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.**

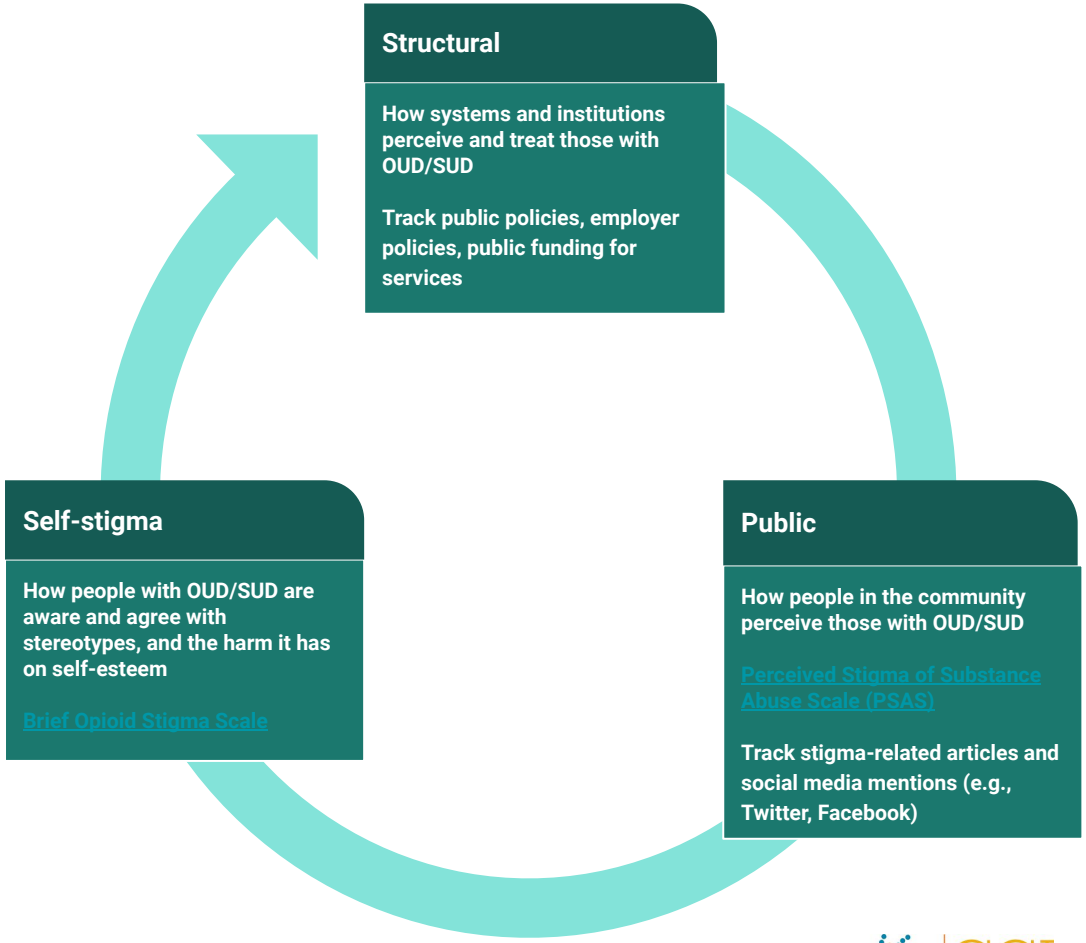
Measuring Stigma

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!



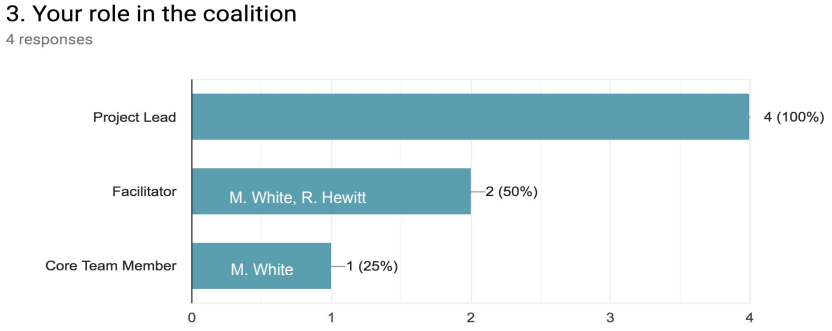
Next Steps

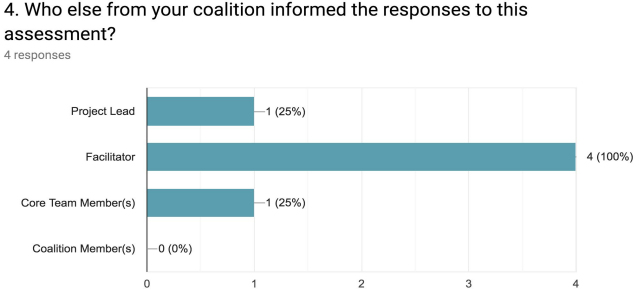
related to evaluation

- 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

PROJECT LEAD	COALITION
Jermaine Brubaker	RxSafe Del Norte
Rita Hewitt	SafeRx Santa Cruz County
Sarah Salven	San Diego Prescription Drug Abuse Task Force
Mary White	San Benito County Opioid Task Force





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.

- This goal was completed at a visioning session with the coalition.

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.

- Each member comes to coalition meetings with the goal of improving opioid safety and wellness in our community.

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.

- This goal has been the shared concern from the coalition's inception and the reason why its members are dedicated.

4

San Diego Prescription Drug Abuse Task Force

To decrease the harms of prescription drugs that we are seeing throughout San Diego County.

- Treatment Delivery System
- Harm Reduction
- Safe Disposal
- Prevention Education
- Strategic Partners

Measures tracked towards aspirational goals

	Deaths	Nonfatal overdoses	ER	Opioid Rx/dispensed pills	Bupe Rx	Naloxone	Safe disposal	MAT providers	School *	Processes**	CURES	Law Enforcement***	Some data stratified
DN											x		x
SB	x		x	x	x	x	x	x	x	x		x	x
SC	x	x								x			x
SD¥	x		x	x		x	x		x			x	x

*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

Systems Practice Capabilities

In early development except for relationship building

Biggest opportunities in working across difference, reflective practice, and equity lens

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

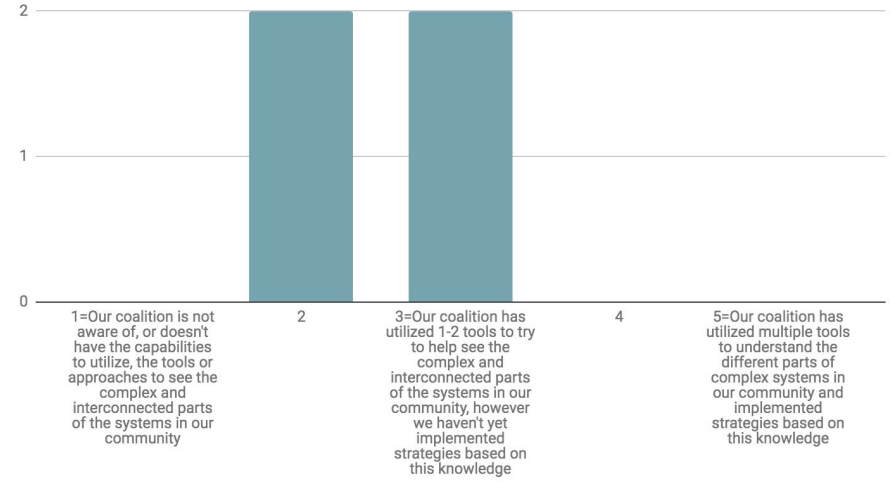
Instructions included:

“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.

