HealthyJoCo
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Johnson County Public Health

HEALTHYJOCO

COMMUNITY PARTNERS ASSESSMENT REPORT

RELEASED JULY 2022

Johnson County Public Health

855 S. Dubuque St.
STE 217
Iowa City, Iowa 52240

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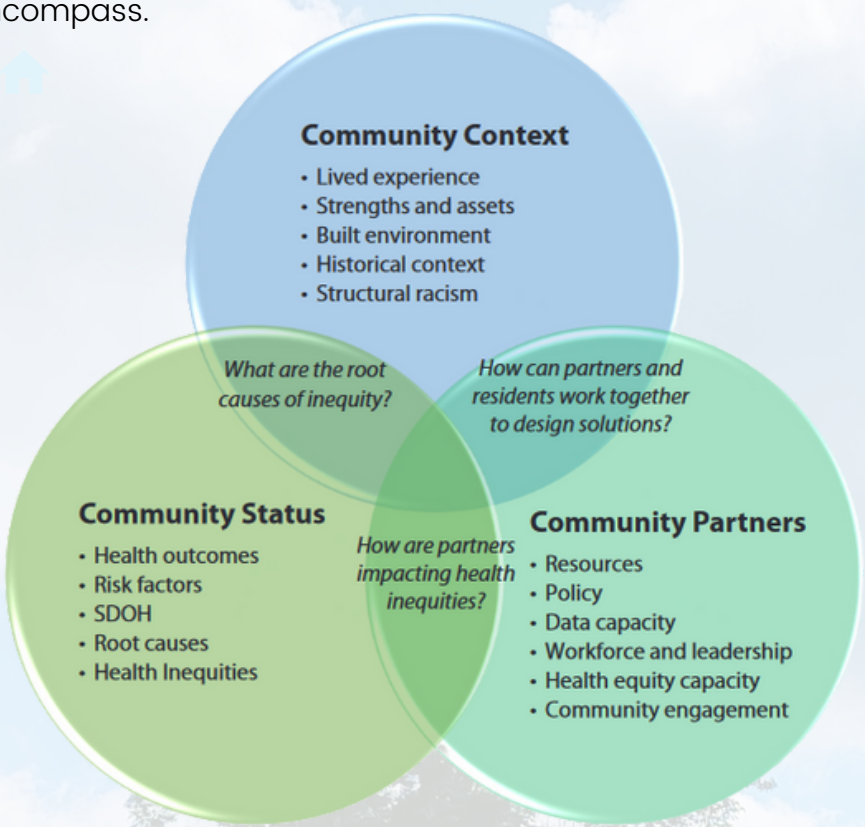
ABOUT HEALTHYJOCO

HealthyJoCo is a community health assessment (CHA) and community health improvement plan (CHIP) effort in Johnson County and is largely supported by Johnson County Public Health and members of the Core Committee.
HealthyJoCo follows the National Association for County and City Health Officials' (NACCHO's) Mobilizing for Action through Planning and Partnerships (MAPP) framework. MAPP is a community-driven strategic planning process for improving community health. The MAPP 2.0 process includes an assessment phase of telling the community story by conducting the three following assessments: Community Status Assessment (CSA), Community Partners Assessment (CPA), and Community Context Assessment (CCA). See the figure below for more information on what these assessments encompass.



VISION

HealthyJoCo strives for Johnson County to be a diverse community where all have the resources, access, and opportunity to thrive in a resilient, safe, and inclusive community. We also strive to be a community where institutions and community members actively work together to deconstruct silos and address health inequities through partnerships, collaboration, and power-sharing.

MISSION

To evaluate, promote, and improve the health and well-being of those who live, work, learn, and play in Johnson County.

VALUES

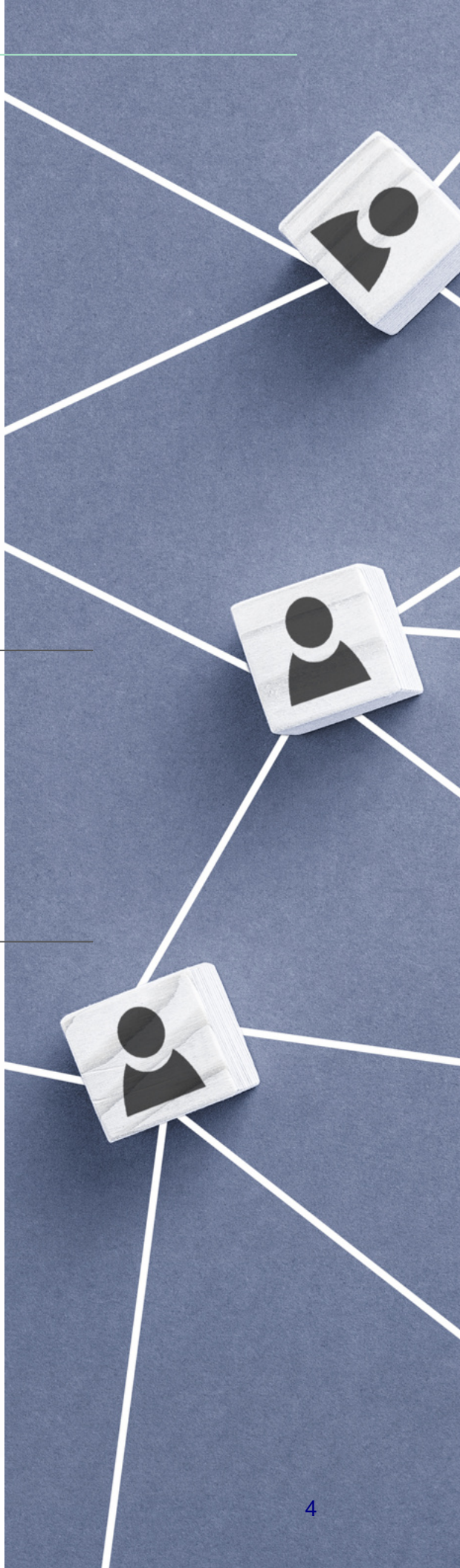
01 Inclusive

02 Collaborative

03 Transparent

04 Progressive

05 Genuine



COMMUNITY PARTNERS ASSESSMENT BACKGROUND

The Community Partners Assessment allows partners to "look critically within their own systems and processes, reflect on their role in the community's health and well-being, and understand the degree to which they are addressing or perpetuating health inequities across a spectrum of action ranging from the individual to systemic and structural levels" (Clayton, 2020). The domains embedded in this assessment are Health Equity Capacity, Community Engagement, Resources, Community Linkages, Leadership, as well as Data Access and Systems. The domains are described below.

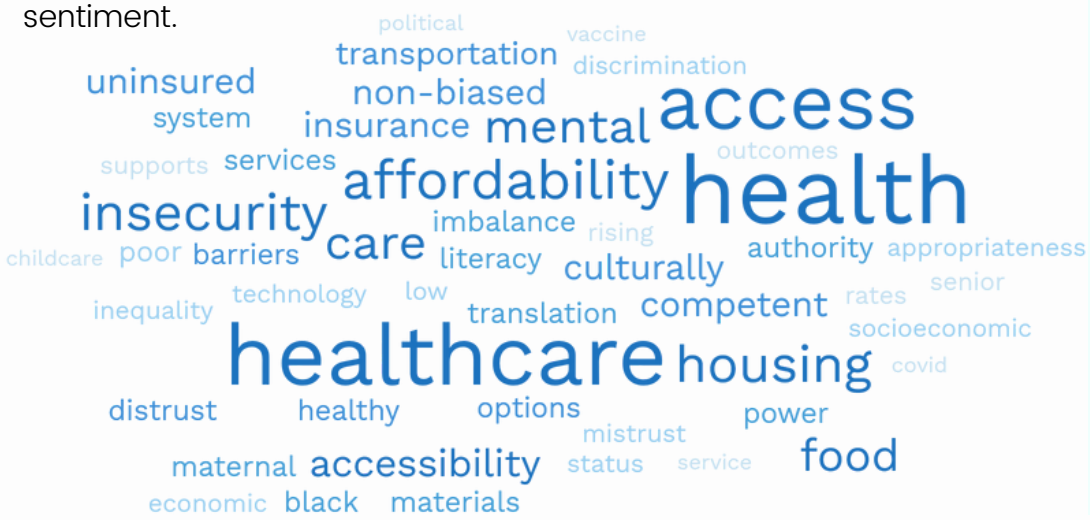
- **Health Equity Capacity:** Assesses each partner's understanding and commitment to health equity and related concepts, their role in addressing health inequities and their perception of the public health system addressing health inequities in Johnson County.
- **Community Engagement:** Assesses each partner's relationship with the community and how they engage the community to participate in shaping programs, services, or other activities designed to help them.
- **Resources**: Assesses partner resources to meet community needs.
- **Community Linkages:** Assesses capacity to coordinate and align with other partners and stakeholders within the community system to improve quality, efficiency, and effectiveness of programs, services, and interventions to address inequities.
- **Leadership:** Assesses each partner's leadership support around achieving equity as it relates to their mission and willingness to participate in the **Healthy**JoCo process.
- **Data Access and Systems:** Inventories available assessments and data across partners that may inform and contribute to the larger community health assessment; explores opportunities for data sharing and transparency across the community; and assesses data infrastructure.

Clayton, A., Verma, P., Weller Pegna, S. (2020). MAPP Evolution Blueprint: Executive Summary. National Association of County and City Health Officials, 21 - 22.

METHODOLOGY

As part of the Community Partners Assessment, the Partnership Assessment Tool for Health (PATH), was identified and amended. The original PATH tool was developed by Partnership for Healthy Outcomes, a collaboration of Center for Health Care Strategies (CHCS), Nonprofit Finance Fund, and Alliance for Strong Families and Communities. The PATH tool was amended by utilizing additional questions from the Bay Area Regional Health Inequities Initiative (BARHII) Local Health Department Self-Assessment Toolkit, specifically the Partners Assessment tool. Detailed survey tool changes can be found at the end of this report.

We reached out to 31 community-based organizations, non profits, health care agencies and already established community partners. In order to have a representative sample, participants were selected based on the work they do in the community and specific subpopulations served. From April 25, 2022 to May 20, 2022, we conducted 15 interviews using the tool described above and in the appendix below. Interviews lasted around 1 hour and were held by either our Public Health Systems Analysis, our Public Health Associate, our Community Health manager or a combination of the above. Interviewees were prompted with questions regarding their mission and who they serve, but did not see the rest of the questions until the interview took place. After each section of questions, the interviewee was asked a benchmark statement to rate 1-5 to assess the current status of our partnership and note areas for opportunities and growth. Notes were taken during each interview and then responses were qualitatively analyzed according to question by theme and sentiment.



ASSESSMENT TOOL NAVIGATION

The Community Partners Assessment tool is separated by the sections outlined below. Each section contains a benchmark statement where each participant is asked to give a rating on a scale from 1 (Needs development) to 5 (Well-Developed) on behalf of their organization or group.

Section A. General Demographics

In this section, organizations or groups select specific subpopulations in which they provide services, products, programs, and/or activities for.

Section B. Health Equity Capacity

This section is comprised of 6 questions asking participants perspectives on health issues in the Johnson County community, as well as attitudes and beliefs of their organizational goals.
Benchmark | My organization/group has a deep understanding of our role in addressing health inequities in Johnson County.

Section C. Internal and External Relationships

A core element of effective partnership is having strong relationships among partners and with other stakeholders, like the community. This subsection focuses on the progress of the partnership towards shared goals.

