
Welcome to the Performance Improvement Managers Network Call

The Role of Community Engagement in Community Health Improvement

June 28, 2012

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Centers for Disease Control and Prevention

Office for State, Tribal, Local and Territorial Support

Agenda

Today's Presenters:

Michael Hatcher, Agency for Toxic Substances & Disease
Registry (ATSDR)

Tres Hunter Schnell, New Mexico Department of Health

Neil Hann, Oklahoma State Department of Health

Moderators:

Liza Corso & Teresa Daub, CDC/OSTLTS

The Role of Community Engagement in Community Health Improvement



Michael T. Hatcher, DrPH
Chief, Environmental Medicine Branch
Division of Toxicology and Human Health Sciences (proposed)
Agency for Toxic Substances and Disease Registry

Disclaimer: The findings and conclusions in this presentation are those of the author and do not necessarily represent the views of the Agency for Toxic Substances and Disease Registry.

<http://www.atsdr.cdc.gov/communityengagement/>

Agency for Toxic Substances and Disease Registry

Division of Toxicology and Human Health Sciences (proposed)



Presentation Objectives

Participants will be prepared to:

- Describe use of Principles of Community Engagement in community health improvement
- Describe the community engagement continuum as an organizing concept for engaging population segments by levels of engagement and participation

Presentation Objectives continued

Participants will be prepared to:

- Discuss the relationship community engagement has in collaborative decision-making and intervention design
- Examine community engagement practice and organizational management in performance improvement of Essential Public Health Services

Defining Community Engagement

Community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people.

Principles of Community Engagement*

- Be clear about the populations/communities to be engaged and the goals of the effort.
- Know the community, including its economic condition, political structure, norms, history, and experience with engagement efforts.
- Go into the community to build trust and relationships and to seek commitments from formal and informal leadership.

Reference: <http://www.atsdr.cdc.gov/communityengagement/index.html>

Principles of Community Engagement continued*

- Accept that collective self-determination is the responsibility and right of all community members.
- Partnering with the community is necessary to create change and improve health.
- Recognize and respect community cultures and other factors affecting diversity when designing and implementing engagement approaches.

Principles of Community Engagement continued*

- Sustainability results from mobilizing community assets and developing capacities and resources for community health decision-making and actions.
- Be prepared to release control to the community and be flexible enough to meet its changing needs.
- Community collaboration requires long-term commitment.

*Condensed in consideration of space limitations.

Principles of Community Engagement - Second Edition

Principles of Community Engagement

- Foreword
- Executive Summary
- Chapter 1. Literature Review
- Chapter 2. Principles
- Chapter 3. Successful Examples
- Chapter 4. Managing Organizational Support
- Chapter 5. Challenges
- Chapter 6. The Value of Social Networking
- Chapter 7. Program Evaluation
- Chapter 8. Summary
- Appendix A: Acronyms
- CTSA Community Engagement Key Function Committee
- Publication Development
- Order a Print Copy

Previous Version

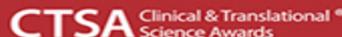
[Principles of Community Engagement, 1997 Edition](#)

[ATSDR](#)

PRINCIPLES OF
COMMUNITY ENGAGEMENT
SECOND EDITION



**Clinical and Translational Science Awards Consortium
Community Engagement Key Function Committee Task
Force on the Principles of Community Engagement**