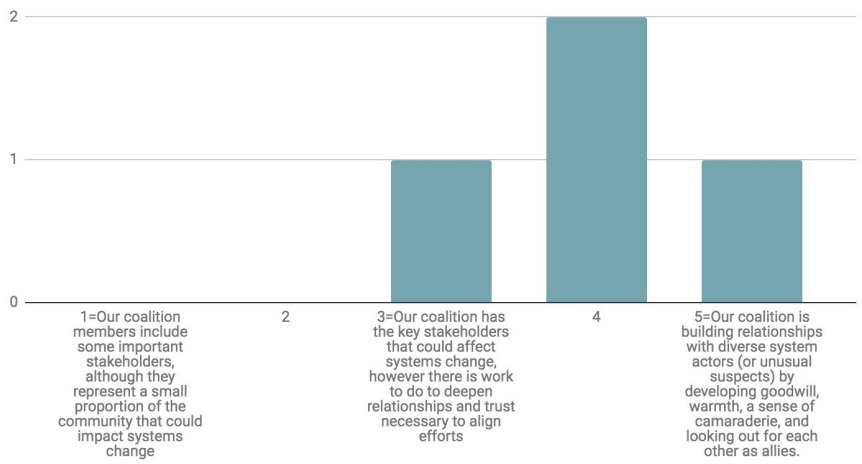
The aim of our systems practice training is to raise awareness in these foundational approaches, not necessarily become experts. Systems practice is an approach that can take some time to learn, practice, and build overtime. We expect most groups to self-rate on the lower end of the scale, especially 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

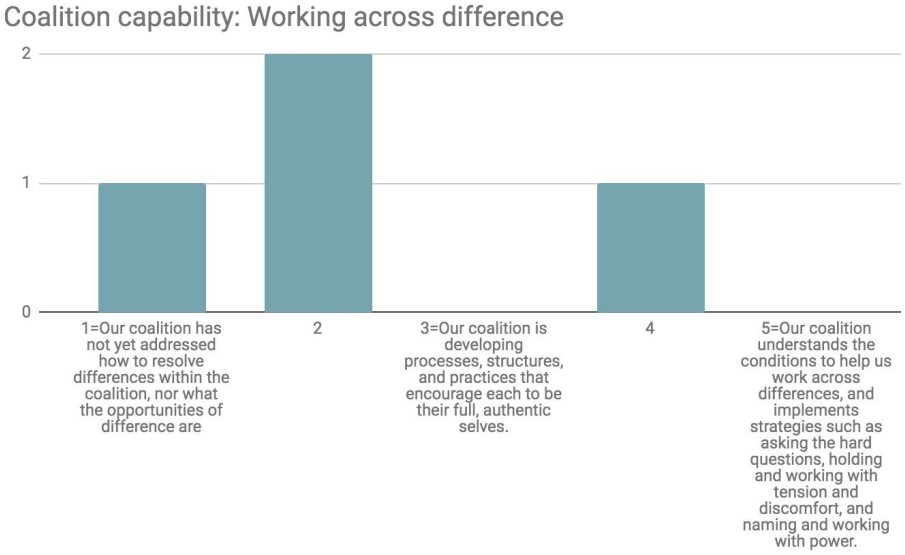
Coalition capability: Seeing & sensing systems