Subsection CA. Shared Goals

This subsection contains 3 questions asking participants what their current organizational goals are, as well as ways **Healthy**JoCo could work with their organization to address community issues and needs.
Benchmark | My partner and I want to share an understanding of the goals our partnership seeks to achieve.

Subsection CB. Community and External Engagement

This subsection contains 3 questions regarding involvement of the community to shape programs designed to help them, as well as engagement with other organizations providing a variety of services in the community.
Benchmark | Both organizations in the partnership engage the community and external organizations/groups in the community to advance our partnership's goals.

Subsection CC. Maximizing Partner Value

This subsection contains 3 questions regarding the value each partner contributes to the partnership, opportunities that exist for collaboration, and additional resources and skills needed to achieve partnership goals.
Benchmark | Both organizations in the partnership engage the community and external organizations/groups in the community to advance our partnership's goals.

Subsection CD. Internal Buy-in

This subsection contains 3 questions regarding support on addressing health inequities in the Johnson County community.
Benchmark | Leadership and key staff at each partner organization understand the importance of collaborating with other organizations to address health inequities in our community.

Section D. Data Collection

This section contains 4 questions regarding organizational data collection efforts, systems, and opportunities for data collaboration and sharing.
Benchmark | Our partnership will strive to collect accurate data that measures progress of shared goals.

Section F. Open Reflection

The participant reflects on anything that may have been left out of the conversation.

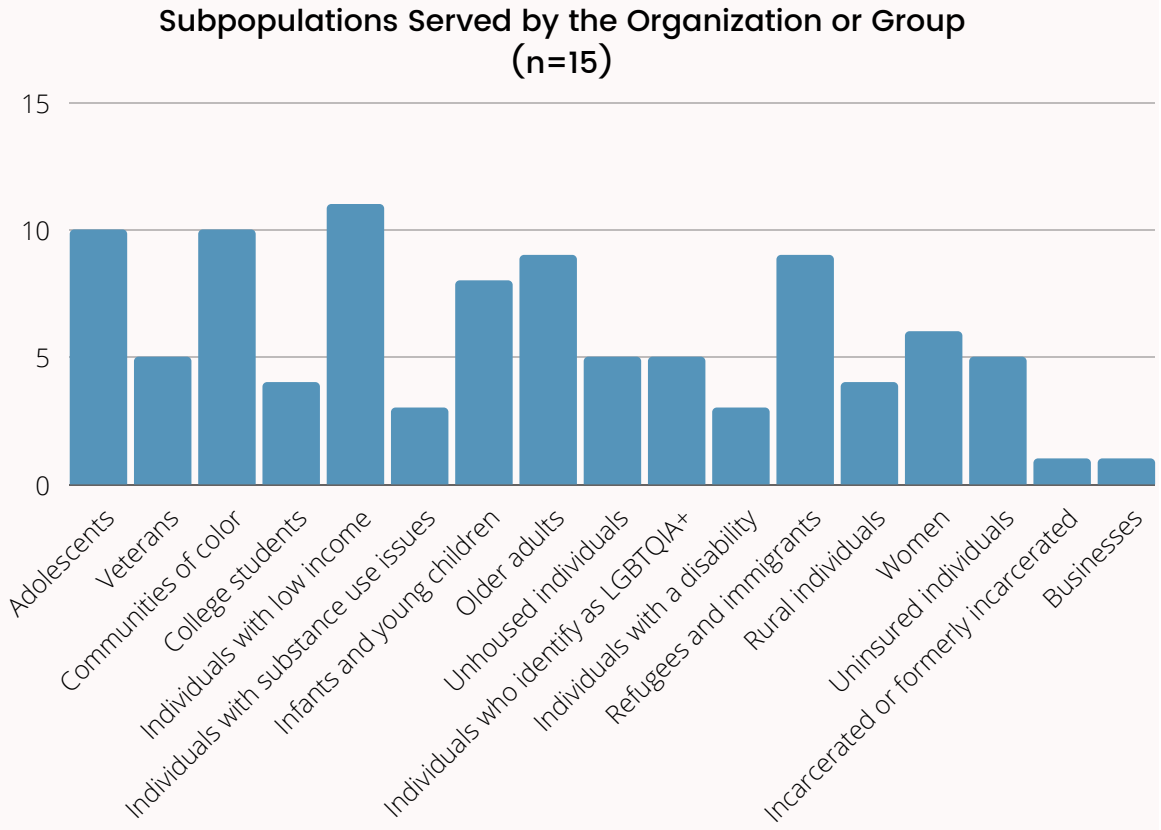
PARTICIPANT DETAILS

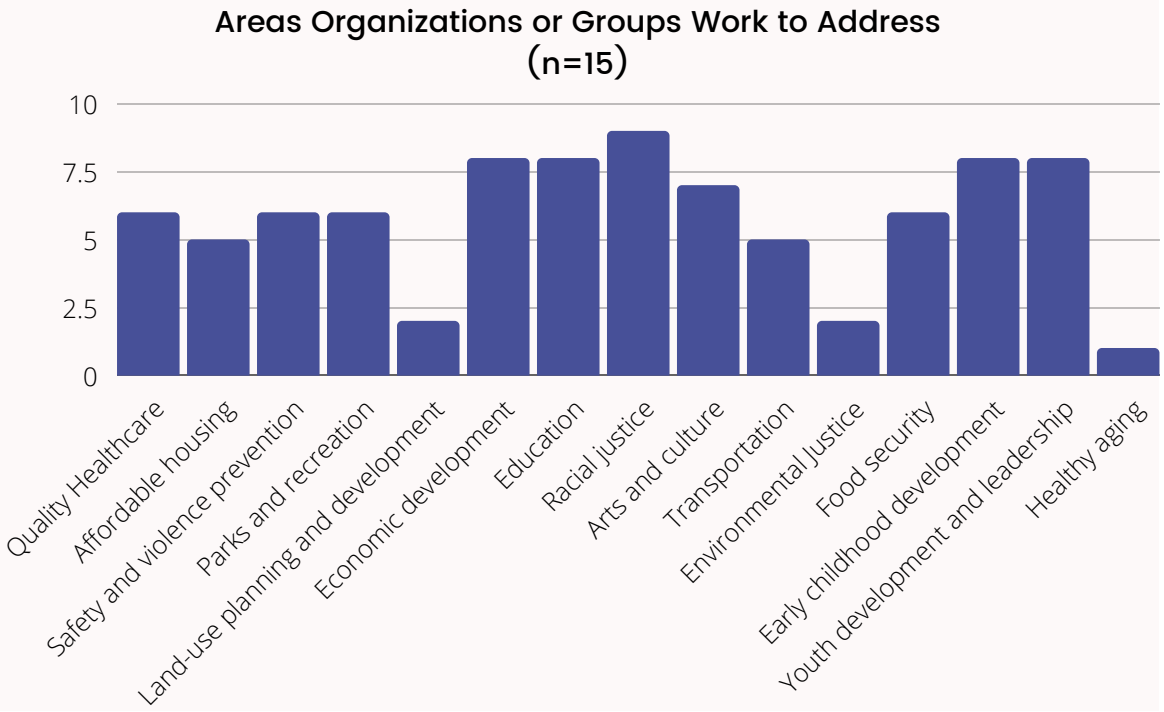
Organizations and Groups Contacted

A total of 31 organizations and/or groups in Johnson County were identified based on the work they do and the subpopulations they serve. Below is a list of the organizations/groups that were contacted and asked to participate in one-on-one discussions. Approximately 48% (15) of those contacted completed a discussion.

Organization/Group Name	Completed Discussion	Organization/Group Name	Completed Discussion
Swisher Library	X	Black Voices Project	
Resurrection Assembly of God	X	Heritage Area Agency on Aging	
Affordable Housing Coalition	X	Iowa City Human Rights Commission	
Project Better Together	X	Johnson County Ambulance	
Neighborhood Centers of Johnson County	X	Johnson County Interfaith Coalition	
Inside Out Reentry	X	Rural Health and Safety	
CommUnity	X	Shelter House	
Center for Worker Justice	X	Solon Library	
Coralville Public Library	X	Towncrest Pharmacy	
City of North Liberty	X	Guidelink Center	
Horizons	X	Iowa City School District Student and Family Advocates	
Proteus Inc	X	Path of Hope	
North Liberty Public Library	X	Four Oaks	
Iowa 4Cs	X	Bur Oak Land Trust	
Johnson County Sheriffs Office			
Coralville Parks and Recreation			

PARTICIPANT DETAILS
(CONTINUED)





HEALTH EQUITY CAPACITY

The Health Equity Capacity section assesses each partner's understanding and commitment to health equity and related concepts, as well as their role in addressing health inequities in the Johnson County community.

B1. In this community, what are the top 5 unevenly and unfairly distributed health issues? (n=15)

Figure 1 below shows the the overall categories discussed by participants for this question.