NIH Publication No. 11-7782

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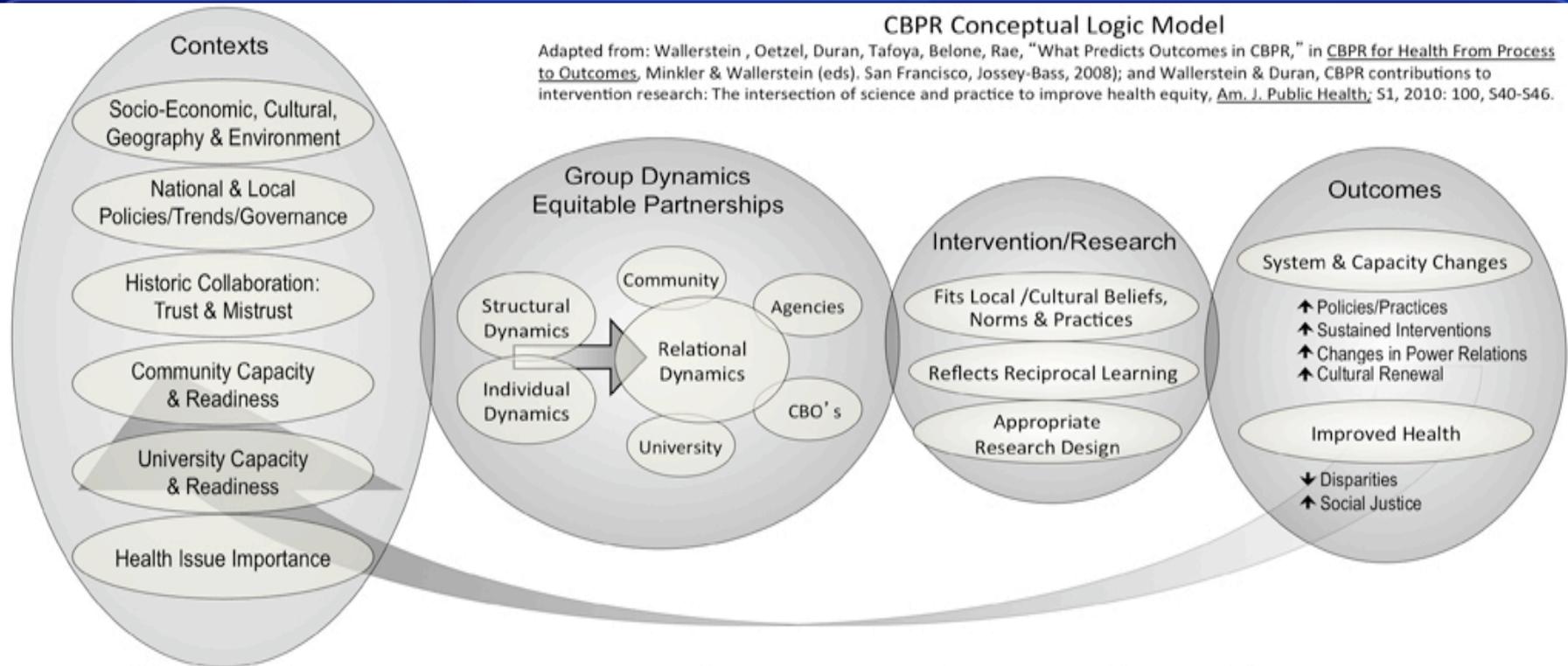
Community Engagement Continuum: Increasing Level of Community Involvement, Impact, Trust, and Communication Flow

Outreach	Consult	Involve	Collaborate	Share Leadership
Some community involvement	More community involvement	Better community involvement	Community involvement	Strong bidirectional relationship
Communication flows from one to the other, to inform.	Communication flows to the community and then back, answer seeking.	Communication flows both ways, participatory form of communication.	Communication flow is bidirectional.	Final decision making is at the community level.
Provides community with information.	Gets information or feedback from the community.	Involves more participation with community on issues.	Forms partnerships with community on each aspect of project from development to solution.	Information is co-developed with the community.
Entities coexist.	Entities share information.	Entities cooperate with each other.	Entities form bidirectional communication channels.	Entities have formed strong partnership structures.
Outcomes: Optimally, establishes communication channels and channels for outreach.	Outcomes: Develops connections.	Outcomes: Visibility of partnership established with increased cooperation.	Outcomes: Partnership building, trust building.	Outcomes: Broader health outcomes affecting broader community. Strong bidirectional trust built.

Reference: Modified by the authors from the International Association for Public Participation
 Figure 1.1. Community Engagement Continuum reproduced from, Principles of Community Engagement: 2nd Edition

CBPR Conceptual Logic Model

Adapted from: Wallerstein, Oetzel, Duran, Tafoya, Belone, Rae, "What Predicts Outcomes in CBPR," in *CBPR for Health From Process to Outcomes*, Minkler & Wallerstein (eds). San Francisco, Jossey-Bass, 2008); and Wallerstein & Duran, CBPR contributions to intervention research: The intersection of science and practice to improve health equity, *Am. J. Public Health*; 51, 2010: 100, S40-S46.