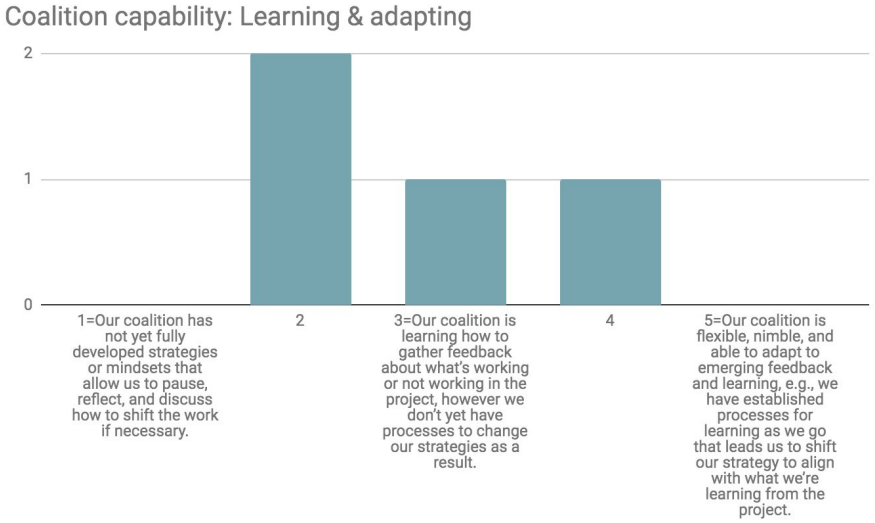


Coalition capability: Relationship building

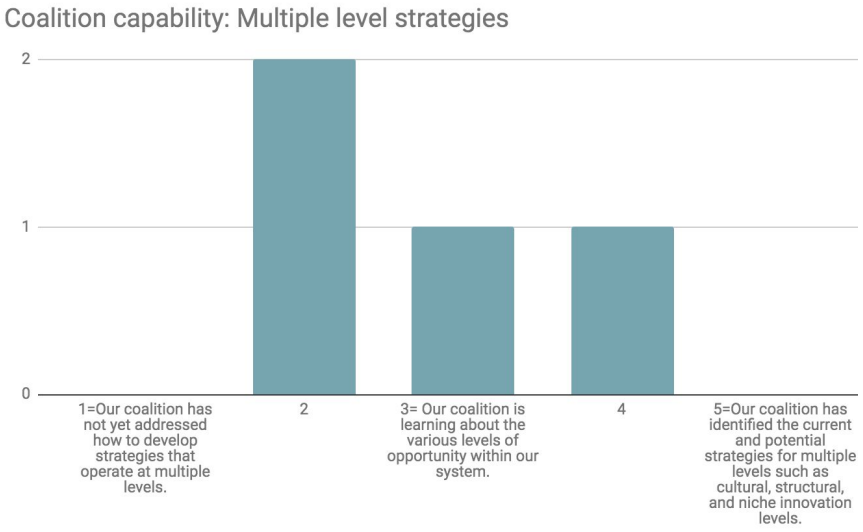


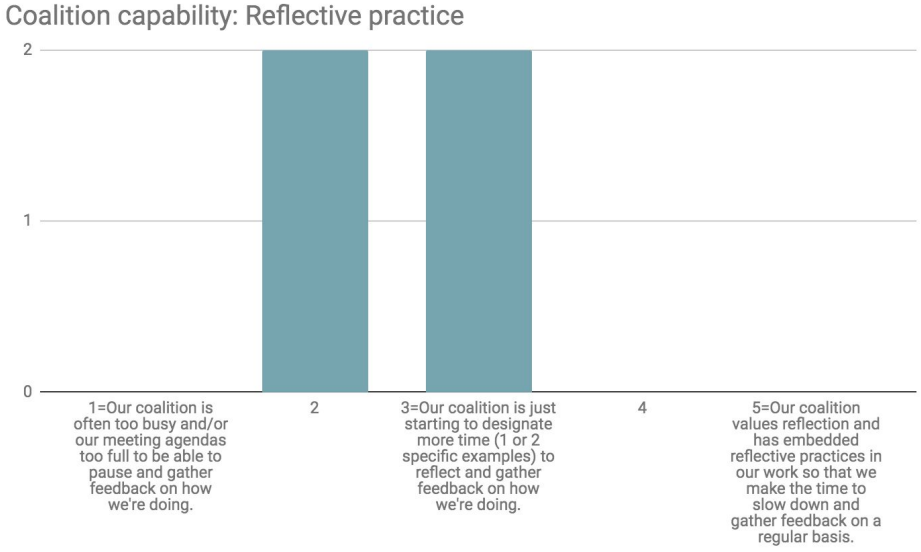
Most coalitions do not have ways to work across difference; half are gathering feedback for learning



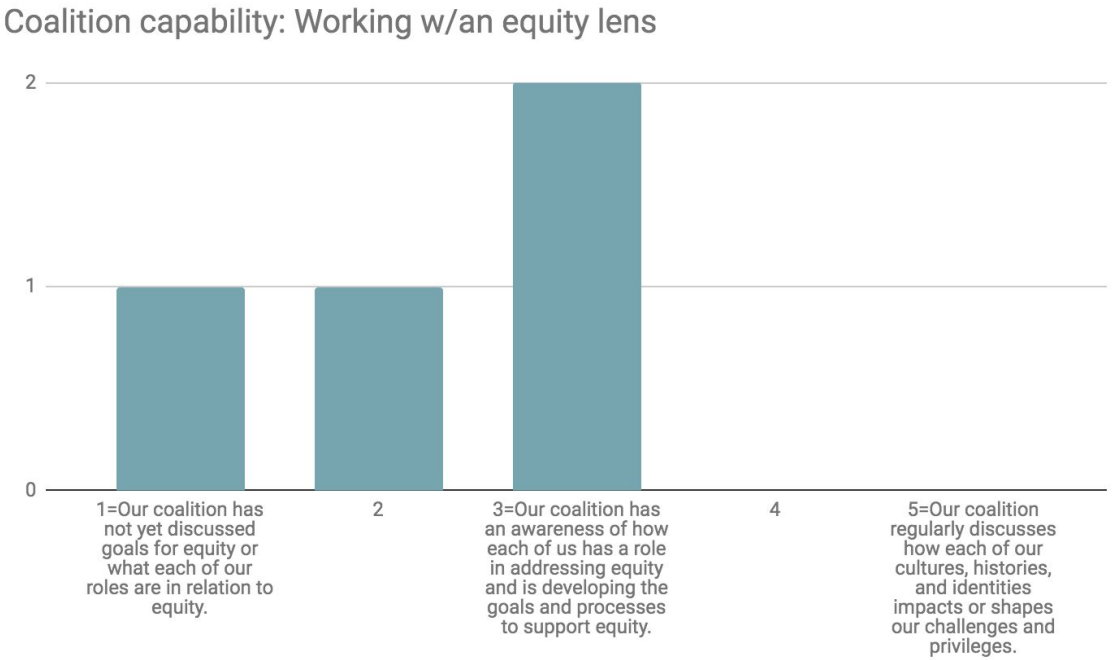


Half of coalitions are just beginning to develop multiple level strategies; half are not taking much time out for reflection





Coalitions are in the beginning stages of developing equity goals and roles or haven't discussed it at all



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

Stakeholders who were ***most*** likely decision-makers

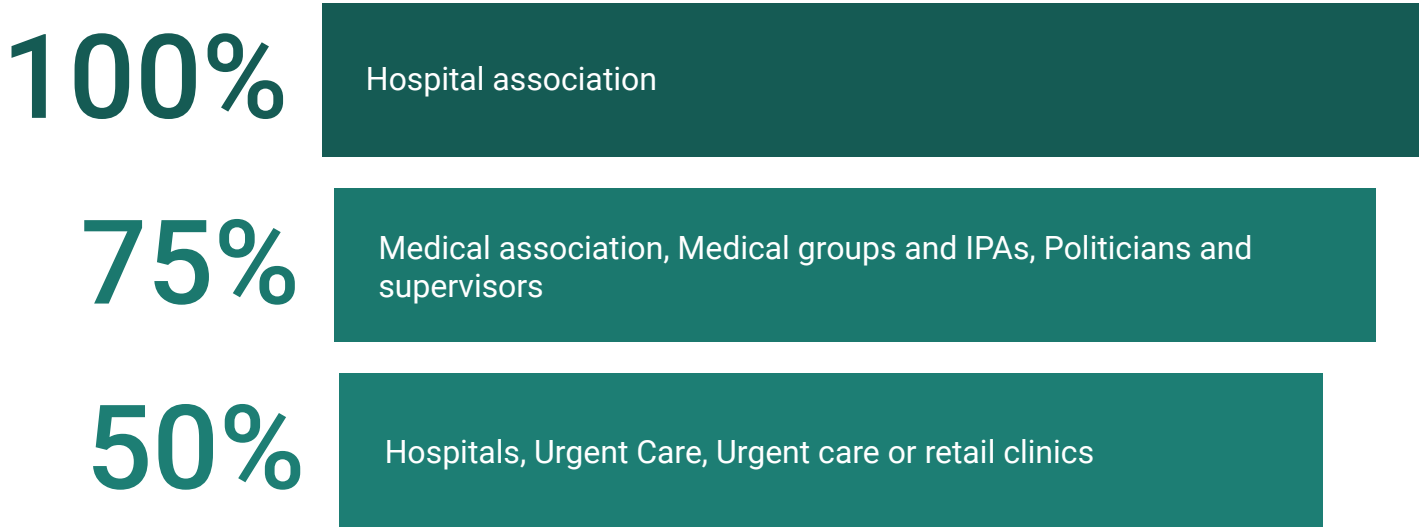
100% County public health and/or county health care delivery system, County Alcohol and other drug dept

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



*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%

Of coalitions did not include...

