Public Health
MADISON & DANE COUNTY
Healthy people. Healthy places.

Phone (608) 266-4821
Fax (608) 266-4858
www.publichealthmdc.com

PHMDC & JFF Collaboration

What are we trying to accomplish?

Increase collaboration in order to enhance programs and services to be more responsive to community needs.

What will collaboration look like?

- Public Health Nurses in collaboration with JFF colleagues will:

    - ***team*** on cases as appropriate to support increased access to care.
    - ***assess*** needs of individuals and community related to access to opportunity,
    - identify, create, and utilize ***data*** to inform decisions, strategies
    - ***research*** evidence based and promising practices that improve (health) outcomes in the community setting,
    - identify and implement ***intervention/prevention*** strategies,
    - ***collaborate*** with stakeholders,
    - provide culturally competent health ***education*** materials and resources to partners and clients.
    - develop ***policy*** to support improving health outcomes and access to opportunity,
    - ***evaluate*** impact of collaboration ***and*** individual/community outcomes; and
    - ***assure*** appropriate services are provided to meet community needs

to support individual, family, and community level needs by mobilizing partnerships, leveraging new or existing resources and informing decision making opportunities to improve health outcomes.

What does our shared success look like?

- Improved neighborhood-level data collection and sharing.
- Streamlined referral process between PHMDC and DCHS will be developed or enhanced.
- Increased understanding of barriers to care
- Improved access to care for individuals and neighborhoods
- implementation of health education trainings
- Inventory of partnerships to determine new and existing opportunities for collaboration to improve health of community
- Creation of new or leveraging of existing partnerships in response to community needs assessment.
- Identification of pathways to achieve a diverse workforce

How will this work be done? 3.0 FTE PHNs to be allocated to work as follows (allocation below per each 1.0 FTE):

(.8 FTE – co-located at a JFF site)

- Serve as an active member of an interdisciplinary JFF team; collaborating to provide evidenced-based, high quality, health and racial equity informed services.
- Collaborate in development and delivery of programs and activities that promote health and racial equity and prevent disease, in settings including, but not limited to Health Department buildings/sites, homes, community organizations, schools, and the community in general.
- Identify and systemize a process for JFF workers to refer to PHMDC and other health related agencies that more effectively link clients to services.
- Collaborate with JFF to deliver targeted, culturally-appropriate information to families to support health promotion and disease prevention.
- Participate in, and act as a liaison with, other community agencies and professionals in collaborative efforts to address community health priorities.
- Use data to drive decision-making.

Activities to include:

- PHNs conduct 1:1s with JFF staff at five sites and document successes and challenges
- PHNs present on their field; host Q&A session to JFF all staff meeting
- JFF present at PHMDC to share social worker scope of practice
- PHNs attend JFF staff meetings
- PHNs attend PHMDC Community Health all staff, team meetings, and required workgroup meetings
- PHN and JFF attend Neighborhood Resource Team meetings
- Inventory JFF focus areas in the neighborhood

- Map stakeholders in the neighborhood
- Shadow JFF workers
- Engage stakeholders through 1:1 meetings
- Collect and analyze data
- Prioritize community health issues
- Document and communicate results
- Identify underutilized resources
- Create links between organizations, between residents and organizations, or between organizations and systems so that clients can take advantage of more than one resource at a time
- Work with partners to identify resources, opportunities, and systems not yet in the neighborhood, but desired by residents, and identify a plan for implementation
- PHNs to familiarize with existing JFF data collection tools for prevention and intervention
- Enhance JFF data collection tools for assessing community needs and tracking referrals
- Establish process metrics to document workflow

(.2 FTE –located at PHMDC to support collaboration)

- Work alongside PHMDC evaluators to identify evaluation timelines and frameworks.
- Work collaboratively with PHMDC Epidemiologists, Planners, and Data Analysts to identify data needs and systems for sharing data.
- Work with PHMDC policy analysts and local policy-makers to advocate for policy and systems change
- Partner with PHMDC programs to ensure systems for tracking and improving referrals between PHMDC and JFF.
- Work with PHMDC content experts to identify and deliver ongoing training to support the needs of JFF staff.

What does this work look like? An example:

In the past month JFF staff have consulted/collaborated (*teaming*) with the PHN several times about a series of client health concerns. The PHN is tracking reoccurring "themes", such as a number of cases of infants experiencing uneven breathing (*assessment*). The PHN reaches out to a partner who specializes in Pediatric Health (*collaboration*). The PHN works with JFF to schedule a training for JFF staff (and other connected service providers) to build their understanding and their ability to support the families they serve in determining if uneven breathing is natural for a baby, or a cause for concern (*education*). The PHN then determines if the intervention/training decreases the number of families experiencing and reporting breathing concerns (*evaluation*). The PHN in collaboration with other PHMDC staff then investigates potential root causes of breathing problems in infants (*research*). The PHN then maps the areas where families

live who are reporting these issues (*data*). The PHN determines if the families are living in smoke-free housing complexes (*prevention*). If the families are not, the PHN or other PHMDC staff (i.e, tobacco control) will work with the landowners to develop best practices to improve residential air quality (*policy*).

Pilot Timeline: