Community Engagement and Leadership in the Statewide Health Improvement Partnership

AN EVALUATION OF THE STATEWIDE HEALTH IMPROVEMENT PARTNERSHIP (SHIP) COMMUNITY LEADERSHIP TEAMS

DEPARTMENT OF HEALTH

Community Engagement and Leadership in the Statewide Health Improvement Partnership

This report is part of a series of Statewide Health Improvement Partnership (SHIP) evaluation studies. For other reports, visit www.health.state.mn.us/divs/oshii/ship/results.html.

January 2, 2018

Minnesota Department of Health
Office of Statewide Health Improvement Initiatives
PO Box 64882
St. Paul, MN 55164-0882
651-201-5443
www.health.state.mn.us

Contents

Background and Purpose

Minnesota's Statewide Health Improvement Partnership is a chronic disease prevention initiative active in all 87 Minnesota counties and 10 Tribal Nations. SHIP funds community health boards and tribal governments to convene, coordinate and implement evidence-based policy, systems and environmental changes to increase access to healthy foods and beverages, expand opportunities for physical activity and decrease exposure to tobacco. Local SHIP staff work with community partners to support changes in early childhood settings, schools, worksites, health care settings and community settings, with a particular emphasis on reducing health inequities.

A unique feature of this work is the emphasis SHIP places on local leadership through community engagement. Community input at the local level is both a critical component of SHIP's philosophy and a statutory requirement of SHIP's implementation. All community health boards receiving a SHIP grant convene a Community Leadership Team (CLT) to inform the development and implementation of SHIP activities in their region, which allows for local tailoring to the needs of the community and prioritization of those needs. CLTs are a structured way of engaging community members in SHIP and form the backbone of SHIP's community engagement strategy. Tribal SHIP grantees utilize different community engagement strategies specific to their culture and context.

In 2016-2017, MDH evaluated the structure and processes of CLTs for three reasons:

- To describe how CLTs contribute to building community leadership for health, reflecting the intention of SHIP in the state statute
- To identity which populations and sectors are and are not represented among CLT membership, to assess the extent to which CLTs can be a tool for advancing health equity
- To characterize the health and functioning of CLTs, for the purpose of identifying the types of support and technical assistance that would be most helpful.

Specifically, this evaluation aimed to answer the following questions:

- What sectors and populations are represented among the membership of CLTs?
- What role do CLT members play in supporting and directing SHIP work at the community level?
- Are CLT members being authentically engaged in the CLT's work?

Methods

Data Collection

MDH collected data from SHIP grantee staff and CLT members as outlined in the table below. Grantees answered questions on their CLT as part of their annual reporting requirements for SHIP in 2016. These questions were designed to identify how grantees organized and facilitated the CLT's work. Grantees also reported CLT meeting attendance and answered descriptive questions on CLT members in REDCap. Finally, CLT members were invited to complete a survey on their participation in the CLT. This survey was designed to characterize the populations that CLT members represent and/or serve, and assess the quality, value and impact of their participation in the CLT.

Table 1. Data Collection Components

Data Collection Tool	Completed By	Description of Content	Due Date
SHIP Annual Report	Grantees	General questions on how CLT is organized	Nov. 30, 2016
Meeting Log *(REDCap)*	Grantees	List of meetings held and number of attendees	Dec. 7, 2016
Membership List *(REDCap)*	Grantees	Up-to-date list of current CLT members, their sector and role	Dec. 7, 2016 Mar. 1, 2017
Participant Survey *(REDCap)*	CLT Members	Communities represented, perceived value and impact of participation	July 17, 2017

In fall 2016, the Participant Survey was piloted with four CLT members and revised in response to feedback from them as well as from SHIP grantees and local public health directors. The final survey took approximately 10 minutes to complete and was written at an 8th grade reading level.

Data collection took place between March and July 2017. MDH partnered with grantees to administer the survey via a web-based platform through REDCap. Grantees chose one or more of the following methods to distribute the survey to their CLT members: MDH sent an email invitation with a link to the web-based survey, SHIP grantee staff sent an email invitation with a link to the web-based survey sent by SHIP grantee staff, and SHIP grantee staff distributed a paper copy of the survey during a CLT meeting (see figure 1). Paper copies were mailed to MDH for data entry into the web-based survey system. All responses were linked to the CLT they came from but were individually anonymous.

Figure 1. Number of CLTs choosing each survey distribution method

Analysis

Summary statistics were calculated for all close-ended questions reported by SHIP grantees and CLT members using Stata version 14. Grantee-reported data were summarized at the grantee level, regardless of the number of CLTs each grantee convened.

Data on CLT meetings refer to the period Nov. 1, 2015, to Oct. 31, 2016. Meetings that occurred outside this reporting period were not included in the analysis. Grantee-reported characteristics of CLT members refer to data reported by grantees in March 2017. Analyses of authentic engagement questions were limited to CLT members who reported serving on the CLT for at least six months (89 percent of the full sample) to ensure that respondents had enough experience on the CLT to provide valid responses to these questions.

All questions on the CLT Participant Survey had a response option of "prefer not to answer." These responses and missing data (no answer choice selected) were excluded from analyses. Open-ended questions on the CLT Participant Survey were coded for themes using Atlas Ti qualitative analysis software.

Results

There were 809 active members of 52 CLTs eligible to complete the CLT participant survey. A total of 528 completed surveys were received, for a response rate of 65%. In 2015-2016, there were 245 CLT meetings held across the state, with over 4,000 member-hours contributed.

Seven grantees convened multiple CLTs covering distinct geographic areas within their jurisdiction, and two grantees shared a single CLT. Two-thirds of grantees (n=27) had a stand-alone CLT to address SHIP work, while 12 percent used either an existing public health group (n=2) or a stand-alone group that addressed SHIP as well as other local public health activities (n=3).

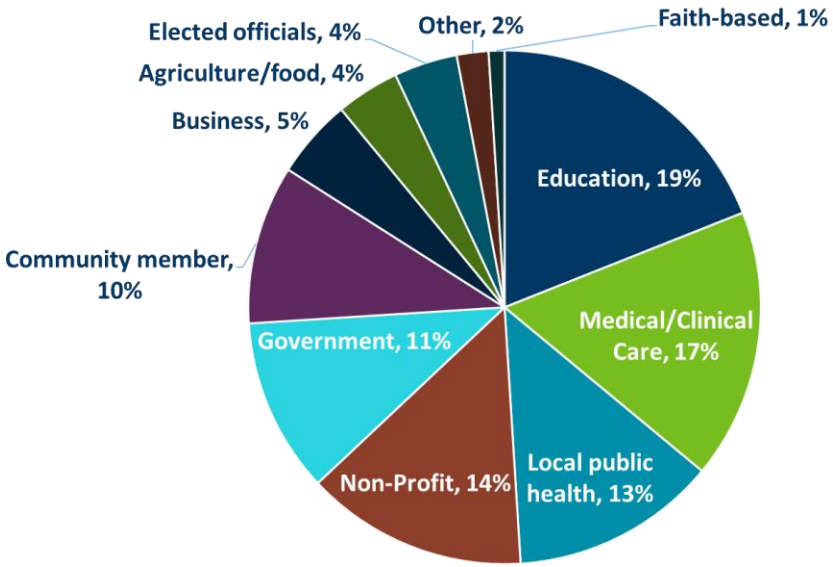
The remaining results were organized around each evaluation question: 1) membership characteristics and representation of populations experiencing health inequities, 2) the role of CLT members in supporting and directing SHIP work, and 3) authentic engagement.