- Hospital association
- Urgent Care
- Retail clinics

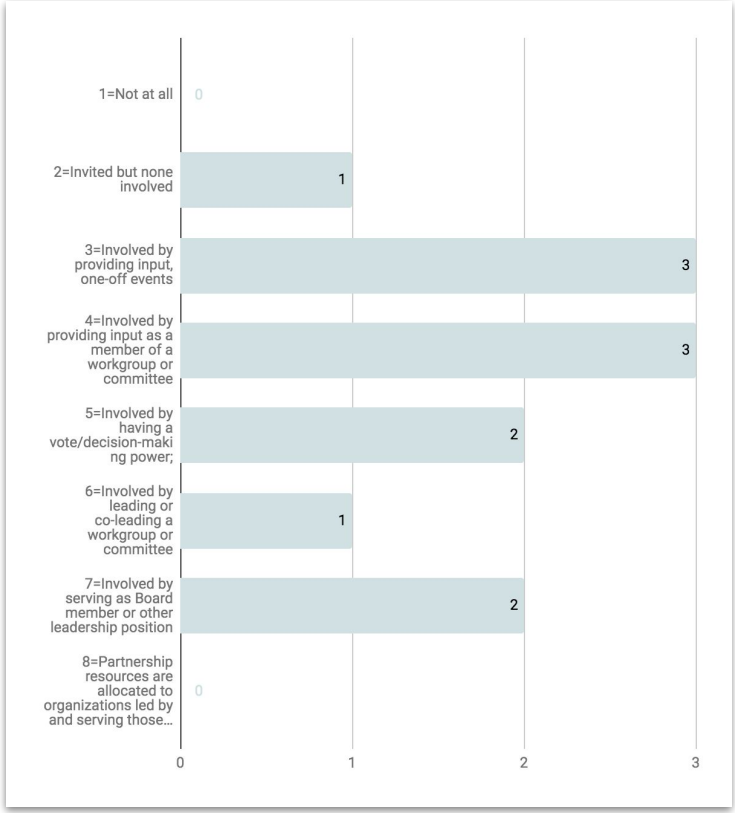
75%

- 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

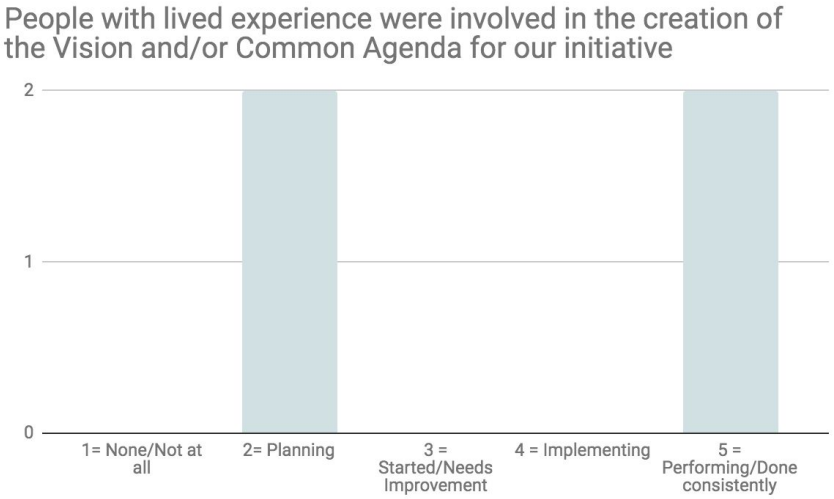
We can learn from the coalitions where they are leading a workgroup or are a Board member or another leadership role. (San Benito, San Diego)

The extent to which residents or people with lived experience participating in specific roles in the coalition



Half of coalitions included people with lived experience in visioning

Framework



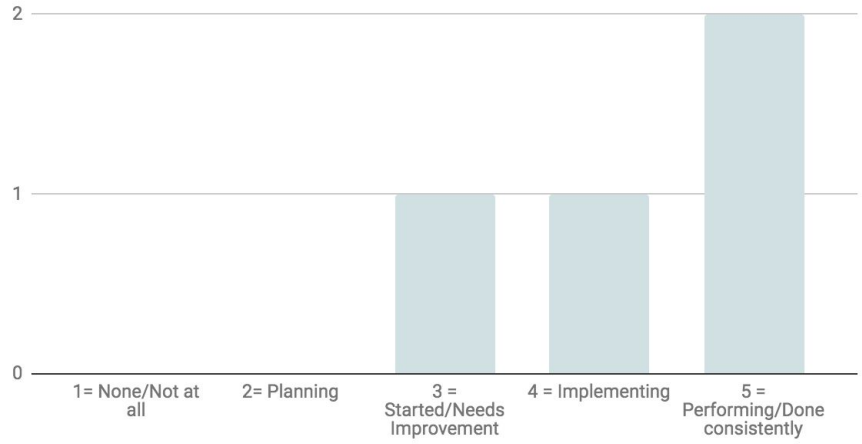
Some strategies and also concerns

- 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

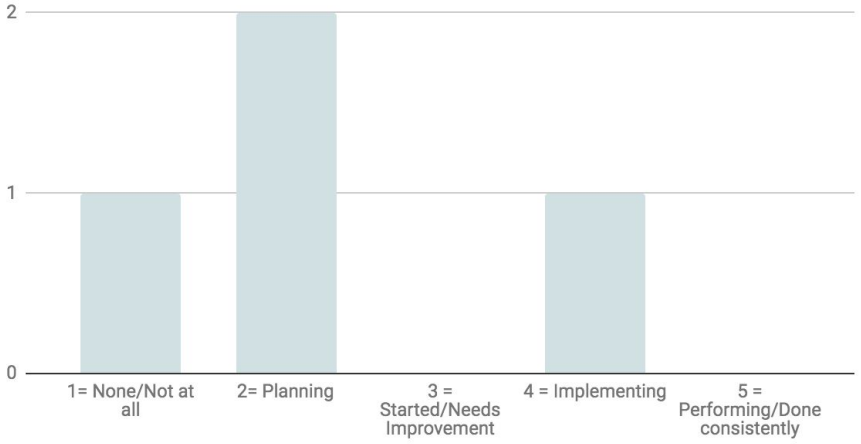
Leadership & Structure

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



Leadership & Structure

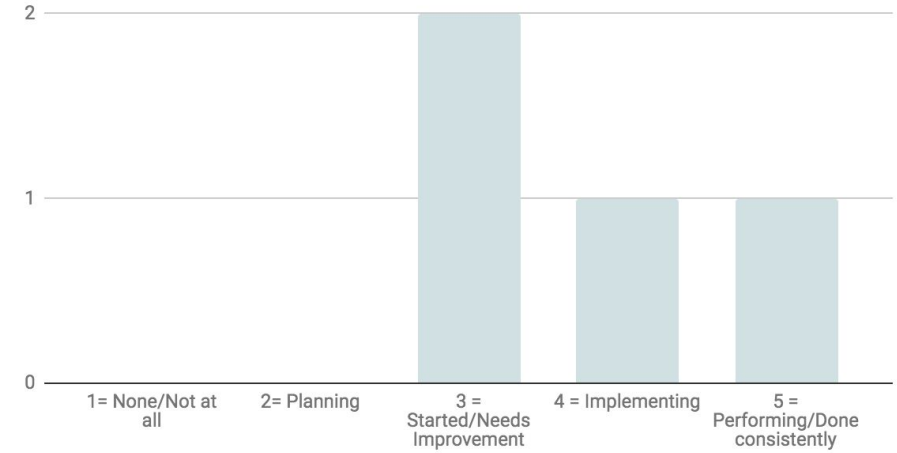
Our group has established a policy that people with lived experience are in leadership roles



Coalitions could review meeting practices that cause barriers, but some using jargon less