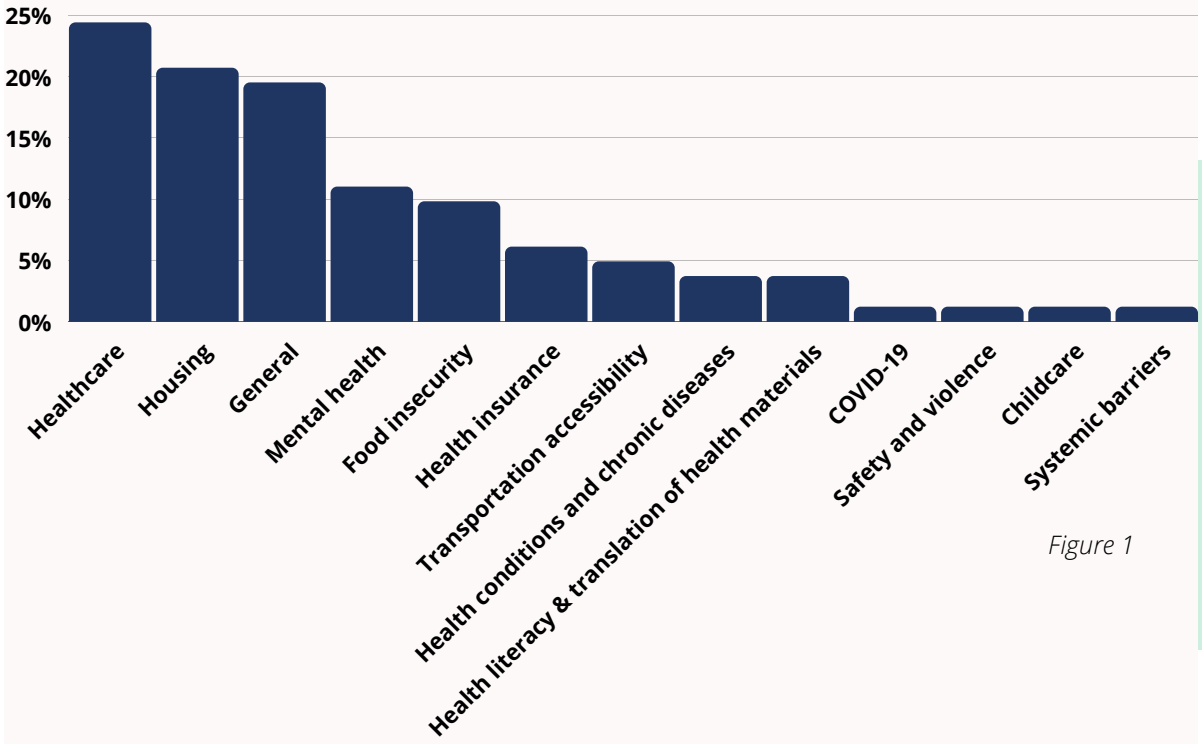


Figure 1

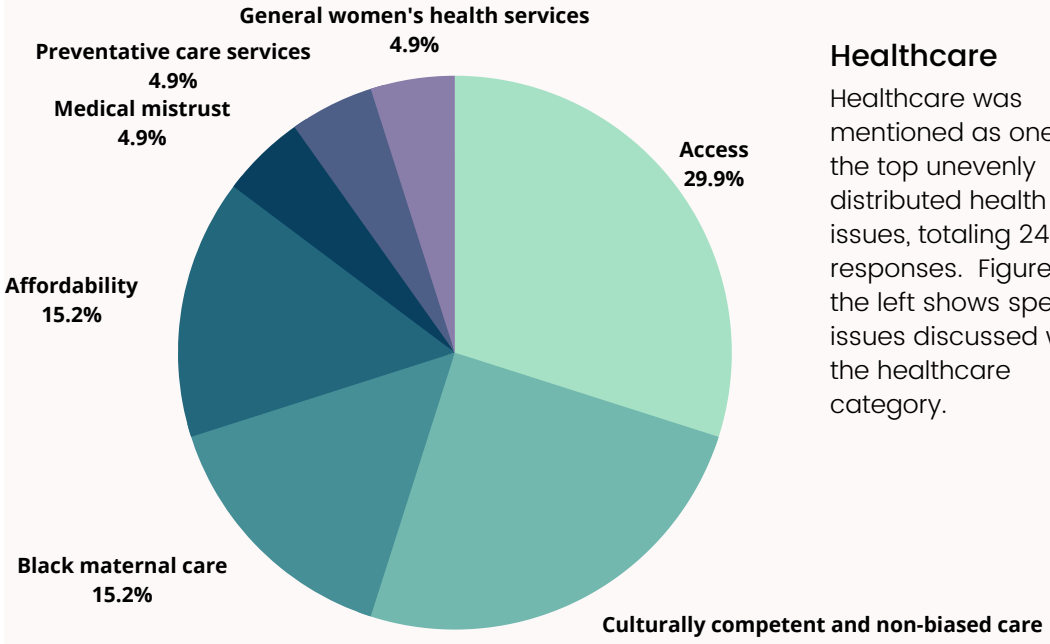


Figure 2

Healthcare

Healthcare was mentioned as one of the top unevenly distributed health issues, totaling 24.4% of responses. Figure 2 on the left shows specific issues discussed within the healthcare category.

HEALTH EQUITY CAPACITY (CONTINUED)

Housing

Housing was mentioned as one of the top unevenly distributed health issues, totaling 20.7% of responses. Figure 3 on the right shows specific issues discussed within the housing category.

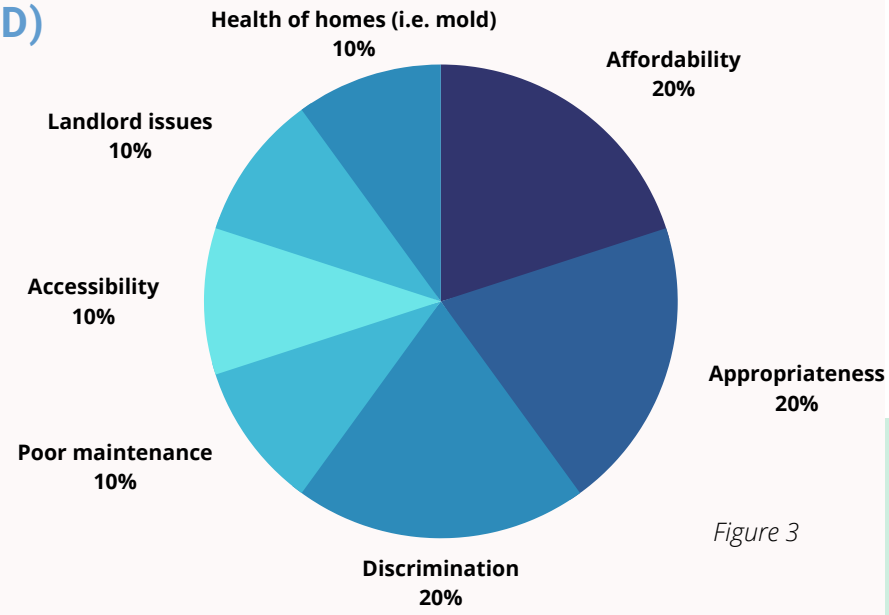


Figure 3

Affordability

Housing is considered "affordable" if a household spends no more than 30% of their income to live there.

Appropriateness

Appropriate housing means housing that meets the different needs of different households (i.e. enough space for all who reside there, etc.)

Discrimination

Under Iowa and federal law, a landlord may not discriminate against a person on the basis of race, color, creed, sex, religion, national origin, disability or family status. However, some participants noted discriminatory practices still happening today.

Poor maintenance

Participants noted poor maintenance of housing leading to poor health outcomes. In example, a non-working shower leads to poor personal hygiene, which puts individuals at a higher risk of hygiene-related diseases and infections.
Source: Centers for Disease Control and Prevention

Accessibility

Accessible housing refers to housing that enables independent living for persons with disabilities, as well as aging individuals.

Landlord Issues

Landlord issues were referenced under terms of fear of retaliation specifically from immigrant and refugee families, serving as barriers for overall self-advocacy in housing issues.

General and Miscellaneous Topics

Figure 4 to the right shows various general topics that do not fit under a specific category.

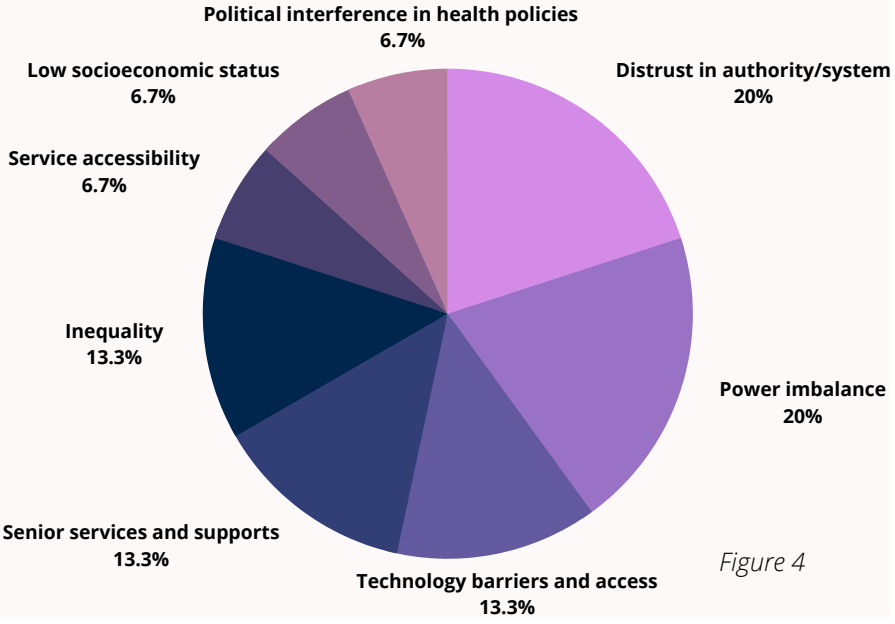


Figure 4

HEALTH EQUITY CAPACITY
(CONTINUED)

Mental Health

Mental Health was mentioned as one of the top unevenly distributed health issues, totaling 11% of responses.
Figure 5 below shows the split between the two specific issues discussed within the mental health category.

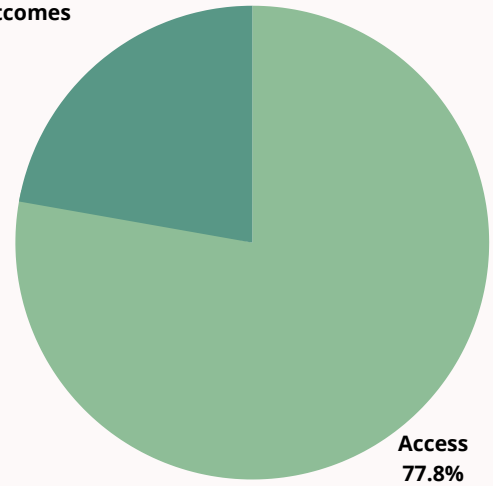


Figure 5

Access

Mental health access was referred to in terms of provider availability. Affordability was also mentioned within access. One participant noted the lack of diverse and culturally adept mental health providers in Johnson County.

Rising rates of poor outcomes

Many participants noted the general feeling of worsening mental health status in the general population in the last few years. Some pointed to a stigma around mental health care. Others noted the compounding of mental health burdens among populations with intersecting identities.

Food Insecurity

Figure 6 below shows the split between the two mentioned issues within food insecurity.

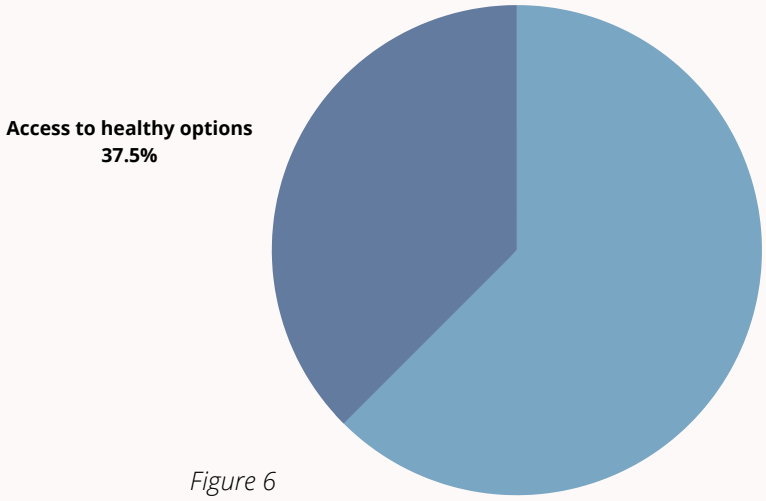


Figure 6

Affordability

Participants discussed the lack of affordable, healthy foods. Often times, when faced with many expenses and a low income, a household may have to choose between paying the rent and buying healthy foods, or any food in general.

Access to healthy options

Many noted the lack of healthy food options like fresh produce in proximity to certain neighborhoods, leaving residents needing transportation. Some residents may not have reliable means of transportation in these cases.