CLT Member Characteristics and Representation

Approximately nine out of 10 CLT members reported that they served on the CLT as a representative of an organization, with the remainder being community members with no organizational affiliation. Of those representing an organization, three-quarters represented an organization that serves an entire geographic community, such as a hospital or school, and one-quarter represented an organization that serves specific communities experiencing health inequities. A large proportion (71 percent) of those serving an entire geographic community served communities with less than 50,000 people, and 31 percent served communities with less than 10,000 people.

Grantees reported a single sector that best represented each member's organizational affiliation. The most common sector represented was Education (19 percent of members) followed by Medical/Clinical Care Service Providers (17 percent of members) (figure 2). They also reported whether each member's organization received SHIP funds. Members from the public health sector who worked on SHIP were considered to receive SHIP funds, as were members whose organizations received mini-grants from SHIP. Overall, one-third of CLT members' organizations received SHIP funds. Excluding members representing the public health sector, 28 percent of other members received SHIP funds (i.e., mini-grants) for their organization.

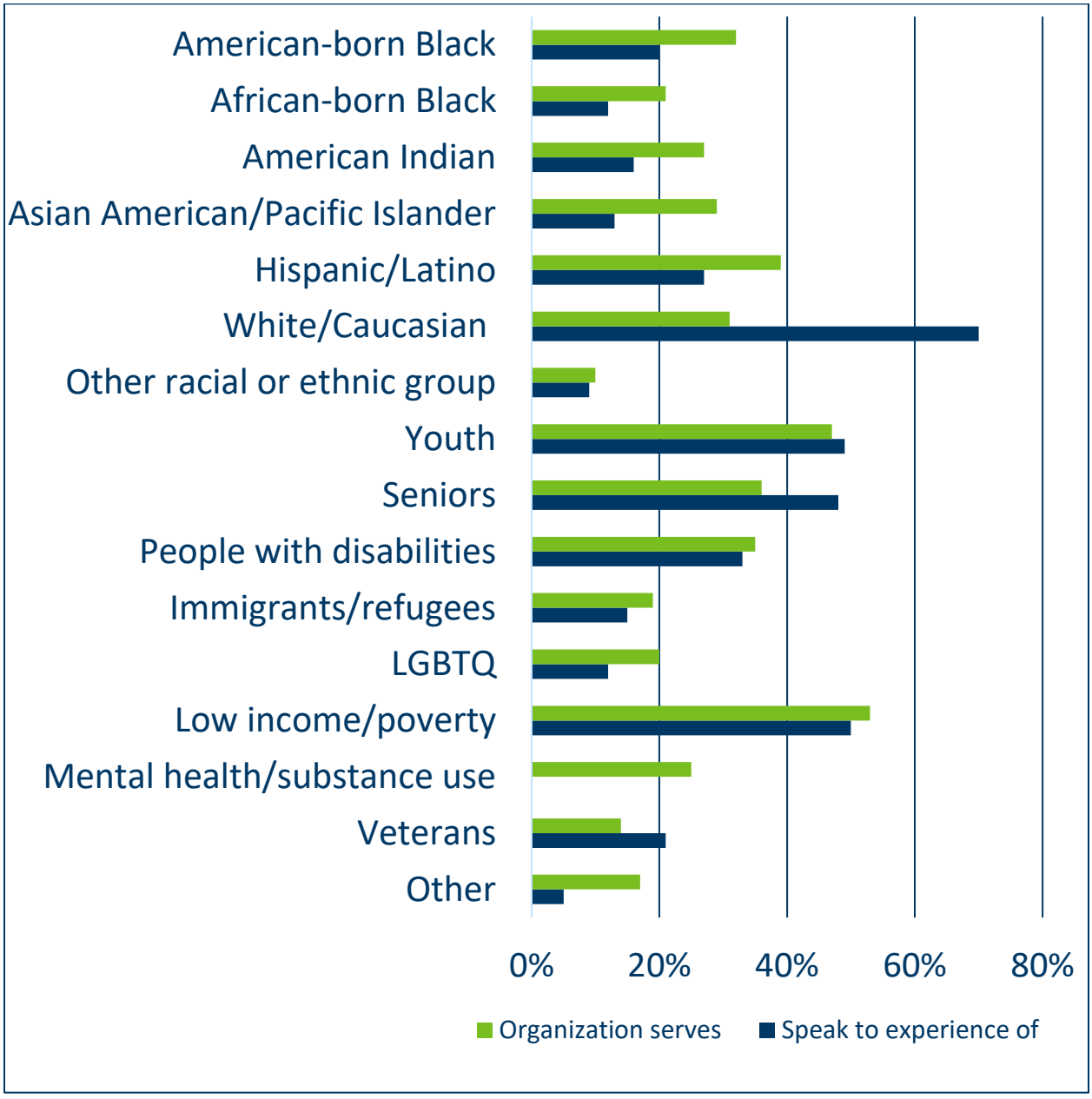
Figure 2. Sectors Represented by CLT Members as Reported by SHIP Grantees



Populations

CLT members that reported they served specific communities were asked which communities their organization served. All CLT members were also asked which specific communities they can speak to the experience of (figure 3). The list of communities included specific races/ethnicities and communities experiencing health inequities, such as seniors, people with disabilities, and refugees. For both questions, multiple response options were allowed.

Figure 3. CLT Members Serve and Can Speak to the Experience of These Populations



CLT members reported that their organizations served a wide range of racial/ethnic groups, youth, seniors, people with disabilities, and people with low-income backgrounds, among others.

While the survey did not contain a demographic question, 70 percent of respondents reported they could speak to the experiences of whites/Caucasians, and 9-27 percent reported they could speak to the experience of other racial/ethnic groups. There were also large proportions of CLT members who reported being able to speak to the experience of youth (49 percent), seniors (48 percent) and people with low income backgrounds (50 percent). The quotes in table 2 demonstrate the difference between the way CLT members describe their contribution as an organizational or professional representative versus a member of a group experiencing health inequities.

Table 2. Example of CLT Member Representation as Reported by CLT Members

Quotes on Organizational Representation	Quotes on Community Representation
"I am the only member of the Early Childhood Community and I can bring forth information from child care providers as well as disseminate information out to them." *(#19)*	"I believe I give a small city perspective to the group." *(#39)*
"Having worked with these groups professionally over many years I believe I can bring perspective and knowledge to discussion involving programs." *(#113)*	"I speak Spanish and English too. I'm trying that the Hispanic community participate in all program that [CLT Name] has." *(#112)*
"Our focus on mental health and senior health are providing resources to these populations." *(#148)*	"As a person that is Caucasian I do not feel I have the right to speak for other community groups. Although I have worked with many individuals from different community groups. I think that it is broad based to ask one person to represent the group as a whole." *(#133)*
"We [represent] a hospital and the 5 communities that formed the hospital 50th *(sic)* years ago. Our support can influence community participation in such areas as physical activities (parks/paths), healthy eating in schools, hosting related meetings in the hospital -- providing support to organizations that are most connected to individual health." *(#164)*	"I can speak to all groups." *(#366)*