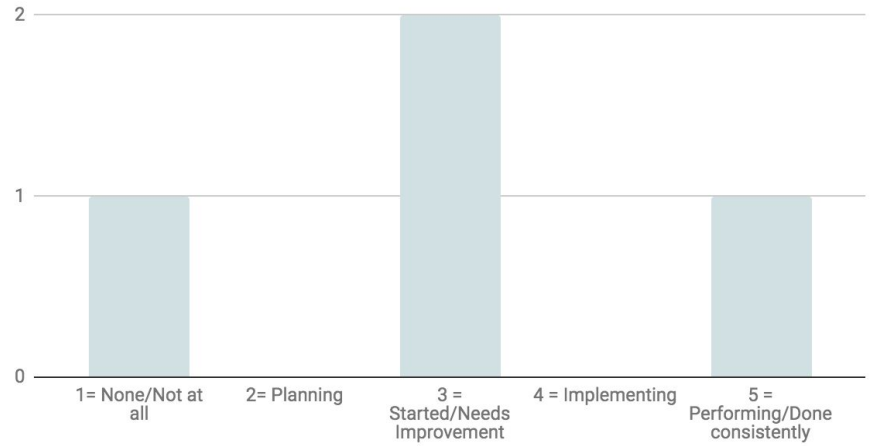
Inclusive Meeting Norm/ Practices

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.hipscc.org/saferx
@SafeRxSCC

COMMUNITY PREVENTION PARTNERS

HEALTH IMPROVEMENT PARTNERSHIP of SANTA CRUZ COUNTY

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)

CRISTOBAL CONSULTING

Framework for Equity and Collaboration

EQUITY VALUES

Value 1	Value 2	Value 3
We are equity focused.	We dismantle dominant culture practices that promote inequity or marginalization.	We are led by and serve the people most affected by inequities.

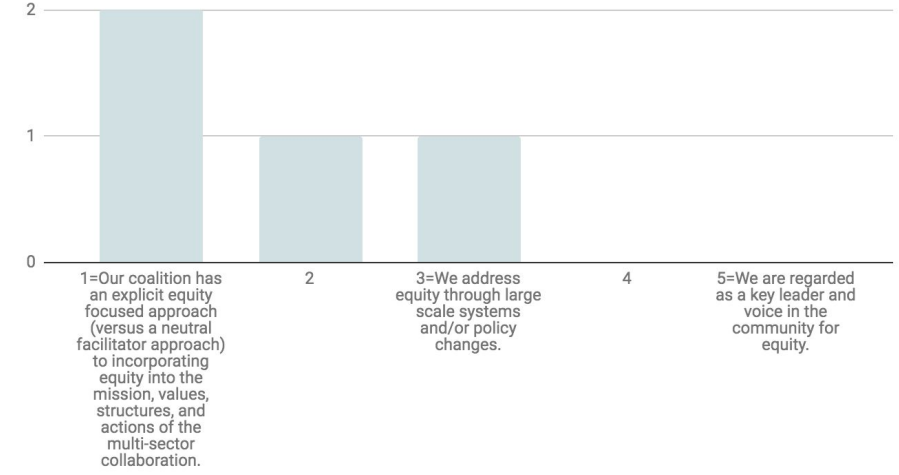
EQUITY CAPABILITIES

STRONG TIES THROUGHOUT COMMUNITY		
Capability 1	Capability 2	
Create meaningful and deep engagement with community	Share leadership and power with residents	
DISCIPLINED IMPROVEMENT AND ACCOUNTABILITY APPROACH		
Capability 3	Capability 4	Capability 5
Define ambitious equity goals	Use a disciplined improvement approach to obtain results that residents want to see	Use data with an equity oriented mindset
STRATEGIES TO ADDRESS THE STRUCTURAL BARRIERS THAT UPHOLD INEQUITIES		
Capability 6	Capability 7	
Recognize and eliminate structural barriers that uphold racism, sexism, homophobia, classism, etc.	Design and implement collective and ambitious equity policy agendas	
BUILD CAPACITY FOR EQUITY AMONGST STAFF, LEADERSHIP, AND COMMUNITY LEADERS		
Capability 8	Capability 9	
Equity is highly valued as a core competency	Design structures and processes to promote equity at individual and organizational levels	

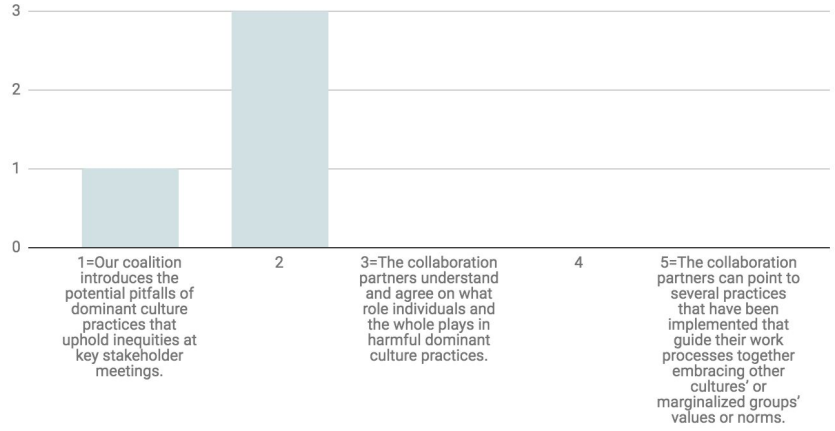
Cristobal Consulting, Blue Shield of CA Foundation

Most CP coalitions do not address equity at scale and have not addressed marginalizing dominant cultural practices

Coalition capability: We are equity-focused

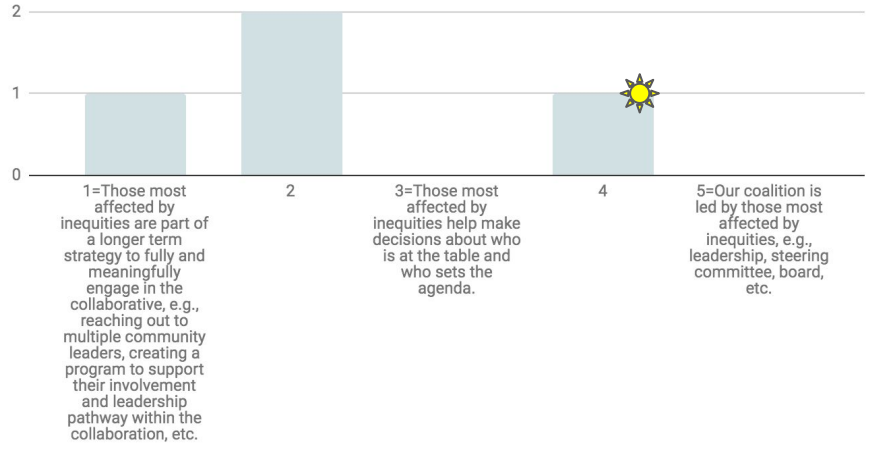


Coalition capability: We dismantle dominant culture practices that uphold inequity or marginalization