Contexts	Group Dynamics		Intervention/ Research Design	Outcomes
<ul style="list-style-type: none"> •Social-economic, cultural, geographic, political-historical, environmental factors •Policies/Trends: National/local governance & political climate •Historic degree of collaboration and trust between university & community •Community: capacity, readiness & experience •University: capacity, readiness & reputation •Perceived severity of health issues 	<p><u>Structural Dynamics:</u></p> <ul style="list-style-type: none"> • Diversity • Complexity • Formal Agreements • Real power/resource sharing • Alignment with CBPR principles • Length of time in partnership <p><u>Individual Dynamics:</u></p> <ul style="list-style-type: none"> • Core values • Motivations for participating • Personal relationships • Cultural identities/humility • Bridge people on research team • Individual beliefs, spirituality & meaning • Community reputation of PI 	<p><u>Relational Dynamics:</u></p> <ul style="list-style-type: none"> • Safety • Dialogue, listening & mutual learning • Leadership & stewardship • Influence & power dynamics • Flexibility • Self & collective reflection • Participatory decision-making & negotiation • Integration of local beliefs to group process • Task roles and communication 	<ul style="list-style-type: none"> •Intervention adapted or created within local culture •Intervention informed by local settings and organizations •Shared learning between academic and community knowledge •Research and evaluation design reflects partnership input •Bidirectional translation, implementation & dissemination 	<p><u>CBPR System & Capacity Changes:</u></p> <ul style="list-style-type: none"> • Changes in policies /practices <ul style="list-style-type: none"> -In universities and communities • Culturally-based & sustainable interventions • Changes in power relations • Empowerment: <ul style="list-style-type: none"> -Community voices heard -Capacities of advisory councils -Critical thinking • Cultural revitalization & renewal <p><u>Health Outcomes:</u></p> <ul style="list-style-type: none"> • Transformed social /econ conditions • Reduced health disparities

Community Engagement Practice Elements

- Know the community, its constituents, and capabilities (2,6,7,9)*
- Establish positions and strategies to guide interactions (1,4,6,8,9)*

Reference:

http://www.atsdr.cdc.gov/communityengagement/pce_mos_intro.html

* Specific community engagement principles

Community Engagement Practice Elements

- Build and sustain networks to maintain relationships, communications, and leveraging of resources (3,7,9)*
- Mobilize communities and constituencies for decision-making and social action (4,5,6,7,8,9)*

Reference: http://www.atsdr.cdc.gov/communityengagement/pce_mos_intro.html

* Specific community engagement principles

Position and Strategy Development

- Authoritative strategy applies rules and regulations to require a desired action
- Competitive strategies attempt to make an organization's position more desirable and attractive to constituents

Reference: Hasenfeld. *Human Service Organizations* (Englewood Cliffs, NJ: Prentice-Hall, 1983)

Position and Strategy Development

- Cooperative strategies establish agreements that offer mutual benefits to constituents and their organizations
 - Contracting
 - Coalition
 - Co-optation
- Disruption strategies are “the purposeful conduct of activities which threaten the resource-generating capacities” of an adversary

Table 4.2. Establish Positions and Strategies to Guide Interactions²

²CCAT propositions and the principles of community engagement are numbered in accordance with their order in their original text, not according to their table Position

Community Coalition Action Theory	Principles of Community Engagement	Structural Capacity Needed
<p><u>Propositions:*</u></p> <p>4. Coalitions form in response to an opportunity, threat, or mandate.</p> <p>7. Coalition formation usually begins by recruiting a core group of people committed to resolving the issue.</p> <p>9. Open, frequent communication creates a positive climate for collaborative synergy.</p> <p>10. Shared and formalized decision-making helps make collaborative synergy more likely through member engagement and pooling of resources.</p> <p>12. Strong leadership improves coalition functioning and makes collaborative synergy more likely.</p> <p>13. Paid staff with interpersonal and organizational skills can facilitate the collaborative process.</p> <p>14. Formalized rules, roles, structures, and procedures make collaborative synergy more likely.</p> <p>16. Synergistic pooling of resources promotes effective assessment, planning, and implementation.</p> <p>17. Comprehensive assessment and planning aid successful implementation of effective strategies.</p> <p>18. Coalitions that direct interventions at multiple levels are more likely to create change in community policies, practices, and environments.</p> <p><small>*References: Butterfoss, 2007; Butterfoss et al., 2009. Reprinted with permission of John Wiley & Sons, Inc.</small></p>	<p><u>Principles:</u></p> <p>1. Be clear about the population/communities to be engaged and the goals of the effort.</p> <p>4. Remember that community self-determination is the responsibility and right of all people who comprise a community.</p> <p>6. Recognize and respect the various cultures of a community and other factors that indicate its diversity in all aspects of designing and implementing community engagement approaches.</p> <p>8. Be prepared to release control to the community, and be flexible enough to meet the changing needs of the community.</p> <p>9. Community collaboration requires long-term commitment.</p>	<p><u>People Skilled in:</u></p> <ul style="list-style-type: none"> • Information and policy analysis, strategic planning and strategy development, and initiative planning and implementation. • Collaborative methods to work with diverse populations and build community capacity to analyze and apply information in decision making. • Resource identification and leveraged resource management. <p><u>Information/Data on:</u></p> <ul style="list-style-type: none"> • Populations potentially affected by positions under consideration and influencing factors of socioeconomic, cultural, and other contextual data. • Population response anticipated based on beliefs, attitudes, past behaviors, and readiness to act and participate. • Opportunities to engage opinion leaders in position and strategy determination. <p><u>Organizational Structures to:</u></p> <ul style="list-style-type: none"> • Establish information systems to obtain formative information on issues for which community engagement is needed. • Analyze the range of solutions or actions, unintended consequences, and the opportunities to successfully address the issue(s) where community engagement is intended. • Project resource needs and potential ways to attract, leverage, and manage resources. • Present positions and negotiate consensus on community actions or what outcomes to achieve. <p><u>Fiscal and Physical Support for:</u></p> <ul style="list-style-type: none"> • Personnel budget for strategic and program planning, and development of community capacity to act. • Office space for staff engaged in strategic and program planning. • Communication and computer hardware and other office equipment to support position and strategy development activities.