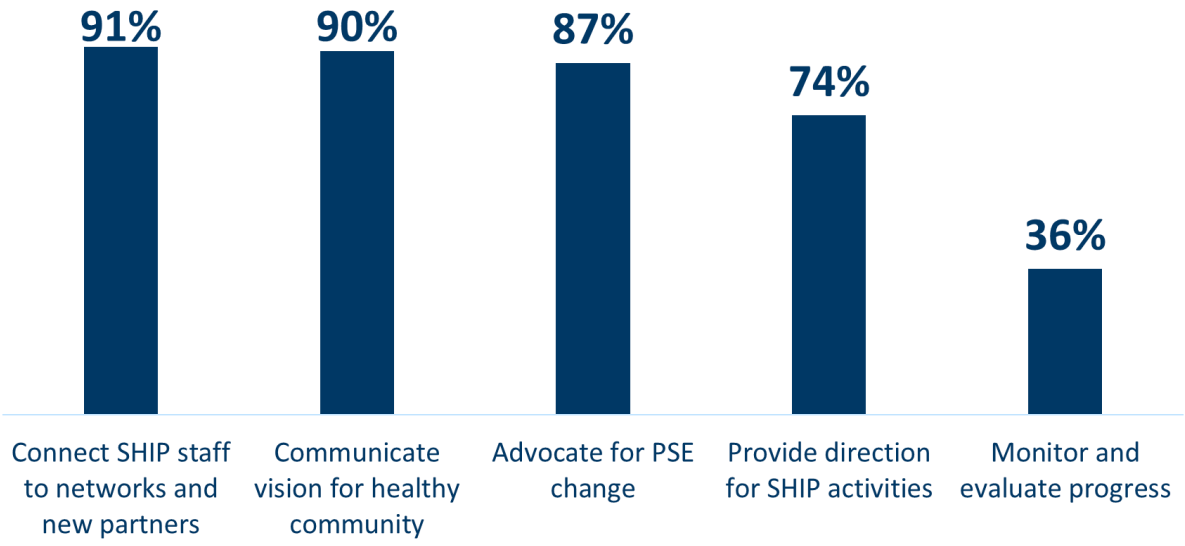
CLT Member Roles

SHIP grantees were asked to select one or more core roles that each individual on their CLT membership list plays on their CLT. The list of roles was developed in 2014 by a group comprised of MDH staff, SHIP grantees and CLT members, and includes the following:

- Connector/Networking
- Articulator of a shared and inspiring vision
- Advocate
- Advisor/Decision Maker
- Monitor: Holding the effort accountable to the shared goals and values

Grantees reported that the vast majority of CLT members served in the roles of connector/networking, connecting SHIP staff to networks and new partners (91 percent), articulator of a shared vision for a healthy community (90 percent), and advocate for policy, systems and environmental change (87 percent) (figure 4). About three-quarters served in the role of advisor/decision maker (providing direction for SHIP activities), and only about one in three served in the role of monitor.

Figure 4. CLT Member Roles as Reported by SHIP Grantees



In open-ended questions, CLT members gave examples of how their organizations and communities benefit from their participation on the CLT. In some cases, their answers aligned with the five core member roles (table 3). This finding suggests that SHIP staff have clearly communicated member roles to CLT members.

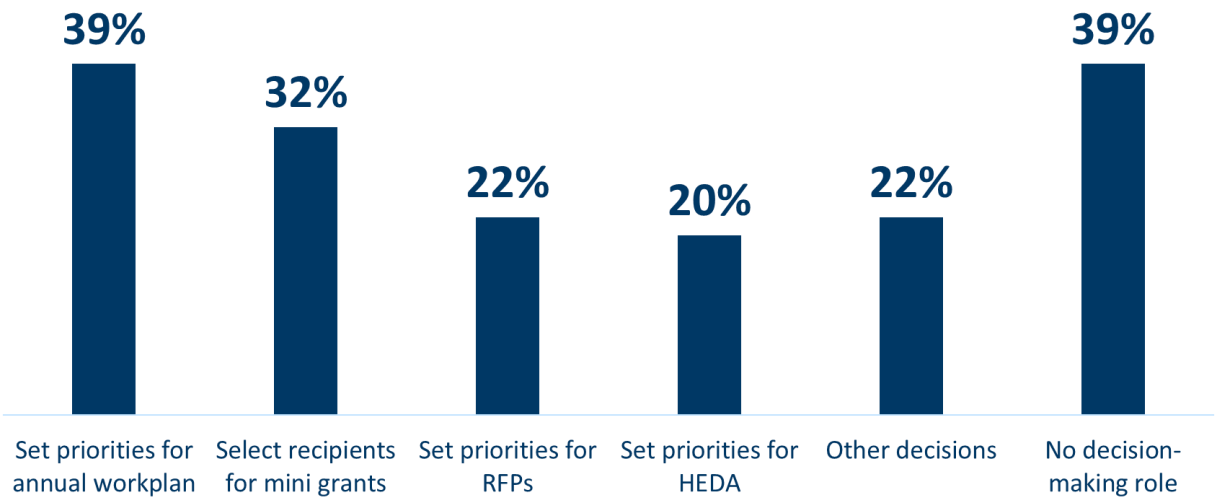
Table 3. Examples of CLT Member Roles as Reported by CLT Members

Member Role	Quote
Connector/Networking	*"By participating in the leadership team, I have an opportunity to network not only with SHIP-funded staff but also with individuals representing many partner organizations." (#15)*
Articulator of a shared and inspiring vision	*"As a relatively new member I was warmly welcomed and included in decisions, etc. This committee is vital to [bringing] the many stakeholders together to clarify the vision of a 'healthy community'." (#170)*
Advocate	*"Advocate for this community/population during group activities, to ensure they are considered in our efforts and that our work is approached with an equity lens." (#511)*
Advisor/Decision Maker/Provide Direction	*"[My participation] will allow the population that I serve to be best served by community policies and priorities." (#49)*
Monitor: Holding the effort accountable to the shared goals and values	*In recent years, I feel the CLT and its partners have strengthened its outreach to include the entire community. There is always room for improvement but I believe the team is making progress with equity in mind. (#154)*

Agenda Setting and Decision Making

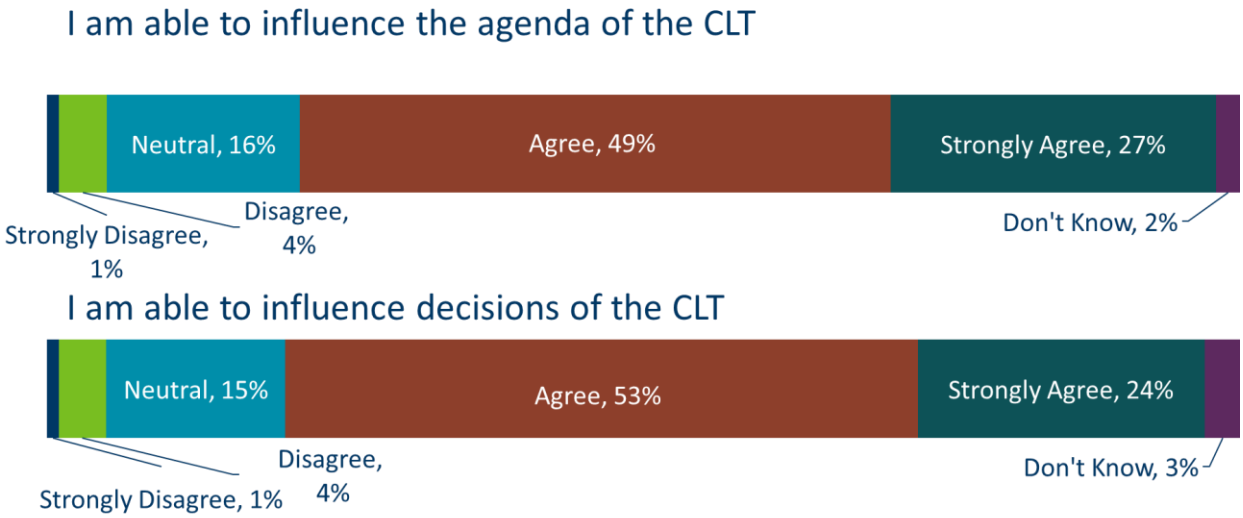
Two measures of how CLT members provide direction include their ability to influence agenda setting and participation in decision-making. Grantees reported the types of decision-making that CLT members contributed to (figure 5). CLTs most commonly made decisions related to setting priorities for annual work plans (39 percent) and selecting recipients for mini grants (32 percent); however, 39 percent of CLTs had no decision-making role for local SHIP activities according to grantees.