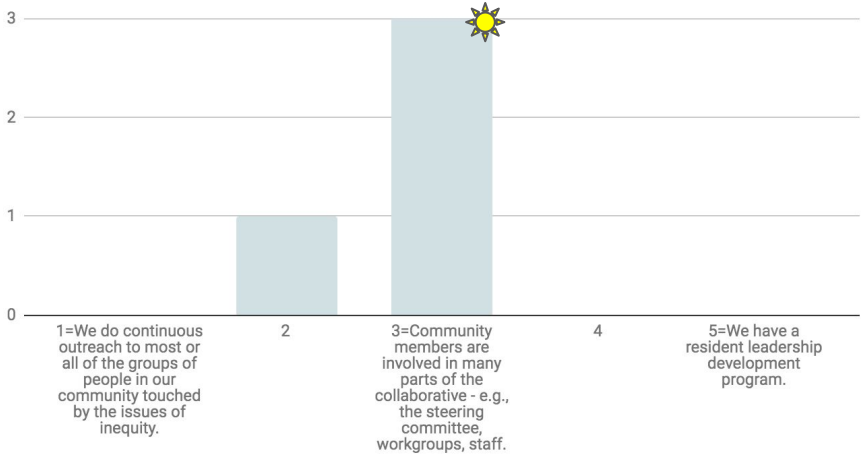


One CP coalition has those most affected by inequity helping with decisions; most coalitions have community members involved

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

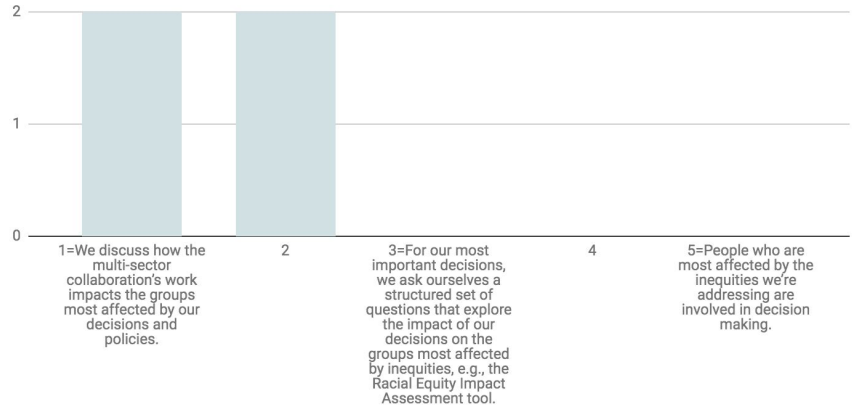


Coalition capability: Create meaningful and deep engagement with community (From outreach to leadership development)

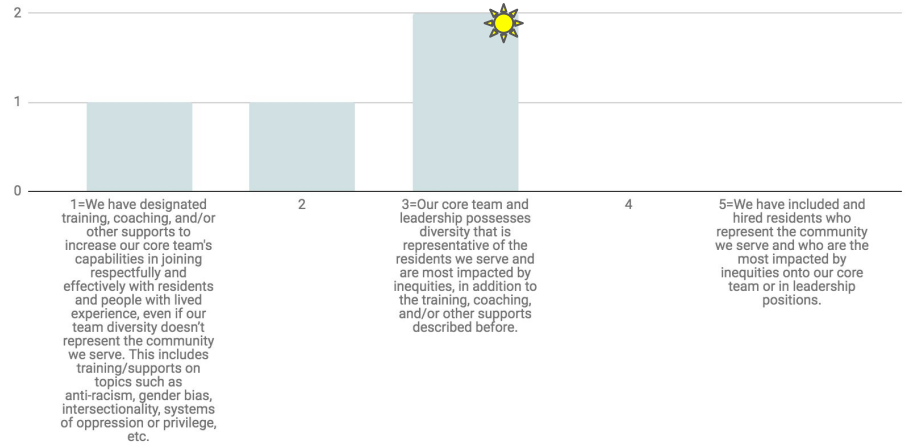


CP coalitions discuss impact on affected groups but not with structured processes; coalitions' core teams have equity training or diverse representation

Coalition capability: Create meaningful and deep engagement with community (From discussing impact on people to involving them in decision-making)

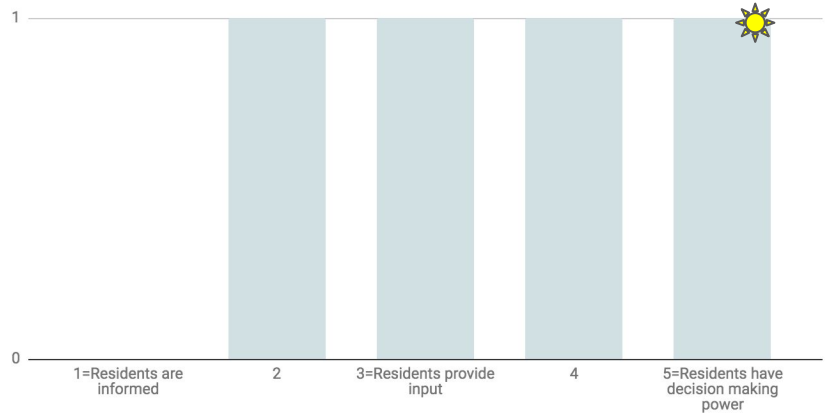


Coalition capability: Create meaningful and deep engagement with community (From core team training to work with residents/people with lived experience to hiring them onto our team)

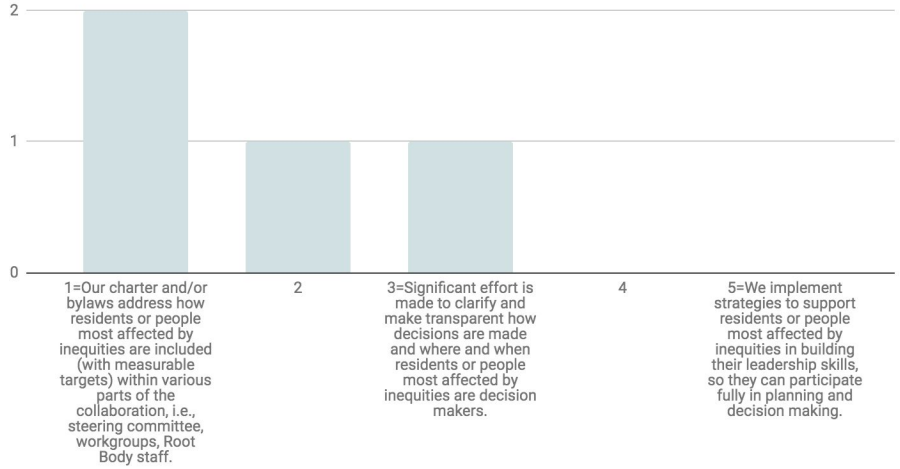


Most CP coalitions' residents/people with lived experience provide input and in one has decision-making power; most don't have explicit guidance on resident inclusion or decision-making

Coalition capability: Share leadership and power with residents (From being informed to making decisions)

