Partnerships-in-Action Session

All Health is Local: Building Collaborations in the Community

Presenters: Mary Jo Baisch, PhD, RN, Assistant Professor, UWM College of Nursing; Bev Zabler, PhD, RN, Special Projects Director, UWM Institute for Urban Health Partnerships; Beth Peterman, MS, RN, APNP-BC, Director, UWM House of Peace Community Nursing Center; Terry Boatman, Children’s Outing Association Youth and Family Centers; Kris Peterka, BSN, RN, Riverwest Health Initiative

Bev Zabler: The University of Wisconsin (UWM) Institute for Urban Health Partnerships (IUHP) includes the Silver Spring Community Nursing Center (SS CNC), the House of Peace Community Nursing Center (HOP CNC), and the Riverwest Health Initiative (RHI).

The evolution of community-based organizations (CBOs) began with a focus on recreation in the 1950s, moved on to social services in the 1960s, education in the 1970s, and finally health care in the 1980s.

The UWM School of Nursing began partner shopping in the 1980s and first linked with the Silver Spring Neighborhood Center at 5450 North 64th Street in 1986. In 1991, a partnership was developed with the House of Peace located at 1702 West Walnut Street. Finally in 1995, the partnership with the Children’s Outing Association Youth & Family Centers at 909 E North Avenue and the Wright Street Resource Center at 901 E. Wright began.

The IUHP follows the Lundeen nursing center model. Our nursing centers are comprehensive, providing care from “womb to tomb”, are collaborative, coordinated, culturally competent, and continuous. It is community-based; not just a building in the community but us in the community. We have a sustained presence in the community and participate in community events. Finally, we are caring in work.

[Handout] – Where do we fit into the picture of comprehensive community-based primary health care? Nursing centers provide primary, secondary, and tertiary prevention services, are located in the community and bridge the gap between public health agencies focused on primary prevention and medical care facilities aimed at secondary and tertiary prevention.

Beth Peterman: The House of Peace houses a food pantry and clothing closet and works in the areas of food access and adult education needs.

Mary Jo Baisch: Our commitment to the community is on an ongoing basis. Typically, academics are governed by academic calendars and funding cycles. Despite these constraints, we have maintained a continuous presence in the community.

What is community health? Community health is grounded in philosophical beliefs of social justice and empowerment. Community health is dynamic and contextual and is achieved through participatory community development processes. Community health is based on ecological models that address broad determinants of health. Community health is promoted by
partnership of community members and professionals who are aligned with the community’s culture. The focus of a partnership’s collaborative work is population-based health promotion and disease prevention.

The IUHP uses Healthier Wisconsin Partnership Program principles and the Community Toolbox’s six components of multicultural collaborations to guide its work. The partnering models are similar in that both include having a shared clear vision and mission, open communication, conscious relationship building, and action steps for partnership development. The two models differ in that the HWPP places emphasis on ongoing evaluation and feedback, outcome measurement, and shared resources and credit while the Tool Box focuses on creating leadership opportunities, actions to combat oppression, and modeling of multicultural relationships.

Terry Boatman: Laying out the foundation and the initial steps are the most difficult part of the partnership process. Partnerships may be initiated catalysts like for example Dr. ?. He had recently moved into Riverwest and knocked on COA’s door stating that he wanted to help improve health in the community. Other catalysts might be personal relationships and risk-taking. At the organization level, we had a series of “what if?” meetings to brainstorm what we would do if we had no limits. During this phase we also explored the different capacities and resources of the partners and identified appropriate models of practice and partnering. We chose the Institute of Medicine model for the Riverwest Health Initiative partnership. The partnership was facilitated by existing relationships between CBOs and in 2004, the original partners included the COA, Pierce Elementary School, Peace Learning Center, SDC Community Partners, Riverwest Pierce Community Nursing Center, Columbia St. Mary’s Family Health Center, and Riverwest Currents, the local newspaper.

Mary Jo Baisch: Long before the search for funding began, we engaged in a community health assessment process which focused on ongoing neighborhood capacity development and a random household survey. The survey component was planned with community members and social marketing was used to promote participation. The survey was adapted from a previously used instrument. A main issue was how we get representation (data) from those that are never at the table. It was decided to randomly select households and oversample target populations. The survey measured various domains included basic demographics, environmental factors, physical and mental health conditions, health behaviors, healthcare access and utilization, and finally, program planning. In all, 257 surveys were returned and the data analyzed with descriptive statistics. The results were validated through community focus groups.

Kris Peterka: I have been the district nurse, based at COA, for the last two years. The results of the assessment indicate several community strengths. In terms of health behaviors, over 70% of respondents had a doctor’s and/or dental appointment in the last 2 years, 81% felt they could get an appointment when they needed one, 60% ate 3-5 vegetables and fruits each day, and 80% exercised at least three times per week. In terms of neighborhood safety, only 18% were worried about being alone in their homes and almost 85% said there were people in their neighborhood who they could contact for help. Less than 30% reported diagnosed health conditions. These included allergies, high blood pressure, depression or other mental health
issues, high cholesterol, asthma, other lung conditions, and arthritis. Less than 20% reported serious health complaints and these included those related to vision, pain, and dental health.