Figure 5. CLT Decision Making Role as Reported by Grantees



In contrast, the vast majority of CLT members reported that they agreed or strongly agreed that they are able to influence the agenda and decisions of the CLT (figure 6). This discrepancy may be a result of the different wording used between the two questionnaires (e.g., decision-making role vs. ability to influence decisions).

Figure 6. Agenda Setting and Decision Making as Reported by CLT Members



Note: Results may not sum to 100% due to rounding.

SHIP Coordinator Role

Grantees also reported what role(s) the SHIP Coordinator played on the CLT because the role of the SHIP Coordinator can influence how and if power is shared with the CLT. Fifty-nine percent

of grantees considered their SHIP coordinator to be a full participating member of the CLT, while only 10 percent of grantees considered their SHIP coordinator to be an ex-officio or non-voting member. In addition, three-quarters of grantees reported that their CLT meetings were facilitated by SHIP staff. The remainder were facilitated by community members, other public health staff, or a combination of community members and SHIP staff.

Authentic Engagement

Authentic engagement was assessed in several ways: level of engagement, member engagement and value, and potential impact on community.

Level of Engagement

Both grantees and CLT members responded to a single question about the nature of the relationship between SHIP staff and the CLT, with answer choices increasing in level of engagement (see below for definitions). Grantees with multiple CLTs were given the higher level of engagement reported across all their CLTs.

Overall, grantees and CLT members reported high levels of engagement: about two-thirds reported working at the level of collaboration or shared leadership (figure 7). Agreement between grantees and CLT members was also high, with the exception of the networking level, which was more commonly selected by grantees than CLT members. CLT members were also given a "don't know" response option.

We also examined whether the distribution of level of engagement differed by CLTs' decision making role. Among CLTs that had no grantee-reported decision making role, the level of engagement was lower, with over half working at the outreach or networking level, 40 percent working at the collaborating level and none working at the shared leadership level.

Definitions of Levels of Engagement

Outreach: SHIP staff provide CLT members with updates and information on SHIP work.

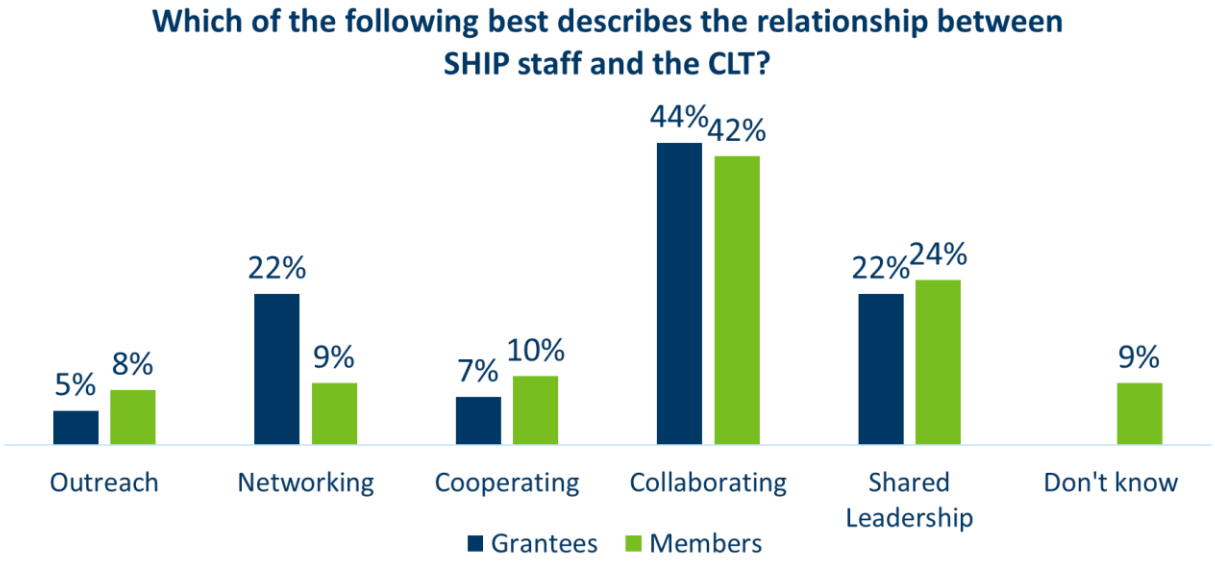
Networking: In addition to Outreach, CLT members share ideas and information with SHIP staff.

Cooperating: In addition to Outreach and Networking, CLT members and SHIP staff share resources and alter activities to achieve common goals, such as engaging in joint communication strategies.

Collaborating: In addition to Outreach, Networking and Cooperating, CLT members and SHIP staff build capacity for mutual benefit, e.g., through shared learning or new partnership opportunities.

Shared leadership: In addition to Outreach, Networking, Cooperating and Collaborating, the CLT has final decision making authority over the direction of the CLT and SHIP work.

Figure 7. Level of Engagement Reported by Grantees and CLT Members



Note: Results may not sum to 100% due to rounding.

Member Engagement and Value

CLT members responded to a series of questions about their perceived influence and engagement on the CLT. Two of these questions (ability to influence agenda and decisions of CLT) are reported above in the Member Roles section. The remaining four questions appear below in table 4. Between 75-93 percent of CLT members agreed or strongly agreed with each statement, indicating a high level of engagement and value of their participation.

Table 4. Perceived Engagement and Value among CLT Members

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know	Total
	%	%	%	%	%	%	N
I am able to actively participate in the CLT	2%	2%	7%	43%	46%	0%	442
I am able to see my impact and know how it has made a difference in CLT	1%	4%	14%	53%	27%	1%	436
I am able to build new relationships with members of CLT	1%	0%	2%	40%	56%	0%	445

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know	Total
I am able to work with other members of CLT to build partnerships or collaborations that impact the overall health of the community	1%	1%	5%	39%	53%	1%	444

Note: Results may not sum to 100% due to rounding.

Potential Impact on Community

After reporting which communities their organization serves and which communities they can speak to the experience of, CLT members responded to questions on the potential impact their participation has on the health of these communities. Just over half responded that their participation has a moderate effect, and another third responded that their participation has a major effect (table 5).