HEALTH EQUITY CAPACITY
(CONTINUED)

B2. What would you describe as the leading environmental, social, and economic conditions that impact the health issues you identified previously? (n=15)

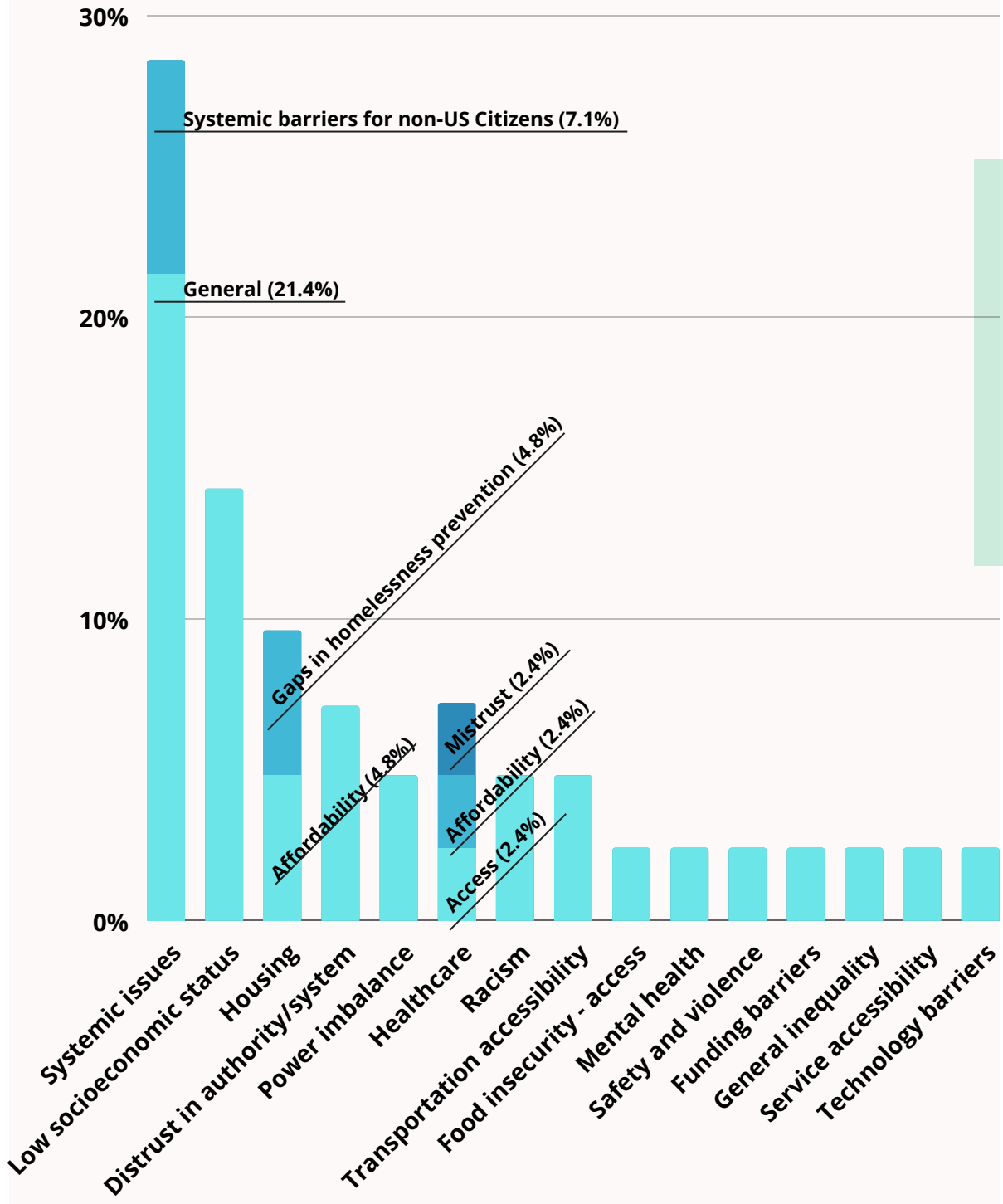


Figure 7

HEALTH EQUITY CAPACITY
(CONTINUED)

B3. My organization's work addresses the environmental, social, and economic conditions that impact health in some way. (n=15)

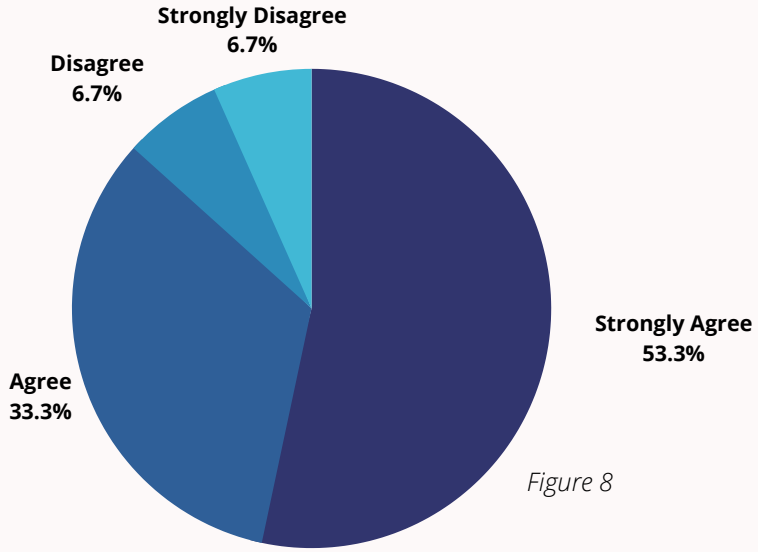


Figure 8

Approximately 86.6% (13) of participants agree in some way their organizations work addresses the environmental, social, and economic conditions that impact health in some way.

B4. I think there is a general awareness of the environmental, social, and economic conditions that impact health among organizations like mine in Johnson County. (n=15)

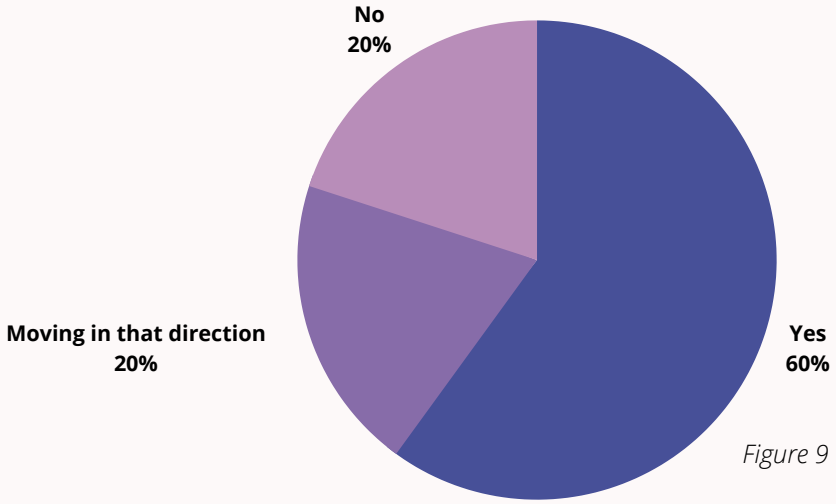


Figure 9

Approximately 80% (12) of participants think there is a general awareness, in some capacity, of the environmental, social, and economic conditions that impact health among organizations like theirs in Johnson County.

HEALTH EQUITY CAPACITY
(CONTINUED)

B5. Addressing the environmental, social, and economic conditions that impact health in the Johnson County community is a high priority among organizations like mine. (n=15)

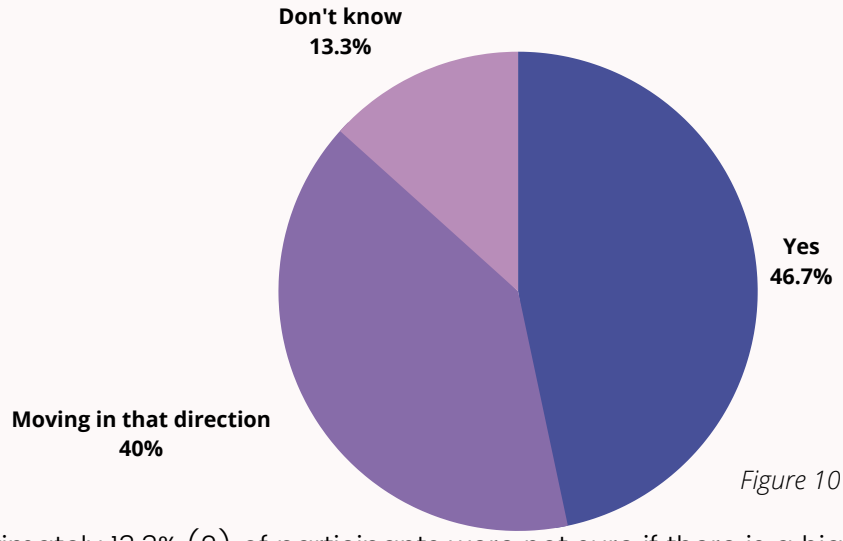


Figure 10

Approximately 13.3% (2) of participants were not sure if there is a high priority to address the environmental, social, and economic conditions that impact health amongst other organizations like theirs in Johnson County. Many felt that they needed more information about what others were doing in order to answer this question.

B6. Where are the areas where innovation is most needed when it comes to addressing health inequities in our community?

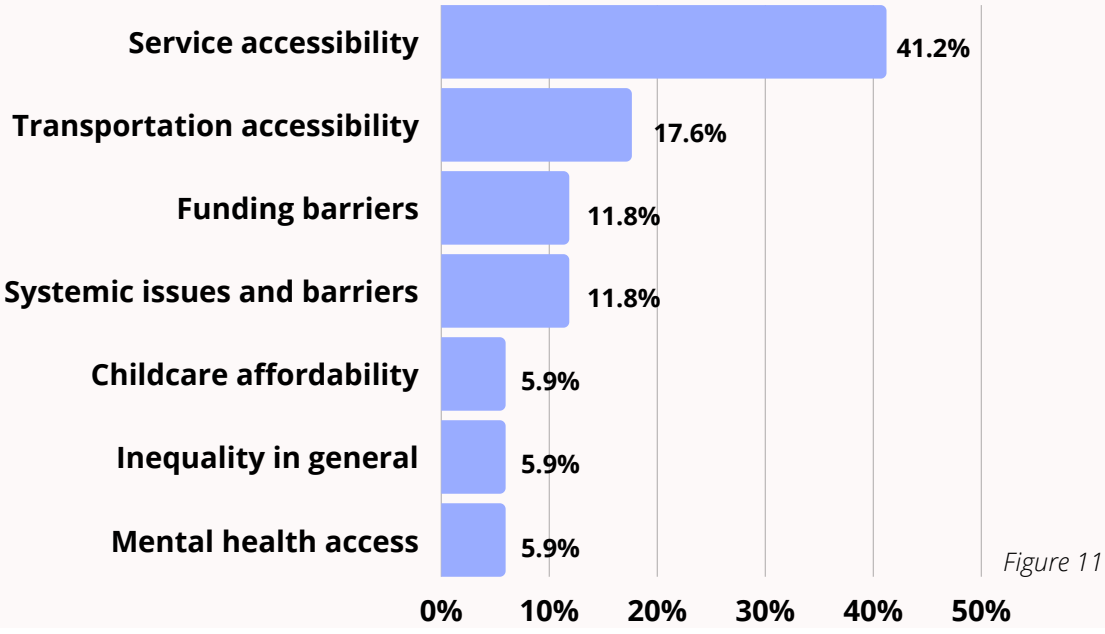


Figure 11

HEALTH EQUITY CAPACITY
(CONTINUED)

Uncategorized participant responses

- Access to healthcare, particularly for seniors is an issue in Northern Johnson County. Some residents receive care in Linn County, but face barriers with transportation to medical appointments there due to lack of options. Johnson County SEATS will not take folks to appointments across county lines.
- Private security presence of guards in low income housing areas lead to increased stress of residents and fear of physical violence on residents.
- Poor maintenance of housing by certain landlords is a huge health issue. (For example, one participant described experience of a resident with a hole in their roof. Other examples include apartments with rotting wood and door frames, mold, and ongoing infestation of bed bugs.)
- Lack of access to affordable and quality childcare is an issue. Often, young children are left in dangerous situations with abusive people, or are left alone, or are taken care of by siblings that are too young to provide supervision.
- There is a deep-rooted mistrust with the University of Iowa and the University of Iowa Hospitals and Clinics amongst certain populations in Johnson County due to the perception that the University is affiliated with luxury student housing that drives up the cost of rent for others not affiliated with the University.
- There is general mistrust amongst the immigrant and refugee population of anyone in authority (government, landlords, etc.) for fear of retaliation and deportation.
- With homelessness, often times there is a gap for folks who are almost going to be homeless. Services often do not help them until they are homeless.
- It is difficult for families experiencing homelessness to stay together, as it is difficult for children to reside at Shelter House with parents and guardians.
- Housing affordability is a large issue in Johnson County. If making minimum wage, one would have to work 3 full time jobs to afford average housing prices.
- If housing is not affordable, people cannot maintain stability in their lives as they would likely have to move out. Many end up moving out of Johnson County due to this reason.
- Evictions disproportionately affect single Black women-represented households at a ratio of 20 to 1.