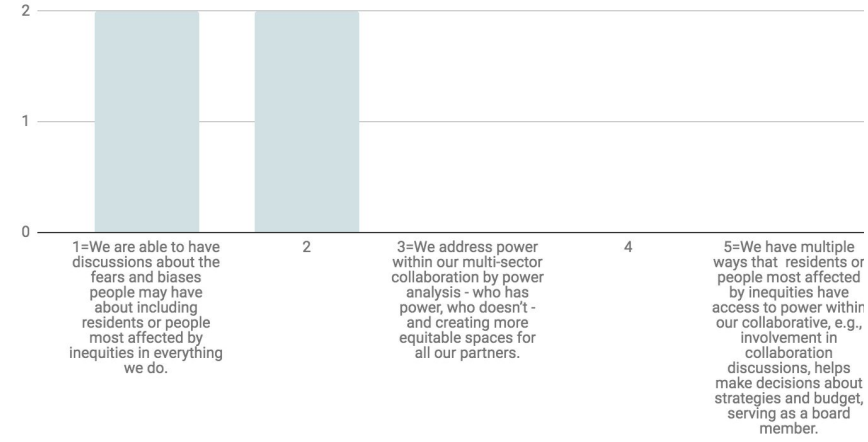


Coalition capability: Share leadership and power with residents (From planning for inclusion to ensuring full participation)

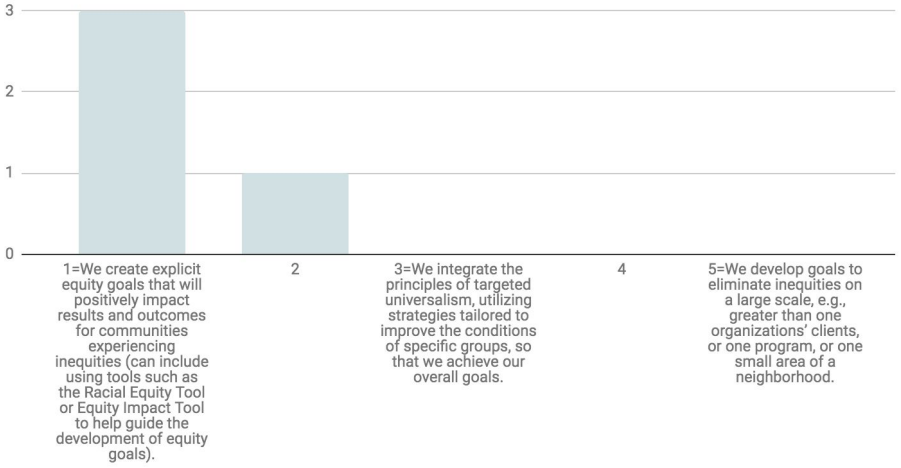


CP coalitions don't address power directly, but some conversations about biases/fears; basic equity goals exist

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

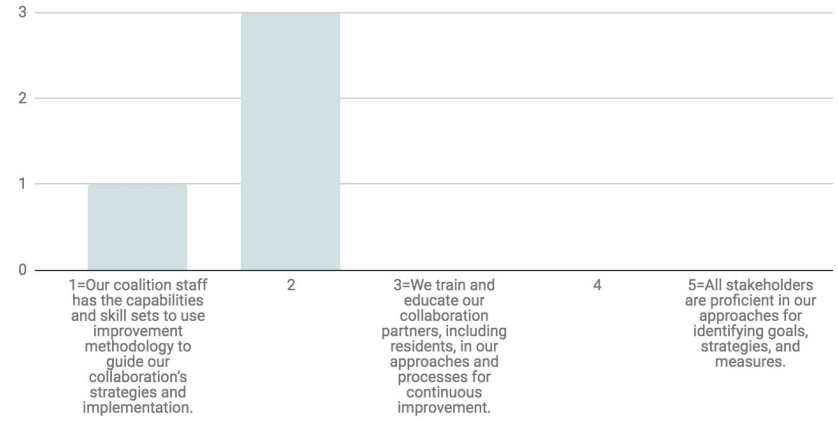


Coalition capability: Define ambitious equity goals (Increasing reach of equity goals)

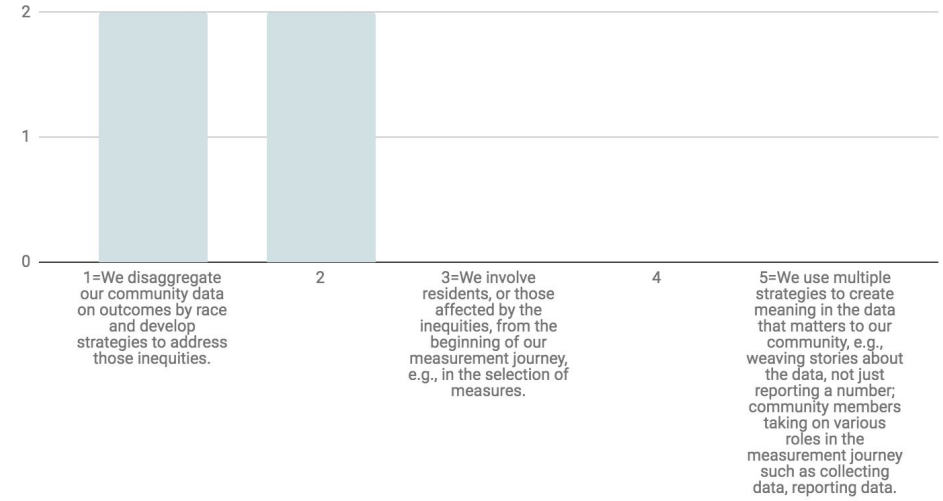


No CP coalitions train partners/residents in improvement, nor include residents from the beginning of measurement journey

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)

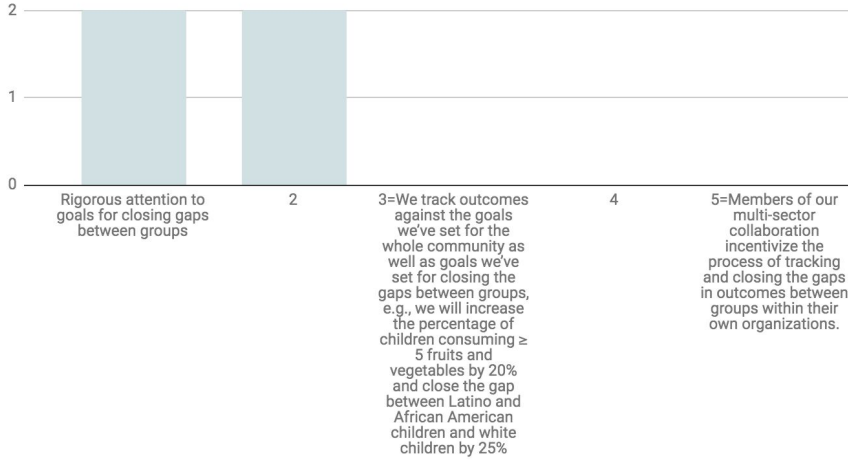


Coalition capability: Use data with an equity oriented mindset (From data disaggregation to data that has deep meaning to residents)



CP coalitions aren't tracking outcomes related to closing gaps between groups; not directly addressing structural barriers that uphold inequities