Table 5. Perceived Impact of CLT Participation on Potential Health of Communities

Response Options	Communities Served			Communities Speak to Experience Of	
	Overall, how much do you think YOUR participation on CLT has the potential to affect the health of the communities your organization serves?			Overall, how much do you think your participation on CLT has the potential to affect the health of the communities you selected above?	
	N	%		N	%
No effect	3	1%		3	1%
Minor effect	50	11%		63	13%
Moderate effect	242	52%		251	51%
Major effect	158	34%		158	32%
Don't know	11	2%		20	4%
TOTAL	464	100%		495	100%

Note: Results may not sum to 100% due to rounding.

Responses to the open-ended questions provided examples of the community changes and impacts CLT members observed as a result of the CLT's work.

"We have the ability to affect positive change and alter the norms of individuals within the County." (#8)

"By working with other organizations and volunteers in our community we are able to better identify needs, inequities etc. in our community - and are able to prioritize and address these needs with available funds." (#30)

"We partnered with SHIP in order to provide fresh, local fruits and vegetables to our participants through (our) … Senior Dining and Meals on Wheels programs.… I appreciate being able to work with community health partners on the CLT in order to complete program outreach and conduct referrals for our customers who could benefit from other community health services." (#46)

"I thought the SHIP grant would be another boring bureaucratic government initiative, instead, the members of [this CLT] have made the SHIP program vital and a productive use of my time and area resources, it makes changes to system, policy and environment, which isn't easy to do successfully." (#100)

"SHIP and WIC [Special Supplemental Nutrition Program for Women, Infants, and Children] have common population health goals and by collaboration and partnering can help create change in community environments where WIC families live. This CLT collaboration has benefitted WIC clients by things like promoting a transportation resource that is funded by another WIC partner that helps people get to WIC sites." (#125)

"Participating and working with the … CLT is important for us as we feel connected in the work and know through partnership we can be more effective in preventing childhood obesity. Examples of our effective partnerships is the work with the … Comprehensive Plan, School Wellness Policies and Walk-A-Thons." (#154)

"We have been able to assist in making policy changes that affect our community. We have helped bring parks and trails, connect trails, safer drives and walks (bike lanes, bump outs), create gardens -- teach people how to grow and cook healthy foods, help so children can walk to school. Make healthy changes to vending machines and concession stands, create plans for low income families/individuals to pick up needed food boxes (filled with healthy options), help business create healthier working environments and the list goes on. We are making an impact in our community for all people." (#163)

Conclusions

Findings from this evaluation indicate that CLTs are active, engaged groups that benefit SHIP and the participating organizations. CLTs serve as a communications and networking forum, work to coordinate and align activities across organizations working in the same community to fill gaps and avoid duplication, and leverage connections and resources between organizations to enhance their work. Collectively, CLTs are developing a shared vision of a healthy community and the vast majority of CLT members believe they have the potential to have a moderate or major impact on the health of the community. As one CLT member described,

> *"The building of community relationships and diversity of input is key to addressing health disparities. … Attendees come from many different backgrounds and each has something of value to share with each other. With many community voices and shared focus, our community is strengthened." (#93)*

This evaluation sought to answer three questions. Conclusions from the findings on each of these questions is discussed in detail below.

What sectors and populations are represented among the membership of CLTs?

Sectors

The sectors with the largest representation were education and medical/clinical care. A substantial proportion of public health staff members were also considered members of the CLTs (13 percent of all members statewide, 0-10 percent per grantee). Over half of grantees considered their SHIP coordinator to be a full participating member of the CLT, and three-quarters reported that their CLT meetings were facilitated solely by SHIP staff.

It is unclear what the optimal distribution of sectors might be for CLTs. It's possible that what is optimal may evolve as the CLT takes on new and different topics. However, interpretation of the sector distribution may be limited because grantees were asked to select only one sector that best represents each member's organizational affiliation. Some organizations are not easily classified into just one sector (e.g., school board member is both education and an elected official, UMN Extension is both education and agriculture/food systems).

In general, CLTs should strive for diverse representation of many sectors of their communities, and having public health staff as members is contrary to the intent of the CLTs. MDH guidance released in June 2017 specified two new requirements for CLTs that sought to address the balance of power on CLTs. The first clarifies that local public health staff are not considered members of CLTs. The second clarifies that recipients of SHIP mini grants are ineligible to be members of CLTs. If this is not possible, that CLT members whose organizations have received

mini grants are ineligible from voting on future mini grant awards. These new guidelines are intended to help CLTs move toward greater inclusivity and community control, for example, having community members chair or co-chair the CLT and facilitate meetings.

Populations

Representatives of populations experiencing health inequities (i.e., people who serve these populations through their organizations or advocate on their behalf) are reflected among the membership of the CLT, but it is unknown whether members of these populations (i.e., people who self-identify as part of these populations) are present among the membership.

MDH initially planned to ask a demographic question, but ultimately decided to ask the question as "populations you can speak to the experience of" after discussions with grantees and public health directors. Some were concerned that a demographic question might offend CLT members. Others felt that having the interests of these populations represented by people who work with, advocate for or serve them was sufficient to answer the evaluation question.

Despite the difficulties of interpreting the question, the results suggest that most CLT members are Caucasian, and some CLT members reported they could speak to the experience of populations of which they are not a member. One reason for this may be that they see themselves as advocates of these populations. Nevertheless, direct engagement of individuals who self-identify as being from a population experiencing health inequities is a core practice of authentic community engagement. MDH strongly encourages SHIP grantees to engage these individuals in their CLTs, as well as their Health Equity Data Analysis projects and other engagement activities.

What role do CLT members play in supporting and directing SHIP work at the community level?

Grantees reported high proportions of CLT members filling each of the five core CLT member roles with the exception of the monitoring and evaluation role. CLT members also gave examples of how they fulfill each of the member roles, with the exception of the monitoring and evaluation role. These findings suggest that SHIP staff have successfully communicated to CLT members the roles they are expected to fulfill through their participation. The lack of focus on the monitoring and evaluation role suggests that grantees have a need for more guidance on how to evaluate progress and success of CLTs' work and how to engage CLT members in this process. This need is not unique to SHIP: In MDH reviews of Local Public Health community health improvement plan annual reports, community involvement in the monitoring and evaluation of plan activities is also limited. MDH may wish to pursue development of agency-wide guidance materials on monitoring and evaluation that could be shared with local grantees across divisions and programs.

A majority of CLT members reported that they had the ability to influence the CLT's agenda and decisions, yet nearly 40 percent of SHIP grantees reported that their CLT has no decision making role. This discrepancy may be a result of the different wording used between the two questionnaires (e.g., decision-making role vs. ability to influence decisions). CLTs may function in practice more as advisory bodies than decision-making bodies. Another reason for the discrepancy may be that some CLTs have a scope of work that is broader than just SHIP. In this case, CLT members may have a decision-making role only on the SHIP-related work or on decisions about the CLT itself (e.g., internal procedures and processes). However, most CLTs were stand-alone CLTs created solely for the purpose of directing SHIP work. An interesting question for future evaluation is how these stand alone CLTs interact with other public health advisory groups in their local area to coordinate local public health efforts.

Are CLT members being authentically engaged in the CLT's work?

Most CLTs are operating at a high level of engagement (e.g., collaboration or shared leadership) as reported by both grantees and CLT members. CLT members also reported a high value of their participation by being able to see their impact on the CLT, build new relationships with CLT members, and build new partnerships and collaborations to influence the health of the community. The vast majority of CLT members also felt their participation on the CLT had the potential to make a major or moderate impact on the health of their community.