HEALTH EQUITY CAPACITY
(CONTINUED)

Uncategorized participant responses

- Housing accessibility is especially difficult for those with low credit scores or no credit, individuals who do not speak English as their first language, and those returning from incarceration.
- Housing either needs to cost less or people need to be able, or have the opportunity, to make more money.
- Services need to shift and meet people where they are.
- If people do not have health insurance, they are not going in for check ups until absolutely necessary (i.e. emergency situations where it may be too late to intervene).
- Immigrant and refugee individuals, or individuals where English is not their first language, have a hard time navigating the system and finding necessary services.
- Access to reliable transportation is an issue, especially when it comes to healthcare appointments. If people miss a healthcare appointment, it could set them back and have a negative impact on their health.
- A lot of community programs focus on children, however, we have a large aging population and need more services for them.
- Maternal mortality is an issue, especially among women of color.
- Many people don't have access to technology, which serves as a huge barrier to finding services. More in person services would help.
- We need to focus on Black maternal health equity. Many Black mothers are often disproportionately affected and die.
- Aging populations that already were disproportionately affected by other issues now have are experiencing increasing health conditions that comes with aging.
- Implicit bias in healthcare is an issue that perpetuates racism. There is no mandatory training for healthcare workers and this can disproportionately affect the health of patients.
- Diabetes, hypertension, hyperlipidemia, hyperthyroidism and musculoskeletal issues are typical problems amongst agricultural workers.
- Amongst agricultural workers, nutritional education is needed as portioning is unknown. There is a lot of unlearning what they've always eaten.
- There is a high cost of living in the Iowa City area compared to other areas in the state where migrant agricultural workers live. Here in Iowa City, people at the Proteus clinic typically ask about any additional governmental or non-profit assistance they would qualify for. Living expenses are constantly more than what these folks are typically bringing in.

SHARED GOALS

1. What goals do you currently have for your work at your organization?

Approximately 70% of responses to this question entailed providing education and resources to clients and the community. Figure 13 below shows the breakdown of specific education and resources.

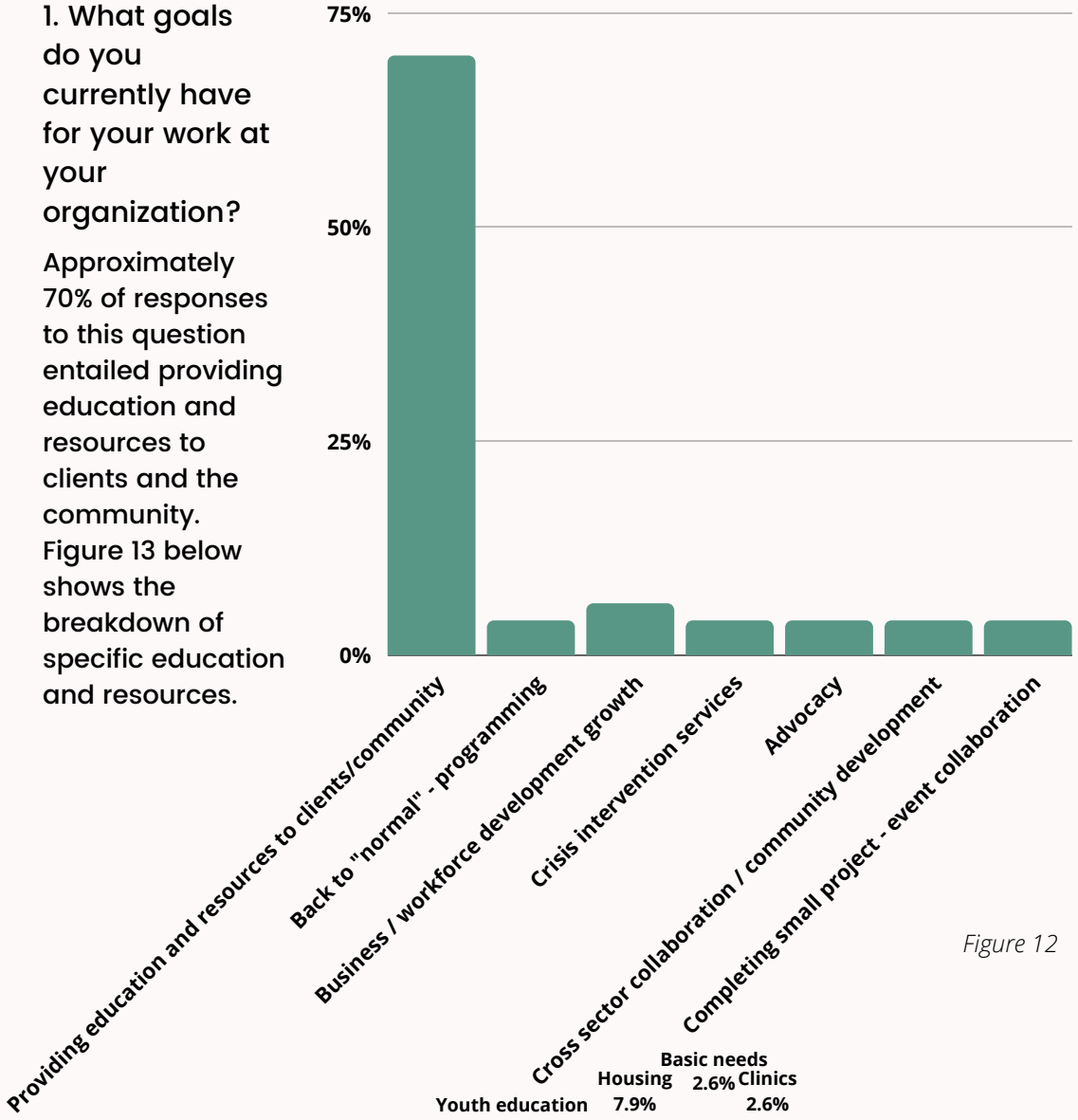


Figure 12

Education and Resources (Expanded)

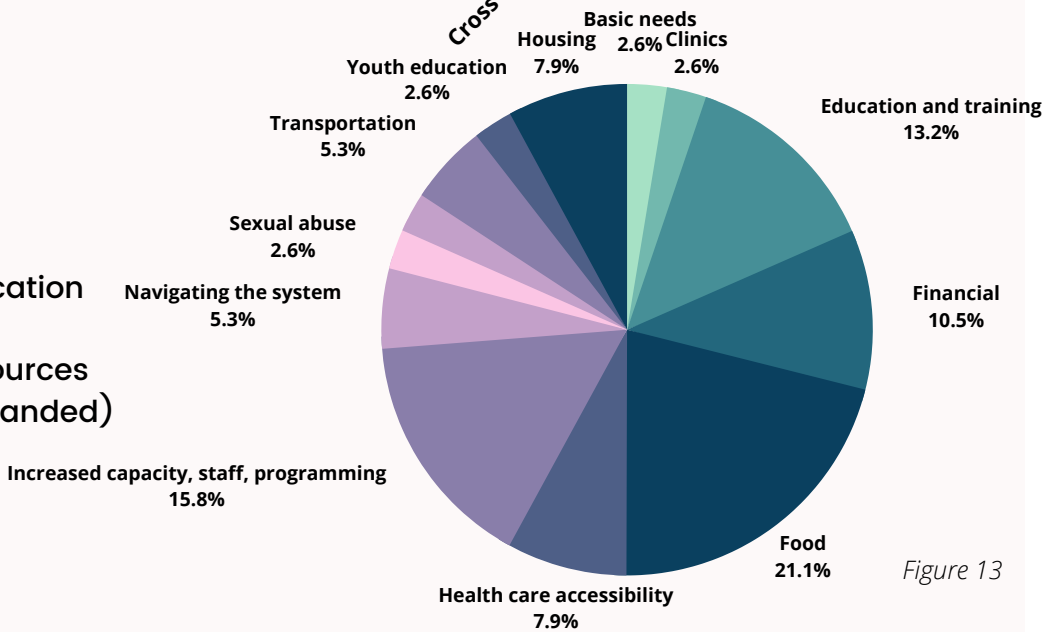


Figure 13

SHARED GOALS
(CONTINUED)

2. What would a partnership mean to you? What need and specific population could our partnership be designed to address?

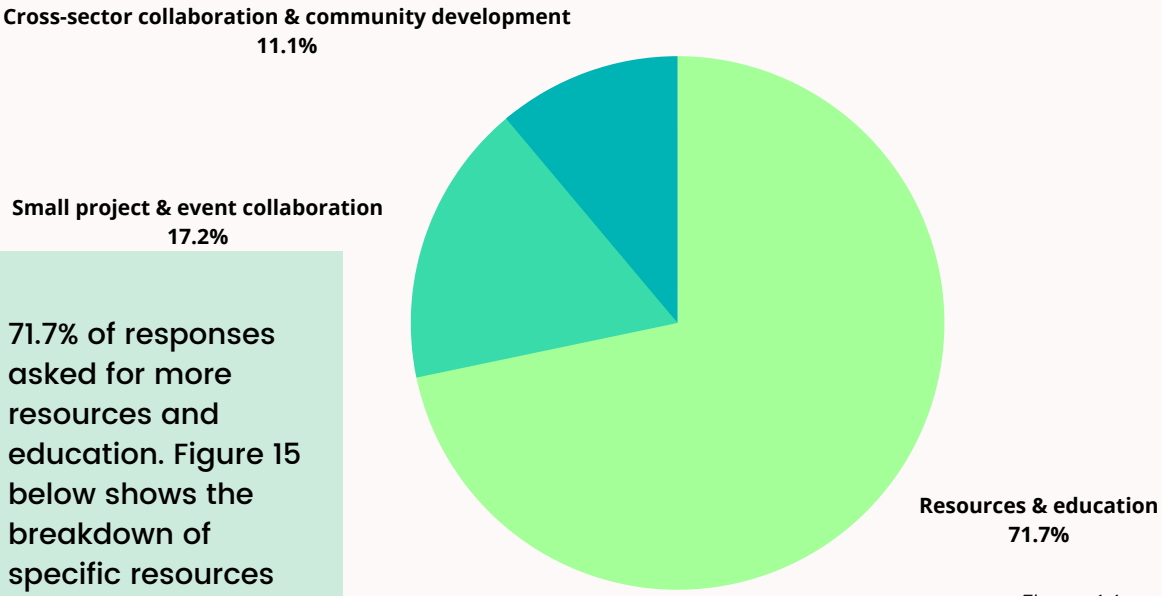


Figure 14

71.7% of responses asked for more resources and education. Figure 15 below shows the breakdown of specific resources and education asked for.