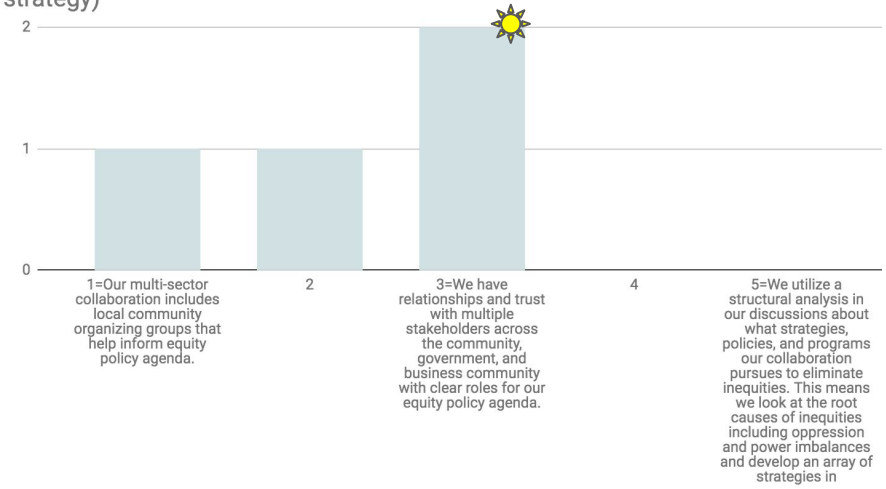
Coalition capability: Use data with an equity oriented mindset (Rigorous attention to goals for closing gaps between groups)



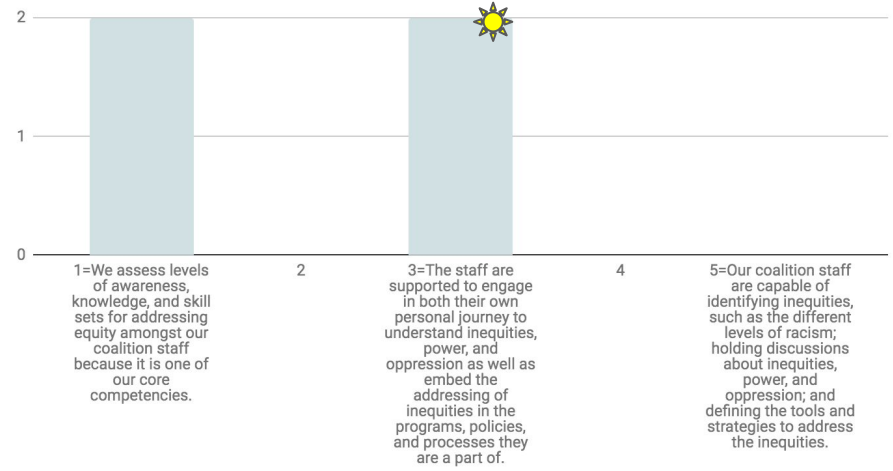
Coalition capability: Recognize and eliminate structural barriers that uphold racism, sexism, homophobia, classism, etc. (From awareness to explicit institutional work to eliminate barriers)

Two CP coalitions articulate equity policy agendas; coalition staff addressing inequity in their projects

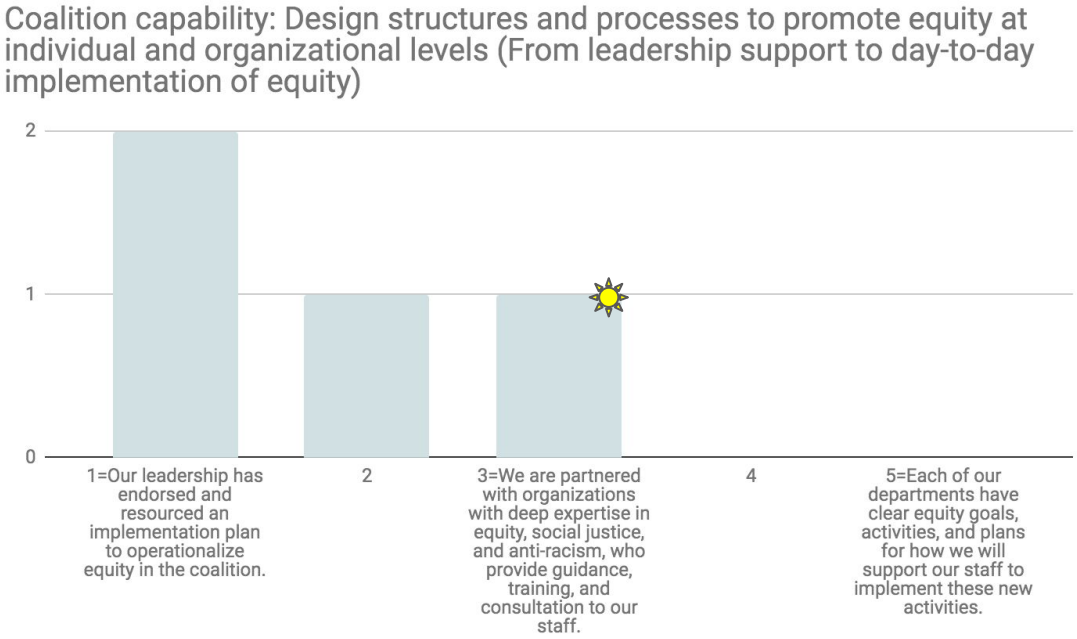
Coalition capability: Design and implement collective and ambitious equity policy agendas (From including community organizers to deliberate multi-level policy strategy)



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



CP coalitions have equity implementation plans and processes



Harm Reduction

Naloxone access is #1 harm reduction strategy; limited needle exchange

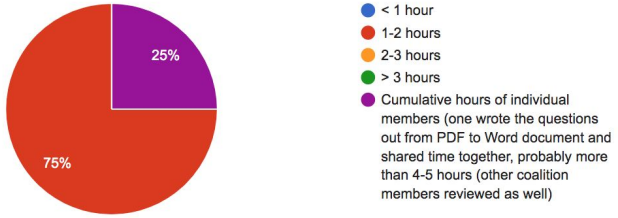
	Naloxone training, distribution	Needle exchange program/ Providing sharps/ Syringe disposal kiosk	Expanding access to MAT, provider education	OUD/SUD stigma reduction	Medication disposal
DN	x	x*	x		x
SB	x				
SC	x	x**		x	
SD	x	x	x		

*Limited
**Supporting Harm Reduction Coalition's application for Syringe Access Program

Most coalitions spent 1-2 hours and understood questions

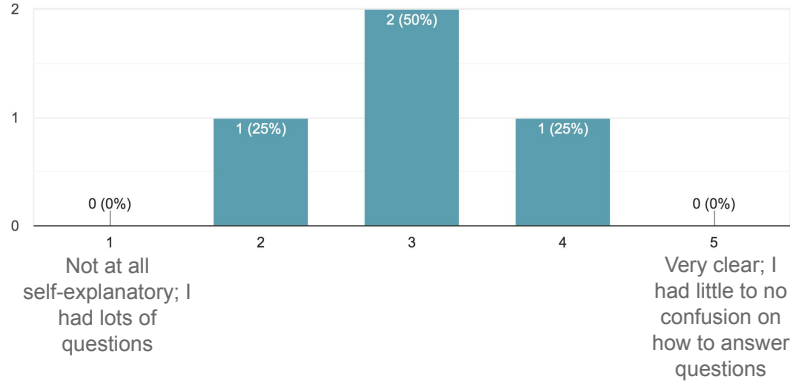
19. About how long did it take to complete this baseline assessment?

4 responses



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

4 responses



"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.