These findings suggest that CLTs have been successful in authentically engaging members in creating new opportunities for shared work, leveraging resources and connections from participating organizations, and creating a shared sense of teamwork and meaningful community impact. Grantees are encouraged to continue engaging members in a way that creates mutual benefit and member buy-in, which are key ingredients for authentic engagement and ongoing successful collaboration.

Implications for Training and Technical Assistance

One of the primary goals of this evaluation was to identify SHIP grantees' training and technical assistance needs for their CLTs.

Grantees receive CLT technical assistance, training and coaching in a number of ways: regular grantee calls, a conference call focused on CLT practice (six times a year), responses to individual grantee requests and a skill-building workshop at the SHIP statewide meeting. In addition, Basecamp posts feature resources and tools including facilitated activities to use with CLTs.

After reviewing the results and discussing them with grantees, the following needs emerged:

- Structuring meetings to promote authentic engagement

  - Strategies to ensure strong and regular attendance
  - Group activities to use with CLTs including health equity exercises
  - Meeting facilitation training
  - Approaches to strengthen CLT members' quality of participation – helping CLT members see their impact, inviting CLT members into shaping their meeting agendas, etc.
- Establishing a strong membership
  - Examples of successful CLTs' membership composition
  - Approaches to and tools for recruitment of new CLT members
  - Approaches to recruiting CLT members that represent the population and sector diversity of the jurisdiction
  - Resources and support to provide orientation to all new CLT members
  - Authentically engaging members of populations experiencing health inequities
  - Avoiding tokenization of members from communities experiencing health inequities
- Supporting CLTs in fulfilling their roles
  - Approaches to engaging CLTs in monitoring and evaluation of SHIP activities
  - Options for engaging CLTs in guiding or making decisions to shape local SHIP work
  - Strategies to overcome barriers to engaging CLTs in decision-making roles
  - Supporting CLT members to share how SHIP activities can make a difference for communities through story telling approaches
  - How to build and clarify a collective voice in the community

CLT conference calls and grantee calls have and will continue to address the identified topics. This process has already started. The October 2017 CLT call looked at how grantees help their CLT members know that their participation has made a difference. Summaries of CLT calls are posted on Basecamp along with helpful resources, tools and facilitation instructions for group activities.

During the fall 2017 grantee calls, many conversations focused on the recruitment of new CLT members and various recruitment and assessment tools. The January 2018 regional meetings will also focus on relationship development and partnership recruitment.

The skills and abilities to work partnerships are not exclusive to SHIP activities. SHIP staff may be able to access training covering similar content provided to support local public health departments around engaging community partners to develop the community health assessment and community health improvement plans.

It would be difficult for MDH to adequately respond to the request from SHIP and other local public health department staff for meeting facilitation training – which is a core public health competency. This training may be more effectively delivered locally and for all public health staff – not just SHIP staff. The SHIP Training and TA Advisory Committee will consider how to address this need, and MDH will ask grantees for local resources they use for this kind of training.

Appendix A. Characteristics of CLTs as Reported by Grantees, 2016

Table A1. Number of CLTs and Meetings

	N
All Grantees	**41**
Grantees with active CLTs	39
Active CLTs (considering multiple CLTs per grantee)	48
Meetings	
Total number of meetings held	245
Total number of member-hours volunteered	4014.5

Note: In 2017, four additional CLTs were reconvened or created, bringing the number of active CLTs to 52.

Table A2. CLT Structure

	N	%
CLT Has Sub-Committees, Workgroups, or Sub-groups	14	34%
CLT Structure		
Stand-alone CLT	27	66%
Multiple CLTs	7	17%
Existing public health advisory group/community coalition	2	5%
Stand-alone, but not just SHIP focused	3	7%
Joint CLT between two grantees	2	5%

Table A3. Meeting Facilitator

	N	%
SHIP Staff	31	76%
Community member	6	15%
Both (co-chairs)	3	7%
Other city staff	1	2%

Table A4. SHIP Staff Provide Orientation for New Members

	N	%
No	14	34%
Yes	25	61%
Some yes, some no (multiple CLTs only)	2	5%

Table A5. Level of Engagement

	N	%
Outreach	2	5%
Networking	9	22%
Cooperating	3	7%
Collaborating	18	44%
Shared leadership	9	22%

Table A6. SHIP Coordinator and CLT Decision Making Role

SHIP coordinator roles (can select more than one)	**N**	**%**
Full participating member	24	59%
Ex-officio or non-voting member	4	10%
Meeting convener or facilitator	37	90%
CLT decision-making role (can select more than one)		
No decision-making role	15	37%
Selects recipients for mini-grants	13	32%
Sets priorities for requests for proposals	9	22%
Sets annual work plan priorities	16	39%
Sets priorities for Health Equity Data Analysis	8	20%
Other	9	22%

Appendix B. Characteristics of CLT Members as Reported by Grantees, 2017

Table B1. Roles Fulfilled by Members (can select more than one)

	N	%
Connects SHIP staff to networks and new partners	790	91%
Communicates vision for a healthy community	780	90%
Advocates for policy, systems, or environmental change that supports a healthy community	754	87%
Provides direction for SHIP activities	643	74%
Monitors and evaluates progress	315	36%

Table B2. Receipt of SHIP Funds

	N	%
All Members	297	34%
Public health members	89	80%
Non-public health members	208	28%

Table B3. Sectors Represented by Members

	N	%
Community member/no organizational affiliation	84	10%
Agriculture/food systems	38	4%
Education	167	19%
Medical/clinical care service providers	146	17%
Faith/religious community	8	1%
Other non-profit	117	14%
Business community	41	5%
Elected officials	35	4%
Local public health agency	112	13%
Other local, state, or tribal government	97	11%
Other/Not listed	20	2%

Appendix C. CLT Participant Survey Results, 2017

Table C1. CLT Member Length of Time Served

	N	%
Less than 6 months	56	11%
Between 6 months and 1 year	92	18%
More than 1 year	372	71%
TOTAL	524	100%

Table C2. CLT Members' Organizational Representation

	N	%
I do not represent an organization	42	8%
An entire geographic community	352	69%
Specific communities	118	23%
TOTAL	512	100%

Table C3. Geographic Area Served by Organizations

	N	%
Less than 2,500	25	7%
Between 2,500 and 10,000	74	22%
Between 10,000 and 50,000	131	39%
50,000 or more	94	28%
Don't know	15	4%
TOTAL	339	100%

Table C4. CLT Members' Community Representation (can select more than one)

	Specific communities served		Personal community experience	
	Q: Which specific communities does your organization serve? (n=118)		Q: Which of the following communities can you speak to the experience of? (n=528)	
Response	**N**	**%**	**N**	**%**
African American (American-born)	38	32%	104	20%
African-born	25	21%	62	12%
American Indian	27	22%	82	16%
Asian American/ Pacific Islander	29	24%	70	13%
Hispanic/Latino	39	33%	140	27%
White/Caucasian	37	31%	370	70%
Other racial or ethnic group	12	17%	48	9%
Youth	55	47%	258	49%
Seniors	43	36%	252	48%
People with disabilities	41	35%	175	33%
Immigrants/refugees	22	19%	79	15%
LGBTQ	24	20%	61	12%
People with low income backgrounds/ people living in poverty	62	53%	264	50%
People with mental health or substance use disorders	30	25%	-----	-------
Veterans	16	14%	113	21%
Other	20	17%	29	5%

Table C5. Perceived Effect of CLT Participation on Community

Response Options	Communities served			Communities speak to experience of	
	Overall, how much do you think YOUR participation on CLT has the potential to affect the health of the communities your organization serves?			Overall, how much do you think your participation on CLT has the potential to affect the health of the communities you selected above?	
	N	%		N	%
No effect	3	1%		3	1%
Minor effect	50	11%		63	13%
Moderate effect	242	52%		251	51%
Major effect	158	34%		158	32%
Don't know	11	2%		20	4%
TOTAL	464	100%		495	100%

Note: Results may not sum to 100% due to rounding.