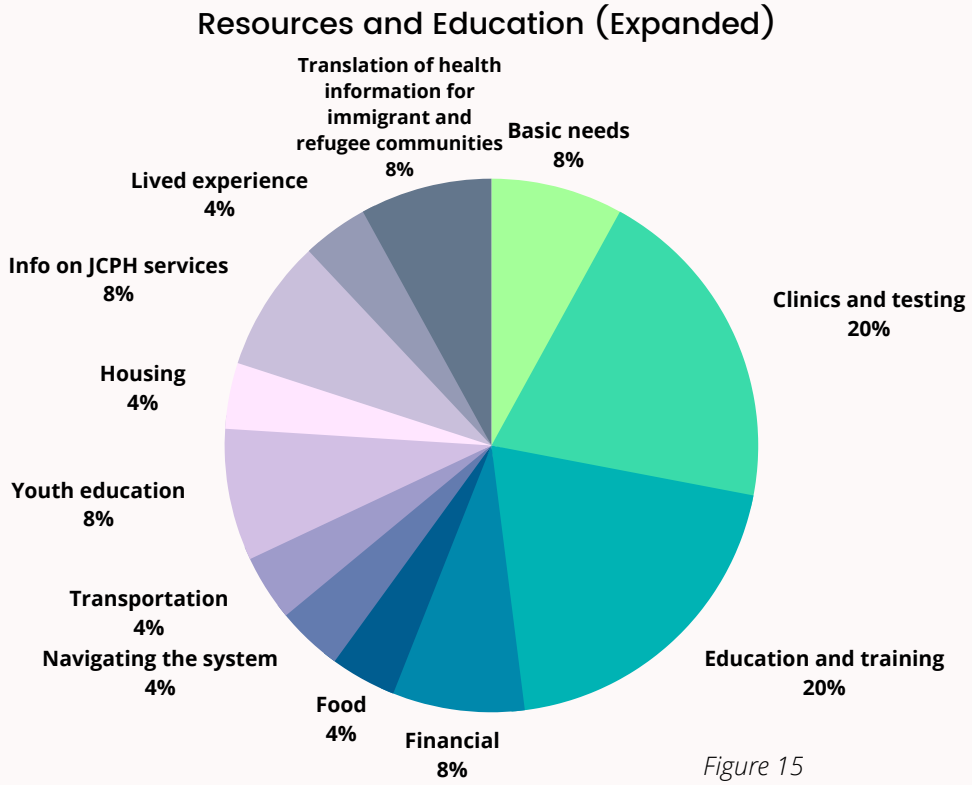


Figure 15

COMMUNITY AND EXTERNAL ENGAGEMENT

What are some ways your organization involves the community in shaping programs, services, or other activities designed to help them?

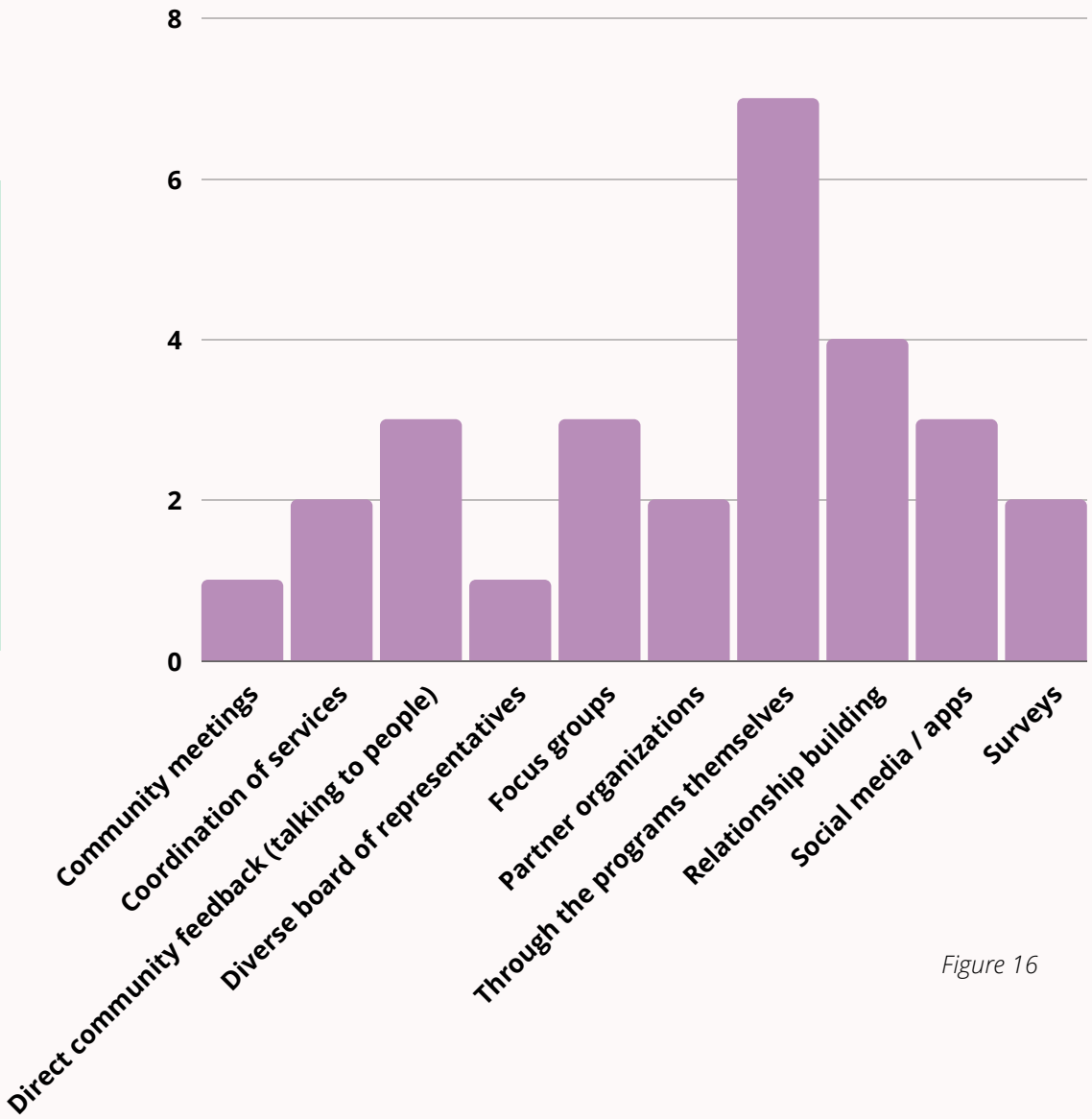


Figure 16

Partners detailed a variety of ways they engage the community with the most common answer being through the programs themselves, meaning direct feedback from the participants of the programs.

MAXIMIZING PARTNER VALUE

1. What value - including skills and expertise - do you see each partner contributing to the partnership?

An overwhelming majority of responses indicated our partners being experts in relationship building and connecting to people, while JCPH has knowledge of community data and access to data analysis tools, as well as connections to expertise and resources with other partners.

"No one organization can do it all. It is important to understand the bigger picture and where we all fit" - Participant

2. What opportunities exist to deepen our partnership? What resources do we need to achieve our goals?

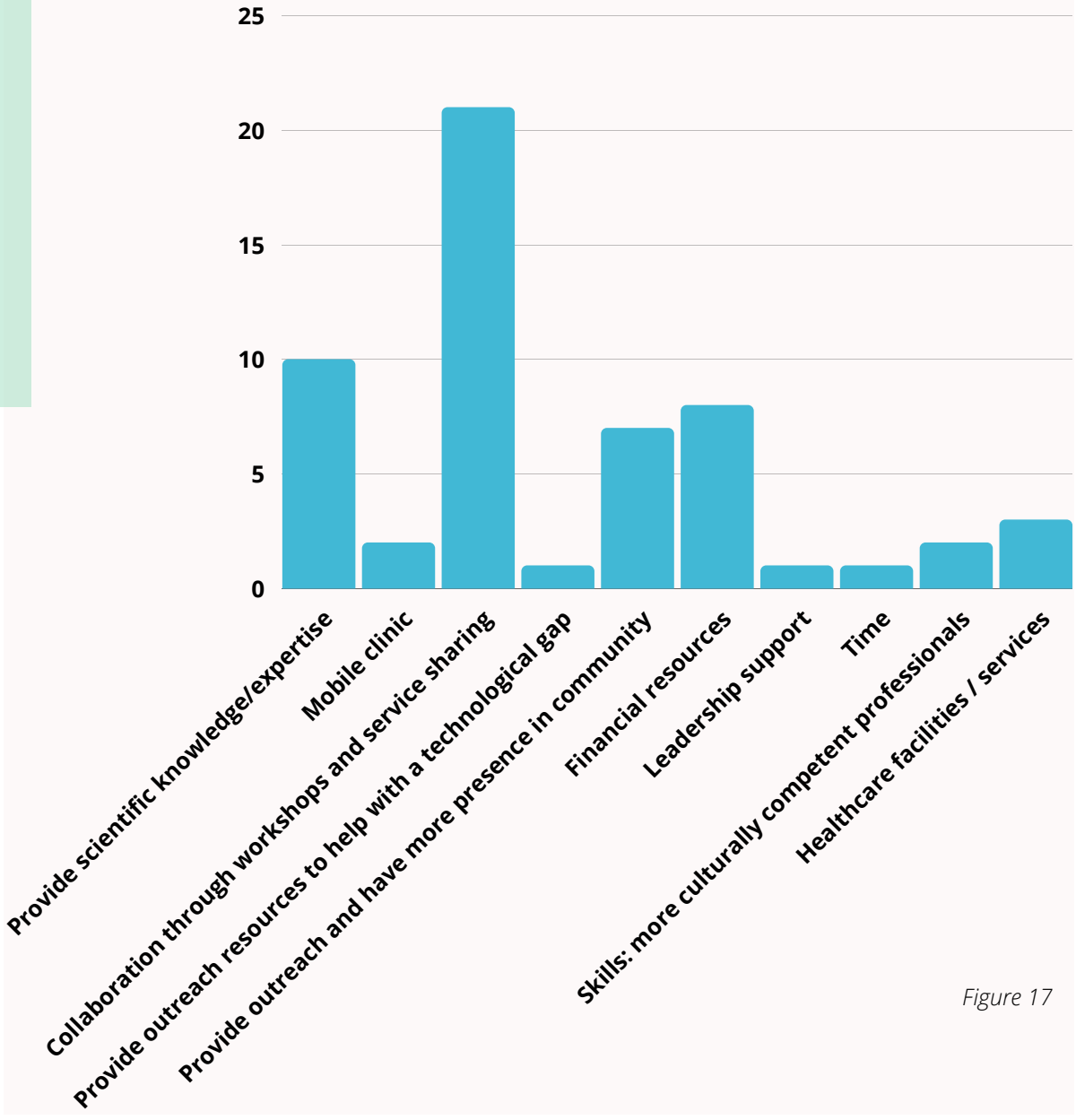


Figure 17

INTERNAL BUY IN

1. Leadership at my organization are supportive of collaborations between programs and sectors to address health inequities. (n=15)

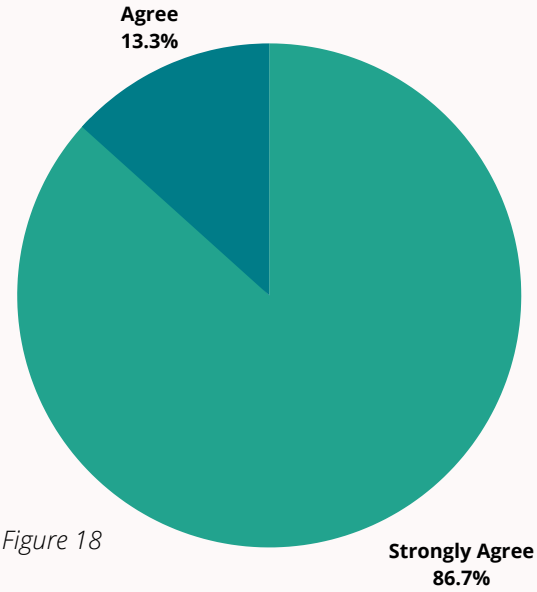


Figure 18

All 15 participants agree in some way that leadership at their organizations are supportive of collaborations between programs and sectors to address health inequities.

