA, medical examiner, individuals with lived experiences, the County Behavioral Health Services, Sheriff's Department, Probation Department and prevention specialists.
- Flat government structure, no reserved seats, seats added as needed. Currently we don't have a steering committee.
SafeRx Santa Cruz County

SafeRx Santa Cruz County is an interdisciplinary coalition of community partners leading efforts in increasing positive outcomes related to prescription medication. The coalition focuses on shifting the culture of prescription medication use, and ensures a safe and compassionate community for patients, medical and behavioral health providers, and all Santa Cruz County residents.

The Role of the Steering Committee is to meet quarterly, keep initiatives on track, provide guidance and support to initiative chairs in meeting their goals.

The Role of the Prescriber Practice Initiative is to provide guidance to clinicians. This includes pain management guidelines and enhancing awareness of non-pharmacy approaches to pain management.

MAT Advisory Group
MAT-AG, in conjunction with Safe Prescribe Monterey, is a peer support and resource group of physicians, advanced practice clinicians, and behavioral health providers focused on improving opioid use disorder recovery and capacity.

The Role of the Community Education Initiative is to develop and publicize patient and community education messaging around prescription medication safety.

Harm Reduction Coalition
The role of the HRC is to advocate for evidence-based harm reduction policies and practices that reduce stigma, promote safety, and improve health. *SafeRx staff participates in the HRC in a consultative role and assists in the dissemination of HRC materials.

The Role of the Metrics Initiative is to develop a community dashboard with accurate, relevant, and easily tracked data.

SafeRx Santa Cruz County
www.hipsc.org/saferx
@SafeRxSCC
## Equity Framework

The following equity values & capabilities (a continuum of behaviors, processes, or approaches that address equity) is adapted from a framework developed by Cristobal Consulting and used with permission of Blue Shield of CA Foundation.

### EQUITY VALUES

<table>
<thead>
<tr>
<th>Value 1</th>
<th>Value 2</th>
<th>Value 3</th>
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<tbody>
<tr>
<td>We are equity focused.</td>
<td>We dismantle dominant culture practices that promote inequity or marginalization.</td>
<td>We are led by and serve the people most affected by inequities.</td>
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### EQUITY CAPABILITIES

#### STRONG TIES THROUGHOUT COMMUNITY

<table>
<thead>
<tr>
<th>Capability 1</th>
<th>Capability 2</th>
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<tbody>
<tr>
<td>Create meaningful and deep engagement with community</td>
<td>Share leadership and power with residents</td>
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#### DISCIPLINED IMPROVEMENT AND ACCOUNTABILITY APPROACH

<table>
<thead>
<tr>
<th>Capability 3</th>
<th>Capability 4</th>
<th>Capability 5</th>
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<tbody>
<tr>
<td>Define ambitious equity goals</td>
<td>Use a disciplined improvement approach to obtain results that residents want to see</td>
<td>Use data with an equity oriented mindset</td>
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#### STRATEGIES TO ADDRESS THE STRUCTURAL BARRIERS THAT UPHOLD INEQUITIES

<table>
<thead>
<tr>
<th>Capability 6</th>
<th>Capability 7</th>
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<tbody>
<tr>
<td>Recognize and eliminate structural barriers that uphold racism, sexism, homophobia, classism, etc.</td>
<td>Design and implement collective and ambitious equity policy agendas</td>
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#### BUILD CAPACITY FOR EQUITY AMONGST STAFF, LEADERSHIP, AND COMMUNITY LEADERS

<table>
<thead>
<tr>
<th>Capability 8</th>
<th>Capability 9</th>
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<tbody>
<tr>
<td>Equity is highly valued as a core competency</td>
<td>Design structures and processes to promote equity at individual and organizational levels</td>
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</tbody>
</table>
Most CP coalitions do not address equity at scale and have not addressed marginalizing dominant cultural practices.
One CP coalition has those most affected by inequity helping with decisions; most coalitions have community members involved

Coalition capability: We are led by and serve the people most affected by inequities

Coalition capability: Create meaningful and deep engagement with community (From outreach to leadership development)
CP coalitions discuss impact on affected groups but not with structured processes; coalitions’ core teams have equity training or diverse representation.
Most CP coalitions’ residents/people with lived experience provide input and in one has decision-making power; most don’t have explicit guidance on resident inclusion or decision-making.
CP coalitions don’t address power directly, but some conversations about biases/fears; basic equity goals exist

Coalition capability: Share leadership and power with residents (From addressing fears about inclusion to having an array of power sharing opportunities)

1=We are able to have discussions about the fears and biases people may have about including residents or people most affected by inequities in everything we do.

2=We address power within our multi-sector collaboration by power analysis - who has power, who doesn’t - and creating more equitable spaces for all our partners.

3=We have multiple ways that residents or people most affected by inequities have access to power within our collaborative, e.g., involvement in collaboration discussions, helps make decisions about strategies and budget, serving as a board member.