Table C6. Perceived Influence and Level of Engagement among Members Serving at Least 6 Months

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know	Total
	%	%	%	%	%	%	N
I am able to actively participate in the CLT	2%	2%	7%	43%	46%	0%	442
I am able to Influence the agenda of CLT	1%	4%	16%	49%	27%	2%	438
I am able to influence decisions of CLT	1%	4%	15%	53%	24%	3%	438
I am able to see my impact and	1%	4%	14%	53%	27%	1%	436

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know	Total
know how it has made a difference in CLT							
I am able to build new relationships with members of CLT	1%	0%	2%	40%	56%	0%	445
I am able to work with other members of CLT to build partnerships or collaborations that impact the overall health of the community	1%	1%	5%	39%	53%	1%	444

Note: Results may not sum to 100% due to rounding.

Table C7. Perceived Level of Engagement Reported by CLT Members Serving at Least 6 Months

Question	Outreach	Networking	Cooperating	Collaborating	Shared leadership	Don't know	Total
	%	%	%	%	%	%	N
Which of the following best describes the relationship between SHIP and CLT?	8%	9%	10%	42%	24%	9%	443

Note: Results may not sum to 100% due to rounding.

Appendix D. Data Collection Instruments

Annual Report Evaluation Questions

After completing the SHIP 4—Year 1 Annual Report in Verint, several questions about how CLTs are organized was presented. Most answers were multiple choice or check all that apply, with some short text boxes for additional description.

1. Who is responsible for facilitating meetings for the CLT? (Choose one)
    a. SHIP Staff
    b. Community member
    c. Other, specify _____
2. Do you provide an orientation for new CLT members? (Choose one)
    a. No
    b. Yes, briefly describe _____
3. As SHIP Coordinator, how would you describe your role on the CLT? (Choose all that apply)
    a. Full participating member
    b. Ex-officio or non-voting member
    c. Meeting convener or facilitator
    a. Other, specify _____
4. Which of the following best describes the relationship between SHIP staff and the CLT? (choose one)
    a. Outreach (SHIP staff provide CLT members with updates and information on SHIP work)
    b. Networking (in addition to Outreach, CLT members share ideas and information with SHIP staff)
    c. Cooperating (in addition to Outreach and Networking, CLT members and SHIP staff share resources and alter activities to achieve common goals, such as engaging in joint communication strategies)
    d. Collaborating (in addition to Outreach, Networking and Cooperating, CLT members and SHIP staff build capacity for mutual benefit, e.g., through shared learning or new partnership opportunities)
    e. Shared leadership (in addition to Outreach, Networking, Cooperating and Collaborating, the CLT has final decision making authority over the direction of the CLT and SHIP work)
5. Does the CLT make any of the following decisions? (Choose all that apply)
    a. The CLT does not have a decision-making role
    b. Select recipients for mini-grants

   c. Set priorities for Requests for Proposals (RFPs)
   d. Set annual workplan priorities
   e. Set priorities for the Health Equity Data Analysis
   f. Other, specify _____
6. What is the structure of your CLT? (choose one answer that best describes your CLT)
   a. Stand-alone CLT for the entire jurisdiction organized specifically for SHIP
   b. Multiple CLTs serving distinct geographic communities across the jurisdiction
      i. Please specify which geographic community or communities are served by each CLT _____
   c. An existing Public Health Advisory Group from our jurisdiction serves as the CLT
   d. Other, specify _____
7. Does your CLT have sub-committees, workgroups or subgroups? (choose one)
   a. Yes, specify _____
   b. No

Meetings

ID _____

CLT Name _____
(If you have multiple CLTs, enter them as separate records.)

Meeting and Attendance Report

How many CLT meetings were held during this grant year? (November 1, 2015 to October 31, 2016) _____
(Include both full meetings and subcommittee meetings, if applicable.)

MEETING 1

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 2

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 3

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 4

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 5

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 6

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 7

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 8

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 9

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 10

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 11

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 12

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 13

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 14

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 15

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 16

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 17

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 18

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 19

Meeting date _____
((MM-DD-YYYY))

Meeting length _____
(Number of hours)

Number of members in attendance _____
(Do not include SHIP staff or contractors)

MEETING 20

Meeting date

_____
((MM-DD-YYYY))

Meeting length

_____
(Number of hours)

Number of members in attendance

_____
(Do not include SHIP staff or contractors)

Membership List

Member ID _____

Member First Name _____

Member Last Name _____

Member's organizational affiliation _____
(If this member is an employee, volunteer, or member of an organization, please type the organization name here. If this member is not affiliated with an organization, please type "community member." Do NOT enter the individual's job title.)

Is this individual a current member of the CLT?
◯ Yes
◯ No

Member Contact Information (MUST PROVIDE EITHER EMAIL ADDRESS OR MAILING ADDRESS)

Member Email Address _____

Member Mailing Address (not required if email is provided) _____

City _____

State _____

Zip _____

Member Characteristics

Is this member a chair or co-chair of the CLT?
◯ Yes
◯ No

Does this member or their organization receive SHIP 4 funds?
◯ Yes
◯ No
(SHIP contractors and staff: Choose "Yes.")

Please indicate which one of the following sectors most applies to this member. (Choose one.)

- ◯ Community member/no organizational affiliation
- ◯ Agriculture/Food Systems (including for-profit and non-profit entities such as food producers, distributors, retailers, and advocates)
- ◯ Education (including public, private and charter K-12 schools, early childhood education programs, colleges, universities, trade schools, and U of M Extension)
- ◯ Medical/Clinical Care Service Providers (including clinics, hospitals, and health plans)
- ◯ Faith/Religious Community
- ◯ Other Non-Profit
- ◯ Business Community
- ◯ Elected officials
- ◯ Local public health agency
- ◯ Other local, state, or tribal government agency
- ◯ Other/Not listed

What role does this member play on the CLT? (Check all that apply.)

- ☐ Provides direction for SHIP activities
- ☐ Communicates vision for a healthy community
- ☐ Connects SHIP staff to networks and new partners
- ☐ Advocates for policy, systems, or environmental change that supports a healthy community
- ☐ Monitors and evaluates progress

MDH Minnesota Department *of* Health

OFFICE OF STATEWIDE HEALTH IMPROVEMENT INITIATIVES

ship statewide health improvement partnership

Community Leadership Team Participant Survey

We invite you to take this survey because you are a member of «CLT_Name», which works with Statewide Health Improvement Partnership (SHIP) staff in your region. The Minnesota Department of Health (MDH) wants to learn more about how people participate in groups like this across the state. MDH will use the results to guide training and support for SHIP staff to strengthen these groups.

In the survey, you will see the phrase "community health." This includes the many ways a community, city, town or county provides support so that all people can develop to their fullest potential. For example, a community may support health by making it easier to find healthy food in stores and restaurants. Another example is a community that installs sidewalks so people can walk to school or the store. A community may also have events to help neighbors get to know each other.