2. Would leaders at your organization support a partnership to address health inequities and issues in our community? (n=15)

14 participants said there would be support in a partnership to address health inequities and issues in the community. Only one participant said there may be some uncertain support and additional questions leadership would ask. A majority of the participants were part of their organizations leadership in some capacity.

DATA COLLECTION

1. What data does your organization collect to understand your social or community impact? Is this data sufficient? (i.e. population health outcomes and indicators collected)

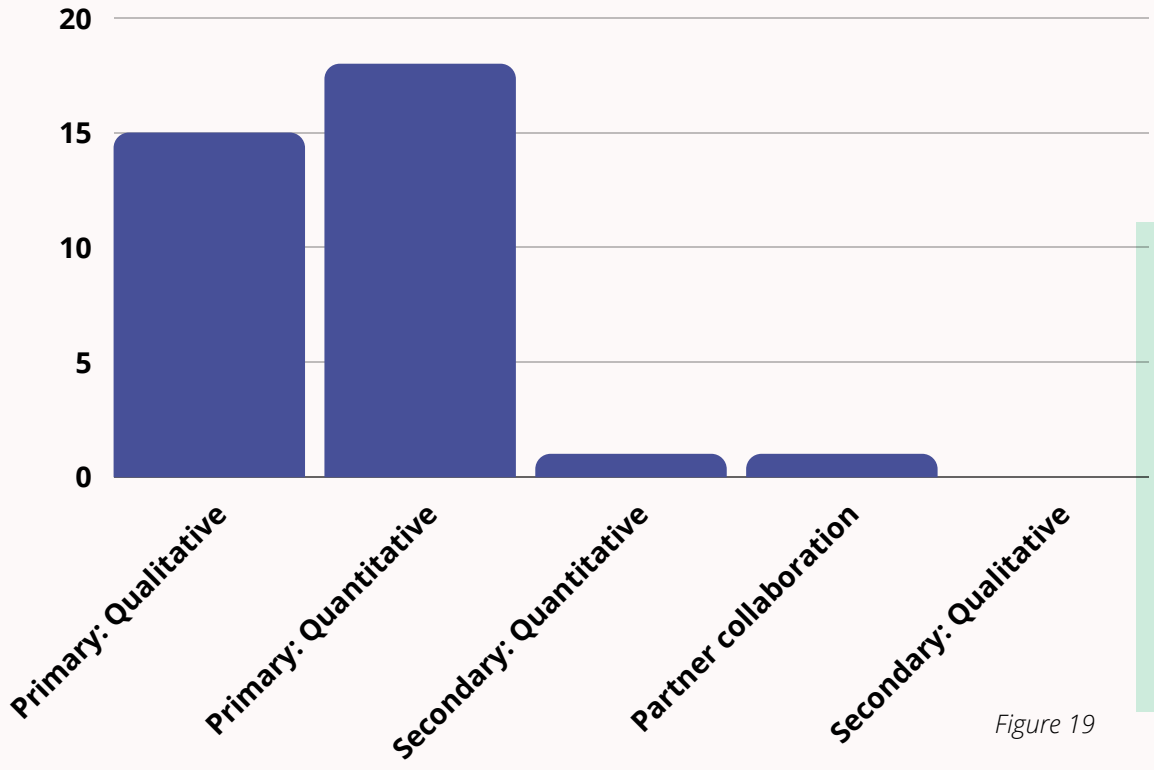


Figure 19

Types of primary qualitative data collected

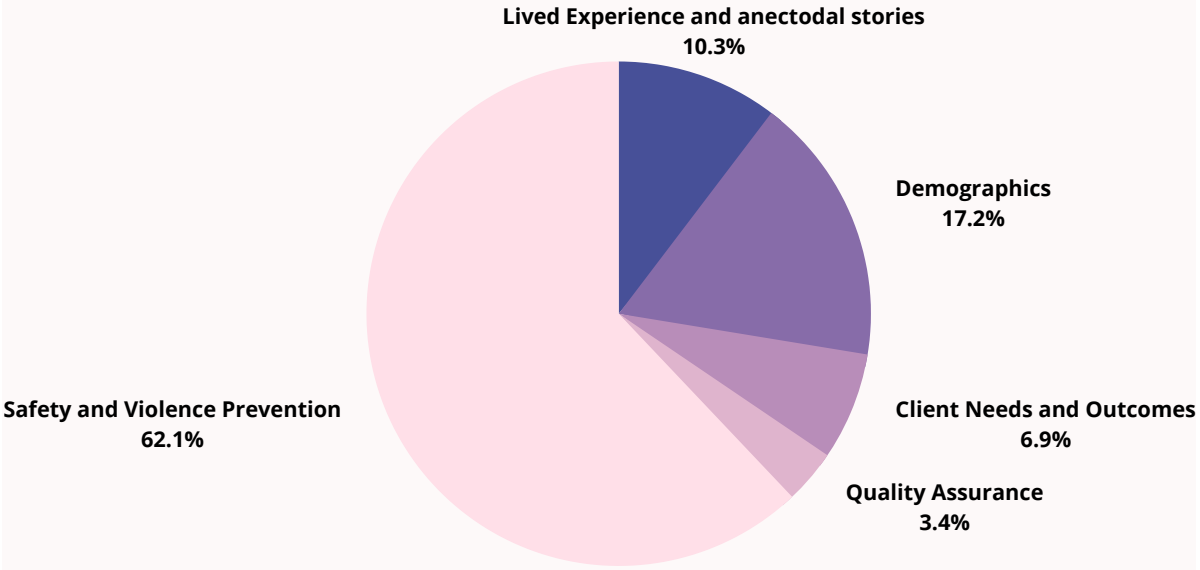


Figure 20

DATA COLLECTION
(CONTINUED)

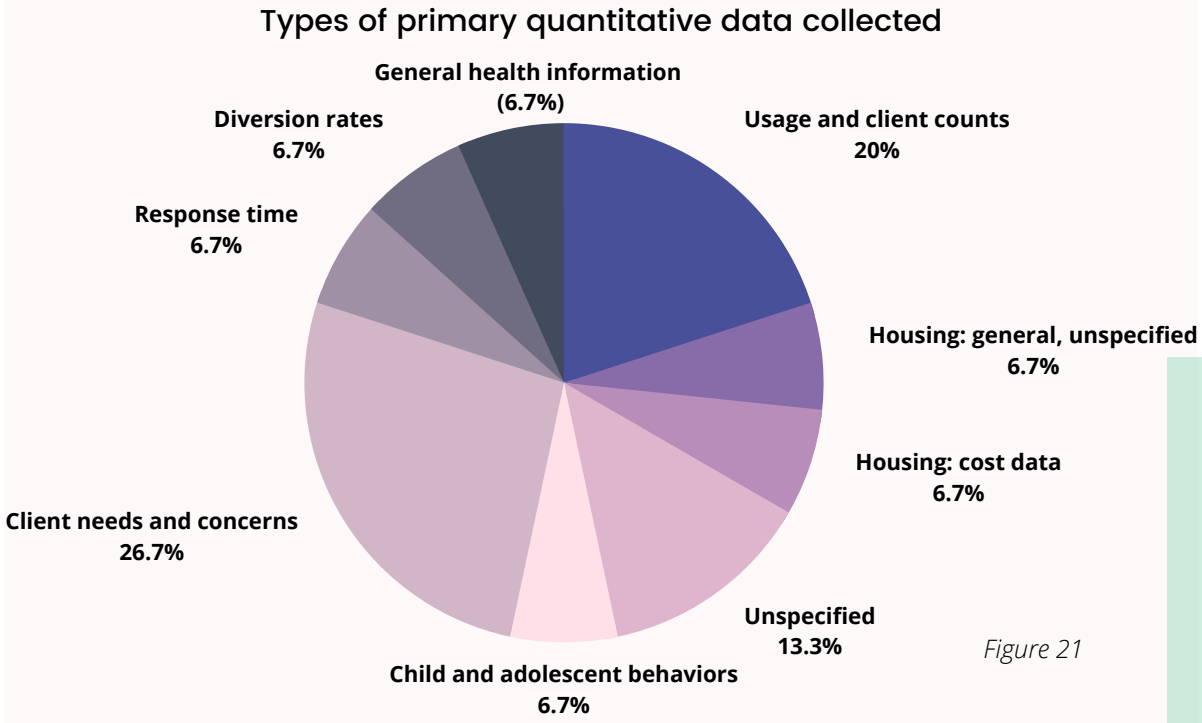


Figure 21

2.What systems and people do you have in place to support data collection and sharing? (i.e. staffing support, funding, timing of data collection, grant requirements)

Several organizations have primary qualitative and quantitative data collection systems in place. Data collection barriers include survey fatigue leading to incomplete or inaccurate responses. One organization felt collaborating with partners would give them more comprehensive data, while one organization lacks the infrastructure to collect data and needs overall assistance with these processes. One organization expressed the desire for resources to modernize their current data collection systems.

Many participants noted only collecting data required of them for grants. Many felt it was burdensome to collect client data, as many clients did not want their data to be collected for various reasons. One participant noted only wanting to collect lived-experience, anecdotal stories with non-identifiable information.

DATA COLLECTION
(CONTINUED)