Framework to Identify Aims

The role of
Public Health
described as:

Definitions of
Public Health

Public Health
Vision

3 Core
Functions

10 Essential
Services

Operational
Definition of a
Local Health
Department

With optimal
improvement in
population health
as the ultimate
goal, what
characteristics
describe:

The fundamental
tactics to fulfilling
the role of public
health?

The expected
outcomes?

Aims (Characteristics)

- Population-Centered
- Equitable
- Proactive
- Health Promoting
- Risk-reducing
- Vigilant
- Transparent
- Effective
- Efficient

Framework to Identify Aims

The role of
Community
Engagement in
Public Health
described as:

Defined as:

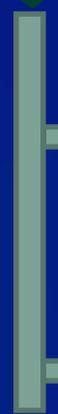
Guidance of the
Principles of
Community
Engagement

Organizational
Management of
Community
Engagement

Service
Elements of the
10 Essential
Public Health
Services



With optimal
improvement in
population health
as the ultimate
goal, what
characteristics
describe:



The fundamental
tactics to engage
the community in
public health?

The expected
outcome levels?



Aims (Characteristics)

- Population-Centered
- Equitable
- Proactive
- Health Promoting
- Risk-reducing
- Vigilant
- Transparent
- Effective
- Efficient

Tactics for Community Engagement

- ❑ Outreach
- ❑ Consultation
- ❑ Involvement
- ❑ Collaboration
- ❑ Share Leadership
- ❑ Individual Dynamics
- ❑ Relational Dynamics
- ❑ Structural Dynamics

Interaction Outcomes for Community Engagement

- Optimally, establishes communication channels and channels for outreach
- Develops connections
- Visibility of partnership established with increased cooperation
- Partnership building, trust building
- Broader health outcomes affecting broader community
- Strong bidirectional trust built
- System and Capacity Outcomes

System and Capacity Outcomes for Community Engagement

- Change in policy and practice
- Change in power relationships
- Empowerment
 - Community voice heard
 - Capacity of advisory councils
 - Critical thinking

Health Outcomes for Community Engagement

- Transformed social and economic condition
- Improved population health indicators
- Reduced health disparities

Evaluation Types and Phases

Table 7.1. Types of Evaluation Questions by Evaluation Phase

	TYPES OF EVALUATION QUESTIONS	
Evaluation Stage	Quantitative	Qualitative
Planning	What is the prevalence of the problem?	What are the values of the different stakeholders? What are the expectations and goals of participants?
Implementation	How many individuals are participating? What are the changes in performance? How many/what resources are used during implementation?	How are participants experiencing the change? How does the program change the way individuals relate to or feel about each other? To what extent is the intervention culturally and contextually valid?
Outcome	Is there a change in quality of life? Is there a change in biological and health measures? Is there a difference between those who were involved in the intervention and those who were not?	How has the culture changed? What themes underscore the participant's experience? What metaphors describe the change? What are the participant's personal stories? Were there any unanticipated benefits?

References: Holland et al., 2005; Steckler et al., 1992.

Reference: http://www.atsdr.cdc.gov/communityengagement/pce_program_approaches.html

Questions to Evaluate Community Engagement

- Are the right community members at the table?
- Does the process and structure of meetings allow for all voices to be heard and equally valued?
- How are community members involved in developing the program or intervention?

Questions to Evaluate Community Engagement

- How are community members involved in implementing the program or intervention?
- How are community members involved in program evaluation or data analysis?
- What kind of learning has occurred, for both the community and the academics?

Thank you for interest and for
the important work you do!

Question?



<http://www.atsdr.cdc.gov/communityengagement/>

Agency for Toxic Substances and Disease Registry

Division of Toxicology and Human Health Sciences (proposed)

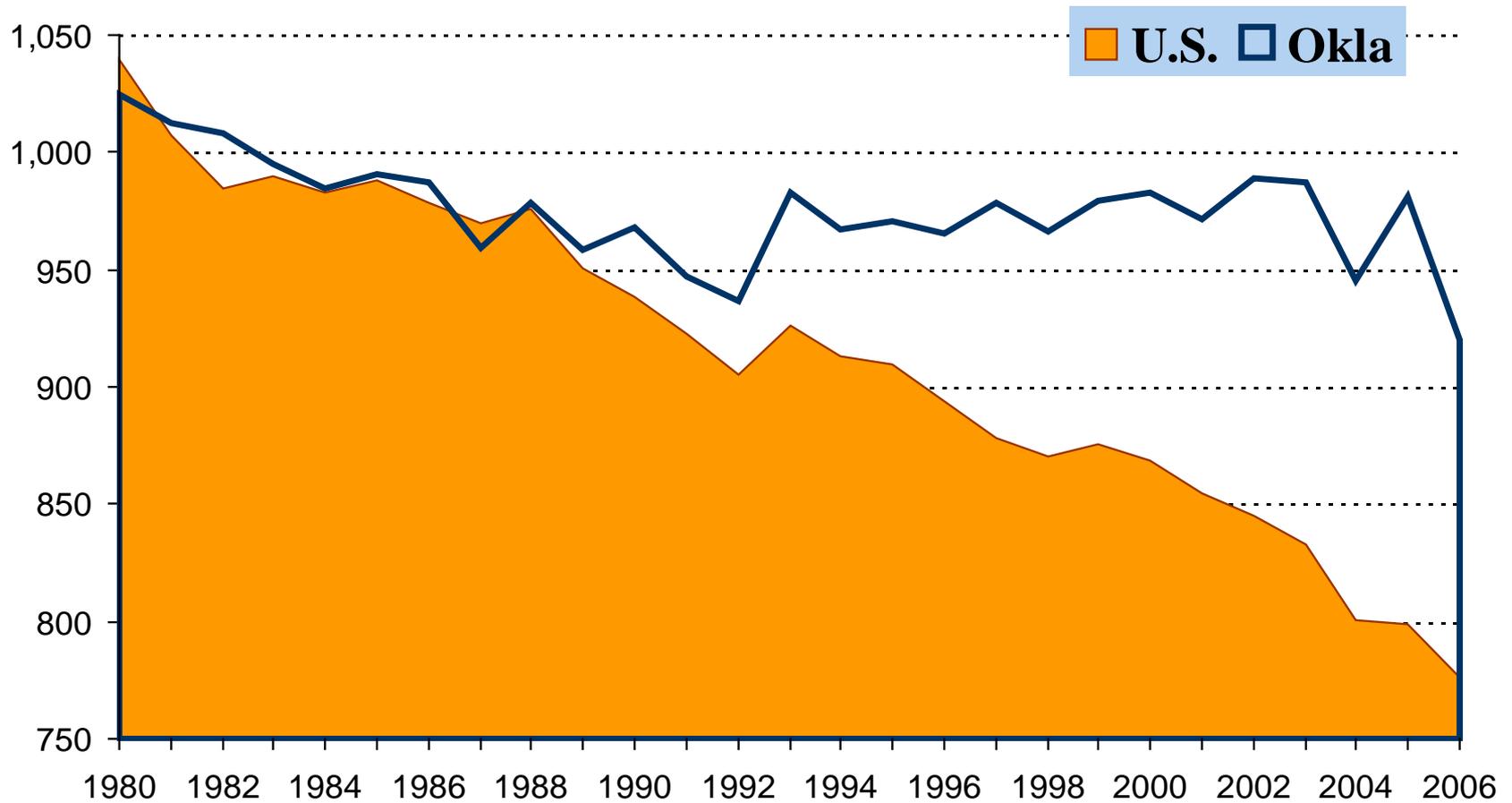


Oklahoma Turning Point

From Poor Health Outcomes to
Community Partnerships

Neil E. Hann, MPH, CHES
Chief, Community Development Service
Oklahoma State Department of Health

Oklahoma Age-Adjusted Death Rates



Public Health Practice in Oklahoma: Historical Perspective

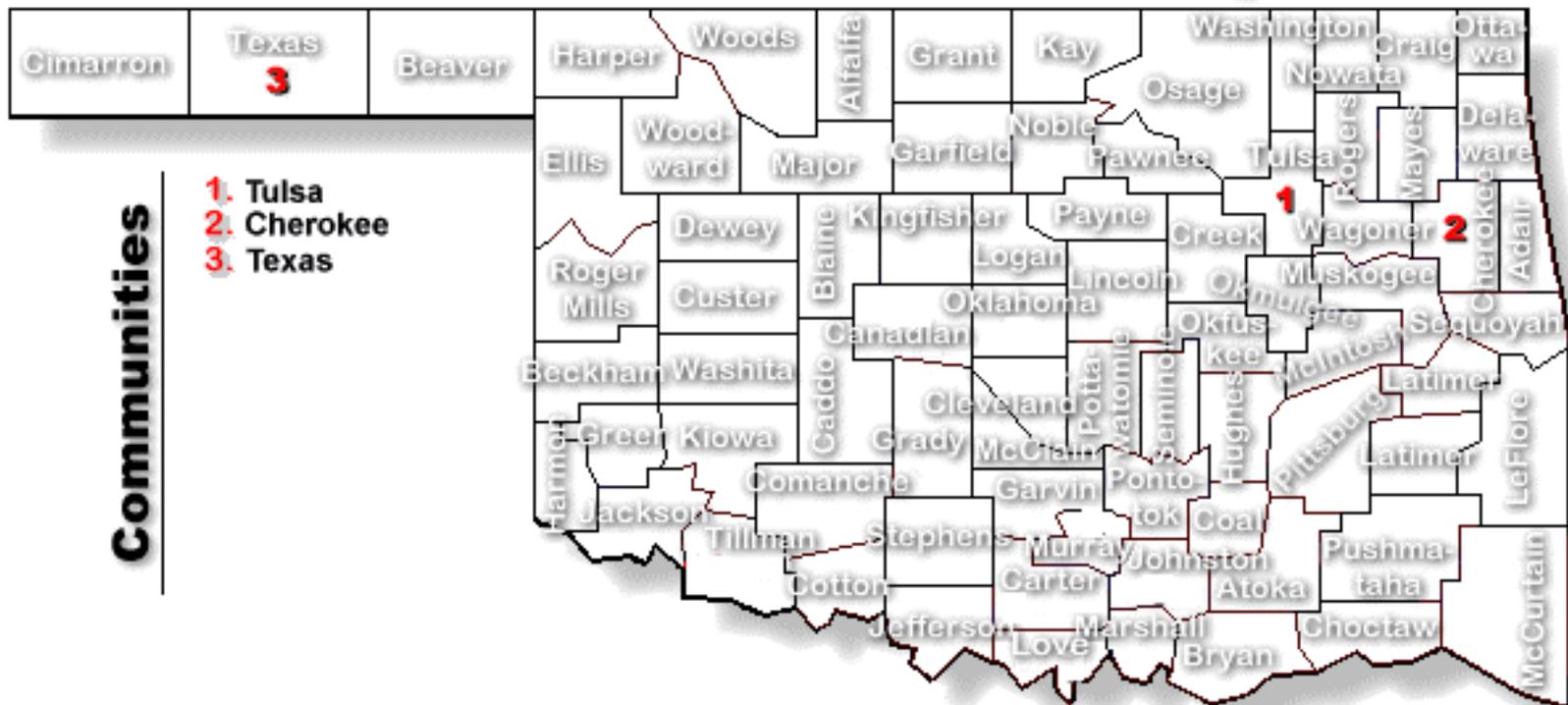
- A Centralized System.
- Decisions made at the Central Office and implemented in communities in a “cookie-cutter” fashion.
- Result -- no health improvement.

Healthy Communities

- Turning Point: Building Healthy Communities in Oklahoma through Partnerships.
- Develop a “new way of thinking” about health in Oklahoma which emphasized collaboration of key state and local partners.

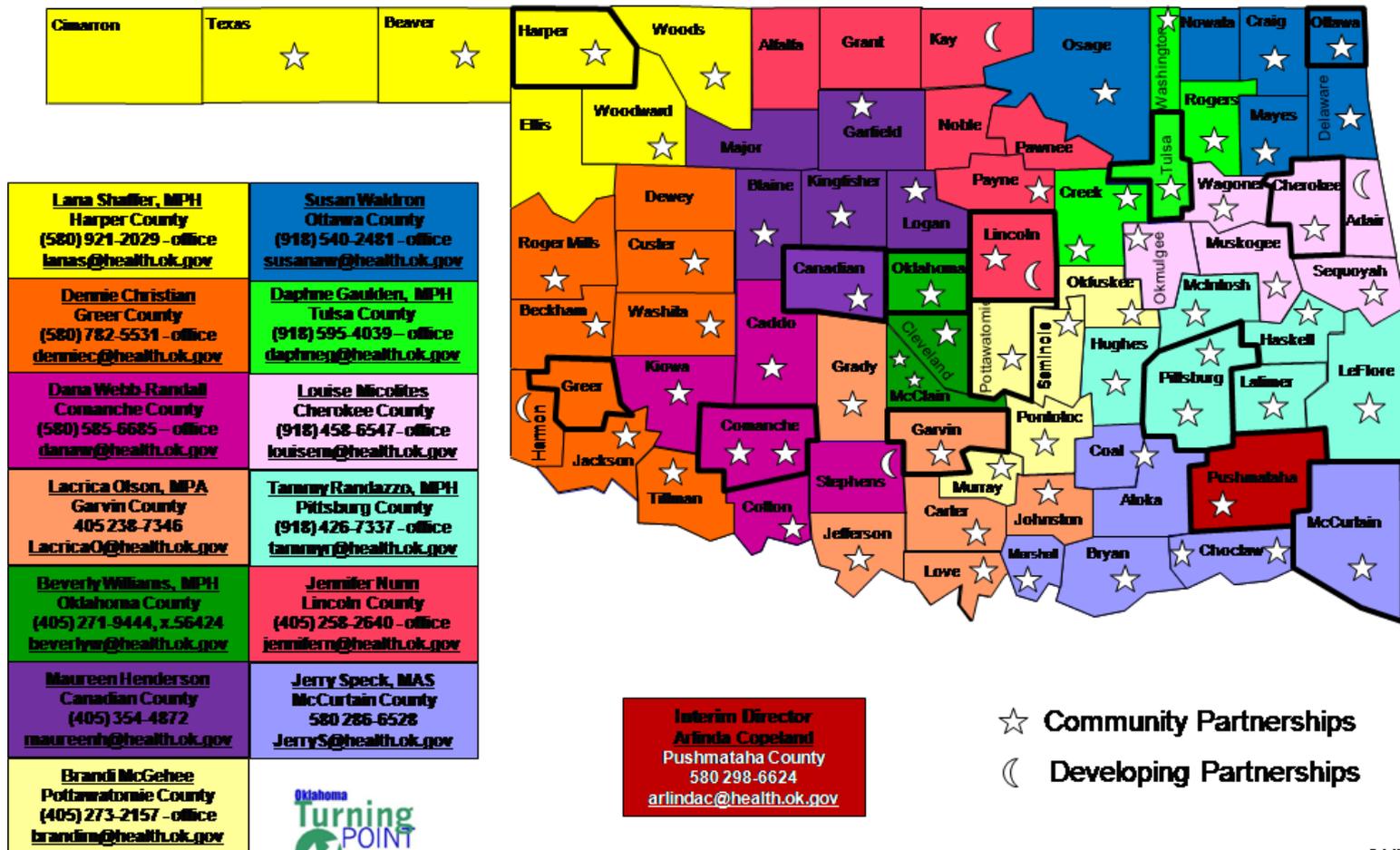
Community Partnerships

- Began in 1998 with three community partnerships.



Community Partnerships

- Today, there are over 70 community partnerships.



Health Improvement System Changes

- Communities with an equal voice in public health decisions.
- Public health workers supportive to community-based decisions and initiatives.



Health Improvement System Changes

- Turning Point formally endorsed by the State Board of Health in 2000 as the key philosophy to approach public health and prevention.
- Turning Point built into the organizational fabric of the State Health Department through the Community Development Service.



Lessons Learned

- Collaboration works!
- Giving up control and not being concerned about who gets credit contributes to the success of partnerships.
- Dedicated staff for partnership development is important.

Final Thoughts

- It's all about relationships.
- It's about *us* working together to build healthy communities.
- The same relationships that are made for community health improvement efforts are needed when a new public health threat emerges.

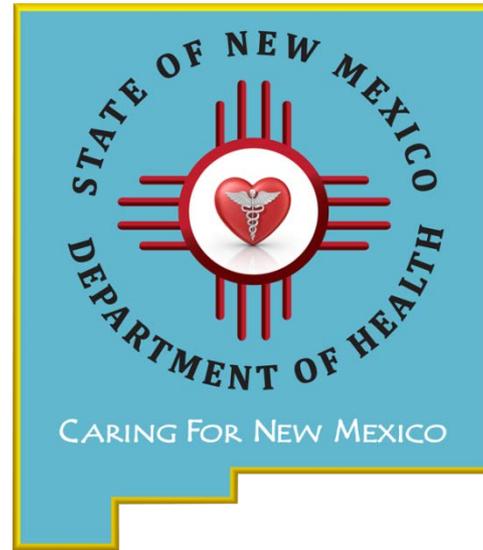


Building Healthy Communities

“Undoubtedly the most important personal change from Turning Point is a better understanding of my community...my involvement in Turning Point created a new enthusiasm for public health and the potential for making an impact. I felt empowered to really create change – something that without the synergy of the group I would not have thought possible to do. Turning Point taught each of us that we can change and can more effectively serve our community if priorities and solutions are developed and implemented locally.”

Ed Kirtley, Past Chair, Texas County Turning Point Partnership

THE JOURNEY TO IMPROVE POPULATION HEALTH



**New Mexico
Department of Health**

NEW MEXICO

Land of Enchantment

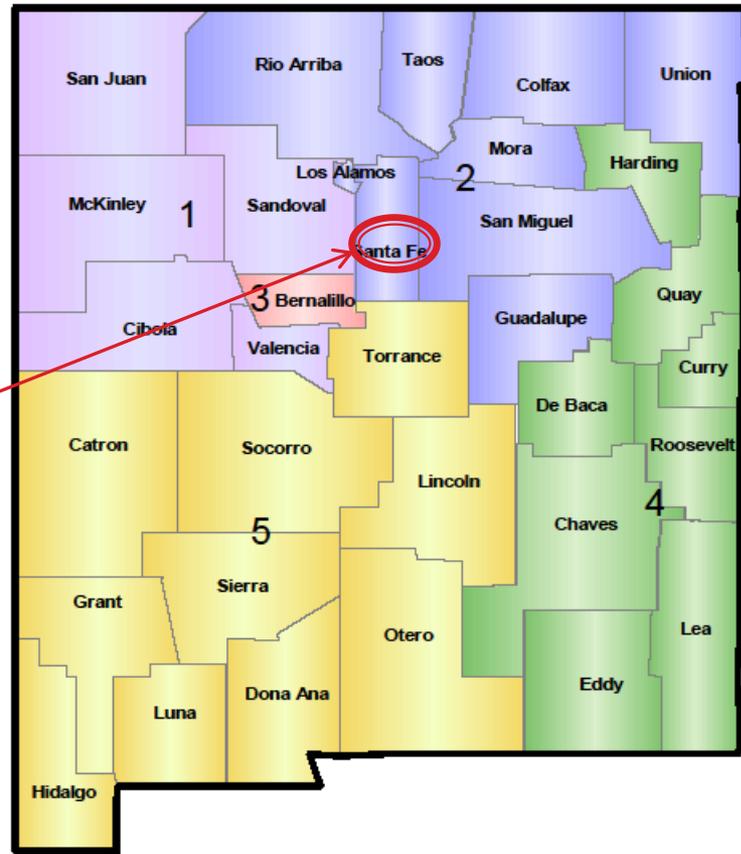


New Mexico... A Centralized Public Health System

Health Cabinet
Secretary and State
Offices

5 Public Health
Regions 55 Local
Public Health
Offices (all state
employees)

PHD Regions



Region 1: San Juan, McKinley, Sandoval, Cibola and Valencia;

Region 2: Rio Arriba, Taos, Colfax, Union, Los Alamos, Santa Fe, Mora, San Miguel and Guadalupe;

Region 3: Bernalillo County;

Region 4: Harding, Quay, De Baca, Curry, Roosevelt, Chaves, Eddy and Lea;

Region 5: Torrance, Catron, Socorro, Lincoln, Grant, Sierra, Hidalgo, Luna, Doña Ana and Otero.

Effective July 1, 2005

Questions & Discussion

All lines are open and live!

*Please remember to use your mute button or *6*

Thank you!

Please send your questions and
comments to:

pimnetwork@cdc.gov



Centers for Disease Control and Prevention

Office for State, Tribal, Local and Territorial Support