There are no right or wrong answers to these questions. Please choose the answers that best apply to you. Your participation is completely voluntary. You may stop the survey at any time. If you don't want to answer a question, please choose "Prefer not to answer."

Your responses are anonymous, which means that no one will know how you personally answered the questions. If you have questions or would like more information, please contact MDH staff at Health.SHIP.Eval@state.mn.us or call 651-201-3667.

Place an X in the circle to choose your answer. Skip ahead if you see "→SKIP TO QUESTION #__" next to your answer.

BEGIN SURVEY ON NEXT PAGE. →

1. **How long have you been serving on «CLT_Name»?**

   ◯$_1$ Less than 6 months.

   ◯$_2$ Between 6 months and 1 year.

   ◯$_3$ More than 1 year.

   ◯$_9$ Prefer not to answer.

Many members of «CLT_Name» represent organizations that they work or volunteer for. The next few questions refer to the organization you represent on «CLT_Name».

2. **Who does your organization serve?** *(Choose one.)*

   ◯$_0$ I do not represent an organization. → **SKIP TO QUESTION #7.**

   ◯$_1$ An entire geographic community. →**CONTINUE TO QUESTION #3.**

   ◯$_2$ Specific communities (e.g., age, race, health care needs). → **SKIP TO QUESTION #4.**

   ◯$_9$ Prefer not to answer. →**SKIP TO QUESTION #7.**

3. **What is the approximate population of the geographic area served by your organization?** *(Choose one.)*

   ◯$_1$ Less than 2,500.

   ◯$_2$ Between 2,500 and 10,000.

   ◯$_3$ Between 10,000 and 50,000.

   ◯$_4$ 50,000 or more.

   ◯$_5$ Don't know.

   What is the name of the geographic area your organization serves?

   _____→ **SKIP TO QUESTION #5.**

   ◯$_9$ Prefer not to answer.

CONTINUE TO NEXT PAGE. →

4. Which specific communities does your organization serve?
(Check all that apply.)

◯1 African American (American-born).

◯2 African-born.

◯3 American Indian.

◯4 Asian American/Pacific Islander.

◯5 Hispanic/Latino.

◯6 White/Caucasian.

◯7 Other racial or ethnic group.

Which other racial/ethnic group(s) does your organization serve?

_____

◯8 Youth (under age 18).

◯9 Seniors (over age 60).

◯10 People with disabilities.

◯11 Immigrants/Refugees.

◯12 LGBTQ (Lesbian, gay, bisexual, transgender, queer/questioning).

◯13 People with low-income backgrounds/people living in poverty.

◯14 People with mental health or substance use disorders.

◯15 Veterans.

◯16 Other.

What other community or communities does your organization serve?

_____

◯17 Prefer not to answer.

CONTINUE TO NEXT PAGE. →

5. **Overall, how much do you think your participation on «CLT_Name» has the potential to affect the health of the communities your organization serves?** *(For example, by making it easier to find healthy food or walk to the store.)*

◯1 No effect.

◯2 Minor effect.

◯3 Moderate effect.

◯4 Major effect.

◯8 Don't know.

◯9 Prefer not to answer.

6. **Please explain how your participation on «CLT_Name» benefits your organization and/or the communities it serves.**

_____

_____

_____

_____

_____

_____

_____

_____

CONTINUE TO NEXT PAGE. →

We know that some communities in Minnesota experience health inequities, and we would like to know whether these communities are directly engaged in SHIP work. The next few questions ask about which communities you can speak to the experience of and how your participation on «CLT_Name» affects those communities. All questions are voluntary.

7. Which of the following communities can you speak to the experience of?
(Check all that apply.)

◯1 African American (American-born).

◯2 African-born.

◯3 American Indian.

◯4 Asian American/Pacific Islander.

◯5 Hispanic/Latino.

◯6 White/Caucasian.

◯7 Other racial or ethnic group.

Which other racial/ethnic group(s) can you speak to the experience of?

_____

◯8 Youth (under age 18).

◯9 Seniors (over age 60).

◯10 People with disabilities.

◯11 Immigrants/Refugees.

◯12 LGBTQ (Lesbian, gay, bisexual, transgender, queer/questioning).

◯13 People with low-income backgrounds/people living in poverty.

◯15 Veterans.

◯16 Other.

What other community or communities can you speak to the experience of?

_____

◯17 Prefer not to answer.

CONTINUE TO NEXT PAGE. →

8. **Overall, how much do you think your participation on «CLT_Name» has the potential to affect the health of the communities you selected above?**
(For example, by making it easier to find healthy food or walk to the store.)

◯1 No effect.

◯2 Minor effect.

◯3 Moderate effect.

◯4 Major effect.

◯8 Don't know.

◯9 Prefer not to answer.

9. **Please explain how your participation on «CLT_Name» benefits you and/or the communities you selected above.**

_____

_____

_____

_____

_____

_____

CONTINUE TO NEXT PAGE. →

We are interested in knowing how you feel about your participation on «CLT_Name». This last set of questions asks you to reflect on your experience working with SHIP staff and other members of «CLT_Name».

10. Please provide an overall rating of the following items as they relate to your experience with «CLT_Name».
(Check one box in each row.)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know	Does not apply to me	Prefer not to answer
a. I am able to actively participate in «CLT_Name».	◯1	◯2	◯3	◯4	◯5	◯7	◯8	◯9
b. I am able to influence the agenda of «CLT_Name».	◯1	◯2	◯3	◯4	◯5	◯7	◯8	◯9
c. I am able to influence decisions of «CLT_Name».	◯1	◯2	◯3	◯4	◯5	◯7	◯8	◯9
d. I am able to see my impact and know how it has made a difference in «CLT_Name».	◯1	◯2	◯3	◯4	◯5	◯7	◯8	◯9
e. I am able to build new relationships with members of «CLT_Name».	◯1	◯2	◯3	◯4	◯5	◯7	◯8	◯9
f. I am able to work with other members of «CLT_Name» to build partnerships or collaborations that impact the overall health of the community.	◯1	◯2	◯3	◯4	◯5	◯7	◯8	◯9

CONTINUE TO NEXT PAGE. →

11. Which of the following best describes the relationship between SHIP staff and «CLT_Name»?

(Choose one answer. Note that answers increase in level of engagement.)

◯1 **Outreach.** (SHIP staff provide «CLT_Name» members with updates and information on SHIP work.)

◯2 **Networking.** (In addition to Outreach, «CLT_Name» members share ideas and information with SHIP staff.)

◯3 **Cooperating.** (In addition to Outreach and Networking, «CLT_Name» members and SHIP staff share resources and alter activities to achieve common goals, such as engaging in joint communication strategies.)

◯4 **Collaborating.** (In addition to Outreach, Networking and Cooperating, «CLT_Name» members and SHIP staff build capacity for mutual benefit, e.g., through shared learning or new partnership opportunities.)

◯5 **Shared leadership.** (In addition to Outreach, Networking, Cooperating and Collaborating, «CLT_Name» has final decision making authority over the direction of «CLT_Name» and SHIP work.)

◯8 Don't know.

◯9 Prefer not to answer.

12. Is there anything else you would like to share about your participation on «CLT_Name»?

_____

_____

_____

_____

_____

_____

_____

Thank you! Please return your survey by July 17, 2017 in the envelope provided. Questions? Comments? Contact Health.SHIP.Eval@state.mn.us or call 651-201-3667.