3. How could our partnership with data deepen our understanding of and impact on the community?

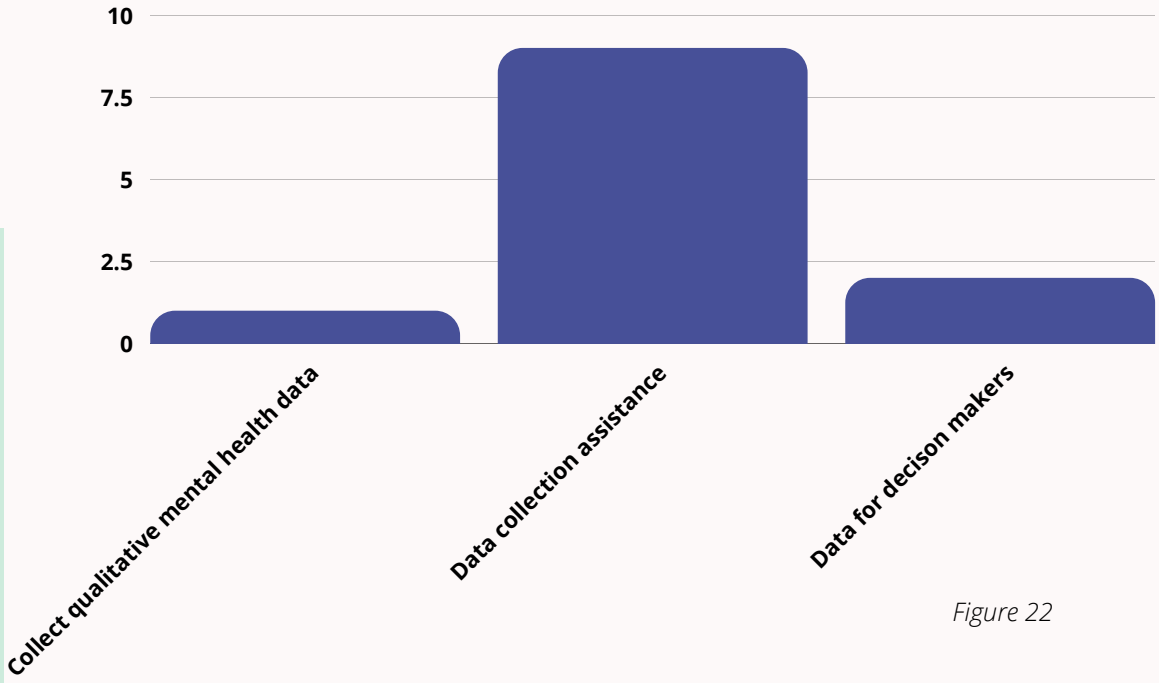


Figure 22

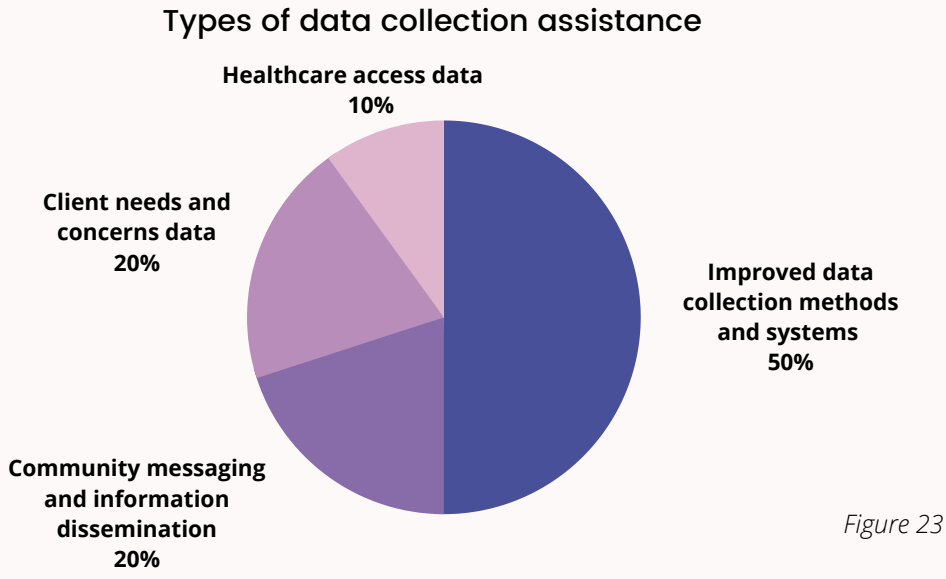
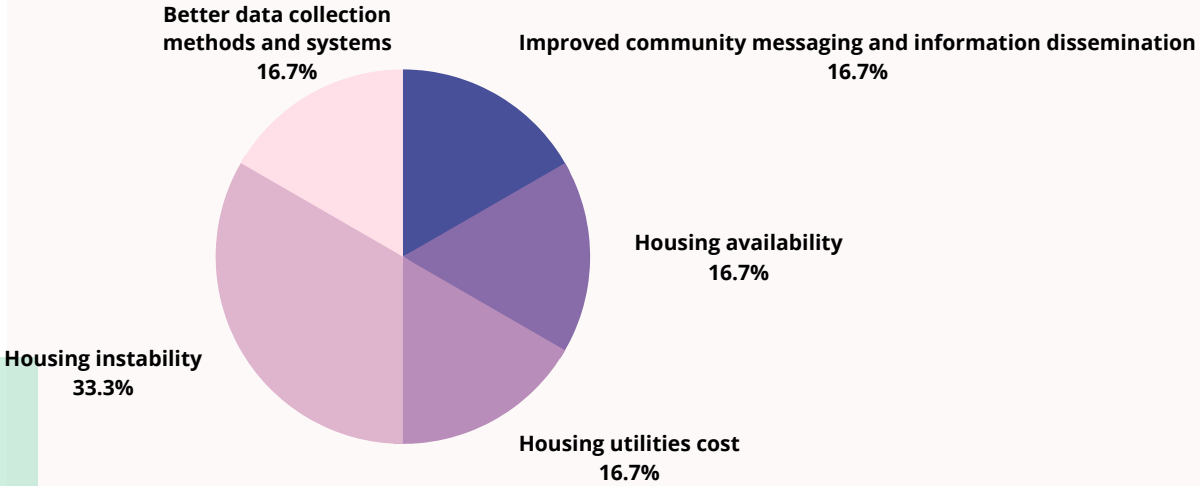


Figure 23

DATA COLLECTION
(CONTINUED)

What could we learn from the data our partnership collects?



Assistance through our partnership would lead to better data collection methods and systems aimed at identifying community needs and gaps. For example, a map of current areas with low access to healthy foods and a map noting areas with low access to transportation. Partners expressed an emphasis on needing resources in order to meet people where they are physically.

Specific data questions from participants

- Do we have enough available, quality, affordable housing for people? How many places are available for $400 per month, $500 per month, etc.?
- How much do utilities cost, on average, for each rental place?
- What is the typical length of stay in housing; and if people leave, what was the reason for leaving?
- For the direct cash payments going on right now, can we look into data collection on any preventive support that could have taken place (for example, for those not able to pay rent before it was late)?
- What do our community members still feel is lacking and what are their perceptions?
- How many people feel like they are not food secure?
- How many people are suicidal in the community right now and how can we connect with them before they hit that point?
- How do people feel about law enforcement in the community?
- What do community members not have access to but need access to? What are the barriers to getting access? How frequent do they see these barriers?

OPEN REFLECTION

Below are comments participants made at the end of each one-on-one discussion.

- Develop and provide more aging resources
- Deeper community understanding of drug/substance abuse and impact on children
- Trust building
- How housing connects to all aspects of health
- Provide more resources for previously incarcerated folks and make it less difficult to navigate the system after incarceration
- How to navigate the American System
- County needs to hire more diverse staff
- Better understanding of racial differences in mortality data
- Reduce stigma around those receiving government assistance
- The County should do something about educating people to learn English. County should support ESL classes as well as job scenario classes. The are very helpful, especially when tailored to the job they are working at.
- Curious to know if there's a way to score community wellness via community profiles.
- Would be helpful to have a map of the areas where food deserts are and where lack of transportation is. Would be helpful to identify where to provide services and tackle K – 6 food insecurity.

APPENDIX

The below areas that are highlighted in yellow were adapted from from the Local Health Department Self-Assessment tool from BARHII.

1. Organization/agency name: ___
2. Do you provide services, products, programs, or activities specifically designed for or targeted to any of the following subpopulations? (Select all that apply.)
   a. Adolescents/school-aged children
   b. Veterans or military personnel
   c. Communities of color
   d. College students
   e. Individuals with low income
   f. Individuals with substance use issues
   g. Infants or young children
   h. Older adults/aging seniors
   i. Individuals experiencing homelessness
   j. Individuals who identify as LGBTQIA+
   k. Individuals with a disability
   l. Refugees and immigrants
   m. Rural communities
   n. Uninsured
   o. Women
   p. Other _____
3. Please indicate the areas in which your organization works to address:

   a. Quality healthcare
   b. Availability of quality affordable housing
   c. Community safety and violence prevention
   d. Recreation opportunities, parks, and open space
   e. Land-use planning
   f. Education
   g. Community economic development
   h. Racial justice
   i. Arts and culture
   j. Transportation planning and availability
   k. Environmental justice
   l. Food security
   m. Early childhood development and education
   n. Youth development and leadership
   o. Please list any other areas you work in _____

4. In the last year, how many individuals have you served? _____
5. Where do you provide services? _____
6. To what extent have you or your organizational leaders been involved in the design and/or implementation of **Healthy**JoCo in the past?

B. Health Equity Capacity

Benchmark | *My organization/group has a deep understanding of our role in addressing health inequities in Johnson County.*

Guiding Questions

In this community, what are the top 5 unevenly and unfairly distributed health issues?

What would you describe as the leading environmental, social, and economic conditions that impact the health issues you identified previously?

Please indicate how much you agree or disagree with the following statement:

1. My organization's/group's work addresses the environmental, social, and economic conditions that impact health in some way.

Scale of 1 – 5 (with 1 being strongly disagree and 5 being strongly agree)

Please indicate the response that most accurately describes the awareness in Johnson County with respect to health inequities.

2. I think there is a general awareness of the environmental, social, and economic conditions that impact health among organizations or groups like mine in Johnson County. *(Yes, Moving in that direction, no, don't know)*

3. Addressing the environmental, social, and economic conditions that impact health in the Johnson County community is a high priority among organizations or groups like mine in Johnson County. *(Yes, moving in that direction, no, don't know)*

4. Where are the areas where innovation is most needed when it comes to addressing health inequities in our community?

Assessment

Circle rating from 1-5: 1 2 3 4 5

Needs development Developing Well-Developed

C. Internal & External Relationships

A core element of effective partnership is having strong relationships among partners and with other stakeholders, like funders and the community. This section focuses on your partnership's progress towards internal and external relationship benchmarks.

CA. Shared Goals

Benchmark | *My partner and I want to share an understanding of the goals our partnership seeks to achieve.*

Guiding Questions

1. What goals do you currently have for your work at your organization?

2. What would a partnership mean to you? What need and specific population could our partnership be designed to address?

3. What are we not trying to achieve through our partnership? What needs and activities are beyond the scope of this partnership?

Assessment

Circle rating from 1-5: 1 2 3 4 5

Needs development Developing Well-Developed

CB. Community and External Engagement

Benchmark | *Both organizations in the partnership engage the community and external organizations/groups/stakeholders in the community to advance our partnership's goals.*

Guiding Questions

1. What are some ways your organization/group involves the community in shaping programs, services, or other activities designed to help them?

2. How does your organization/group coordinate with other organizations/groups that are delivering similar programs, services, and interventions in the community? What about other organizations in different sectors than your own? (How often are they being engaged, etc)

3. What other organizations/groups could be a valuable addition to our partnership in order to advance our goals?

Assessment

Circle rating from 1-5: 1 2 3 4 5

Needs development Developing Well-Developed

CC. Maximizing Partner Value

Benchmark | *My partner and I bring complementary expertise to the partnership and maximize the unique value we each bring.*

Guiding Questions

1. What value—including skills and expertise—do you see each partner contributing to the partnership?

2. What opportunities exist to enhance/deepen/establish a partnership with you?

3. What additional **resources** and or **skills** are needed to achieve our goals?

Assessment

Circle rating from 1-5: 1 2 3 4 5

Needs development Developing Well-Developed

CD. Internal Buy-in

Benchmark | *Leadership and key staff at each partner organization understand the importance of collaborating with other organizations to address health inequities in our community.*

Guiding Questions

1. On a scale of 1 to 5, with 5 being strongly agree, please rate this statement. Leadership at my organization are supportive of collaborations between programs and sectors to address health inequities.

2. Which leaders at your organization/program/initiative would support a partnership to address health inequities and issues in our community?

3. Do you foresee individuals in your organization who either would not support a partnership to address health inequities and issues in our community or whose support is uncertain?

Assessment

Circle rating from 1-5: 1 Needs development 2 3 Developing 4 5 Well-Developed

D. Data Collection

Benchmark | *Our partnership will strive to collect accurate data that measures progress of our shared goals.*

Guiding Questions

1. What data does your organization collect to understand your social or community impact? Is this data sufficient? (i.e. population health outcomes and indicators collected)

2. What systems and people do you have in place to support data collection and sharing? (i.e. staffing support, funding, timing of data collection, grant requirements)

3. How could our partnership with data deepen our understanding of and impact on the community?

4. What could we learn from the data our partnership collects?

Assessment

Circle rating from 1-5: 1 Needs development 2 3 Developing 4 5 Well-Developed

F. Open Reflection

1. Partner reflects on any items that may have been left out of the conversation thus far.

2. How interested would you be in being an ongoing partner of **Healthy**JoCo?

AWKNOWLEDGEMENTS

Thank you to all of our partners who participated in this assessment. Your input and feedback is incredibly valuable and we look forward to continuing our connection with you and the wonderful work you are doing in the community.

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