4=We create explicit equity goals that will positively impact results and outcomes for communities experiencing inequities (can include using tools such as the Racial Equity Tool or Equity Impact Tool to help guide the development of equity goals).

5=We integrate the principles of targeted universalism, utilizing strategies tailored to improve the conditions of specific groups, so that we achieve our overall goals.

Community Partnerships Baseline Assessment July 2019
No CP coalitions train partners/residents in improvement, nor include residents from the beginning of measurement journey

Coalition capability: Use a disciplined improvement approach to obtain results that residents want to see (Improvement skill sets for core staff to wider spread training of coalition members)

Coalition capability: Use data with an equity oriented mindset (From data disaggregation to data that has deep meaning to residents)

1=Our coalition staff has the capabilities and skill sets to use improvement methodology to guide our collaboration’s strategies and implementation.

2.3=We train and educate our collaboration partners, including residents, in our approaches and processes for continuous improvement.

4.5=All stakeholders are proficient in our approaches for identifying goals, strategies, and measures.

1=We disaggregate our community data on outcomes by race and develop strategies to address those inequities.

2.3=We involve residents, or those affected by the inequities, from the beginning of our measurement journey, e.g., in the selection of measures.

4.5=We use multiple strategies to create meaning in the data that matters to our community, e.g., weaving stories about the data, not just reporting a number; community members taking on various roles in the measurement journey such as collecting data, reporting data.
CP coalitions aren’t tracking outcomes related to closing gaps between groups; not directly addressing structural barriers that uphold inequities

Coalition capability: Use data with an equity oriented mindset (Rigorous attention to goals for closing gaps between groups)

1=We track outcomes against the goals we’ve set for the whole community as well as goals we’ve set for closing the gaps between groups, e.g., we will increase the percentage of children consuming 5 fruits and vegetables by 20% and close the gap between Latino and African American children and white children by 25%

2=Members of our multi-sector collaboration incentivize the process of tracking and closing the gaps in outcomes between groups within their own organizations.

Coalition capability: Recognize and eliminate structural barriers that uphold racism, sexism, homophobia, classism, etc. (From awareness to explicit institutional work to eliminate barriers)

1=Our multi-sector collaboration discusses how our community has been impacted by specific inequitable policies and events from at least a couple hundred years ago to today. We understand how the disparate outcomes that we are working on today are connected to these policies and the institutions that have upheld inequities, whether intentionally or not.

2=Our collaboration has identified at least one program or policy that addresses a structural barrier we’ve identified in our community.

4=Our collaboration has one or more large institutions in our community that have committed to eliminating a structural barrier(s) to a specific inequity(ies) system wide.
Two CP coalitions articulate equity policy agendas; coalition staff addressing inequity in their projects

Coalition capability: Design and implement collective and ambitious equity policy agendas (From including community organizers to deliberate multi-level policy strategy)

1=Our multi-sector collaboration includes local community organizing groups that help inform equity policy agenda.

2=We have relationships and trust with multiple stakeholders across the community, government, and business community with clear roles for our equity policy agenda.

3=We utilize a structural analysis in our discussions about what strategies, policies, and programs our collaboration pursues to eliminate inequities. This means we look at the root causes of inequities including oppression and power imbalances and develop an array of strategies in.

Coalition capability: Equity is highly valued as a core competency (From equity awareness to ability to facilitate others’ learning)

1=We assess levels of awareness, knowledge, and skill sets for addressing equity amongst our coalition staff because it is one of our core competencies.

2=The staff are supported to engage in both their own personal journey to understand inequities, power, and oppression as well as embed the addressing of inequities in the programs, policies, and processes they are a part of.

3=Our coalition staff are capable of identifying inequities, such as the different levels of racism; holding discussions about inequities, power, and oppression; and defining the tools and strategies to address the inequities.
CP coalitions have equity implementation plans and processes

Coalition capability: Design structures and processes to promote equity at individual and organizational levels (From leadership support to day-to-day implementation of equity)
Harm Reduction
Naloxone access is #1 harm reduction strategy; limited needle exchange

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<th></th>
<th>Naloxone training, distribution</th>
<th>Needle exchange program/Providing sharps/Syringe disposal kiosk</th>
<th>Expanding access to MAT, provider education</th>
<th>OUD/SUD stigma reduction</th>
<th>Medication disposal</th>
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*Limited
**Supporting Harm Reduction Coalition’s application for Syringe Access Program
Most coalitions spent 1-2 hours and understood questions

19. About how long did it take to complete this baseline assessment?

- 25% spent < 1 hour
- 75% spent 1-2 hours

20. To what extent were the questions self-explanatory?

- 25% not at all
- 50% very clear

“Demonstrates our need for learning!”
“... it will be interesting to see where we go from here, and we hope it will be useful to look back at these answers.”

Some suggestions:
- This was a time-consuming survey. Make it a shared document to work on it collaboratively.
- Include an answer column for "not yet addressed"
- Consider more likert scales vs open-ended questions.
- We are at varying levels of fully understanding the equity lenses.