The assessment data also revealed several challenges. Reported wellbeing problems included: managing stress, feeling sad, hopeless, or worthless, feeling alone, eating nutritious meals, family problems, and communication among family members. Between 18-20% reported serious concerns regarding drug use, noise, theft or burglaries, and violence in Riverwest. In terms of health behaviors, about 40% were not eating enough fruits and vegetables and 35% ate fast food daily or a few times a week. 26% smoked cigarettes and/or were at risk for second hand smoke in their homes. 21% reported skipping meals because they can’t afford them. In only 66% of household was every member covered by health insurance, cost kept 37% from seeing a doctor or buying medication in the previous year, and only 18% had an advance care plan for end of life. Based on these findings, we developed four health priorities: access to care, food insecurity, mental health, and neighborhood safety. Also seen as important, community capacity was added as an additional priority.

In my work, I get to be embedded in the neighborhood. I go to schools, and attend street festivals and association meetings. I try to listen with openness, sincerity, and non-judgment in order to get residents to want to work with me. Projects that we have been able to launch include the Wright Street Resource Center which houses a free store. People can donate items and anyone who is in need may take them. There is also a time exchange program taking advantage of the assets and capacities of residents. We have a 123-bed community garden, a mental health support group, and an elderly group.

What began in 2004 with 7 partners now has over 60 partners.

Beth Peterman: Reflecting on the application of these models on our partnerships, we see a multitude of cultures that are necessary to be able to do this kind of work: academic, health care provider, CBOs, community culture including ethnic, religious, and gender, and private business. The challenges in partnering that we have confronted include funding, particularly categorical funding, the general political and economic context, opportunity costs for example do it well now or pay for it exponentially later, and as always, issues of sustainability. Another major challenge is that of understanding your partners. What are their core principles, assumptions, and values; their philosophies; pre-set agendas and preconceived notions. As well, we have to develop a common language, accept the diverse roles each partner fills, and value the expertise of each and their cultural nuances and traditions. Organizational and structural changes also represent challenges. Communication issues, such as are we actively, compassionately, and nonjudgmentally listening? Do we sit with the community? Who represents the community? We have realized that you have to welcome the elephant in the room, acknowledge and talk about it. IRB protocols can also be an issue due not only to the trans-organizational nature of the partnership but its transdisciplinary nature as well.

The rewards of the partnership have included a continuous improvement of communication skills and validation of academic evidence through grassroots expertise feedback.
Mary Jo Baisch: Are there any successes or challenges that you [the audience] would like to share with us?

Audience Member: I am in Waukesha where we have a growing Hispanic population. Their needs are also growing; how can we address this?

Mary Jo Baisch: The issues of racism are huge; it's the elephant in the room. We need to figure out ways to address racism in Wisconsin. It has a huge impact on incarceration, health, and education. We have not been addressing racism, or segregation.

Terry Boatman: It's helpful to let the community say what its needs are, allowing them a voice. Our predetermined agenda for them may not be where they want to start. You need to be flexible, focus on capacity building and be prepared for the process to be time and labor intensive.

Audience Member: Did you do more than one needs assessment?

Terry Boatman: We did just one needs assessment. We held community meetings and checked in with residents to see if they thought the results were reliable and rang true to them.

Beth Peterman: In the Hmong community, we needed to go back several times in order to make sure we were on the same page as their needs.

Audience Member: I see mostly women in the room and an all woman panel. How do we bring our men into this? How can we strengthen our families by including men again?

Kris Peterka: I actually do get to work with a lot of men. Surprisingly, the mental health piece has allowed me to interact more with men.

Bev Zabler: The way you invite people in and are present to them is important. For the Silver Spring Center we held town hall meetings, interest groups formed, and people felt listened to. An example of this is the Pearls For Girls school program. The boys wanted to know why they weren't getting anything. They were able to voice this because they knew they would be listened to. We need to address gender issues and be conscious of them.

Audience Member: 35% of African-American men are unemployed. Many are uninsured and there is a long waiting list for BadgerCare Plus. How can they access health care?

Kris Peterka: I'm really frustrated by that. There are 80,000 on the waiting list. What I do is help piece together the available resources, refer to free clinics, etc. It's very frustrating.

Beth Peterman: Has there been any kind of task force for men returning from prison? We try to help in nursing centers but we have limitations. How do we get a task force going?

Emmanuel Ngui (MCW): It's possible they're getting better care in prison than in the community. Men have totally been left out of discussions of maternal and child health here in WI and NC. Focus has been so much on women and the stress is wearing them out and there's no one to help. How do we actively engage men? An NIH forum on perinatal depression found
that 10-15% of men suffer from post-partum depression. What are the underlying causes? Most of these men are not working and so are hidden.

Mary Jo Baisch: As health care providers we see categorical approaches to health care are more severe than ever. For example, the Family Planning Waiver in Wisconsin in late 90s. I was excited not because it offered family planning but because it provided access to care to women and now men. We as health care providers do a bad job; we need to look at individuals in the context of their families. The provider is looking at body parts and not the person. We need to look carefully at what we do to get over this categorical approach.

Audience Member: The Salvation Army is doing great work in transitional programs from prison. MATC, and WATC, as well as the YMCA, offer free training.

Mary Jo Baisch: They are doing great work but their budgets are so small that they can only serve a few. We need to advocate for policy changes. We need to document what we do and the impact, implications, and importance of our work.