

The Role of Community Engagement in Community Health Improvement

CDC Performance Improvement Managers Network Call

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Today's Presenters: Michael Hatcher, Agency for Toxic Substances and Disease Registry (ASTDR)
Joyce Marshall & Neil Hann, Oklahoma State Department of Health

Moderator: Liza Corso, CDC/OSTLTS

Kelly (Operator): Welcome and thank you for standing by. At this time all participants are in a listen only mode. To ask a question during the question answer session, please press star one. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I will turn the call over to Ms. Liza Corso. Ma'am you may begin.

Liza Corso: Thank you very much. Welcome, everyone, to the June Performance Improvement Managers Network Call. I'm Liza Corso with the Office for State, Tribal, Local and Territorial Support, and I'm joined here today by quite a few of our colleagues from OSTLTS. We are delighted that you could join us for today's call. This is our fifth call this year in the monthly webinar series for performance improvement managers. As you know, the PIM Network is a forum intended to support all performance improvement managers in learning from each other as well as from partners and experts in the field, and we have one of those with us today. These calls are also a way for members of the Network to get to know each other better, learn about best practices in quality improvement and performance management, and share information about resources and training opportunities. And as such, you will hear from two of your colleagues and grantee jurisdictions as well. So on today's call we'll have a look at community engagement with an emphasis on community health assessment and community health improvement planning, a topic quite relevant to NPHII activities. But before we introduce our speakers, let's review some of the technological features of today's call. Teresa Daub is going to be doing that.

Teresa Daub: Thank you, Liza. For those of you who are not able to access the web portion of the call, please refer to the slides that were emailed to you yesterday. They will be covered during today's presentation. For those of you who are on the Live Meeting site, you will see the slides on your screen. You may also download these slides via the icon at the top right of your screen. This is the icon that looks like three sheets of paper. If you're on the web, you may see other sites participating in today's



call by looking at the “Attendees” button under the link at the top left. We will be taking questions on the call today and there are two ways that we can take your questions and feedback. First, you may type in your questions and comments at any time during the call by using the Q and A box, which you can find by clicking “Q and A” in the toolbar at the top of your screen. Secondly, we’ll open the lines for discussion after our presentation so please mute your phones now, either by using the mute button on your phone or pressing star six on your phone’s keypad. This will help us keep background noise to a minimum when the lines do go live. One thing to note about questions that are submitted via Live Meeting, the “Q and A” box, if you prefer to remain anonymous in your question, please type “Anon” either before or after your question to help us with that.

The call today will last approximately one hour. It is being recorded and the full presentation will be archived on the OSTLTS PIM Network web page. As usual, we’ll have a few polls on our call today. Our first poll is right now. The question at hand is “Please indicate your affiliation. State health department, tribal health department, local, territorial, national public health organization or other. We like to get a sense of who is joining the network on the call. Okay. Thank you for participating. We will want to hear your feedback on today’s call as well so in addition to the polls during the presentation, we will have a final poll at the end of the hour where you can tell us what you thought about the call today. Now I’ll turn it back to Liza.

Liza Corso: Thanks, Teresa. Our first presenter today is Dr. Michael Hatcher. Dr. Hatcher is the Chief of the Environmental Medicine branch in the Division of Toxicology and Human Health Sciences of the Agency for Toxic Substances and Disease Registry, ATSDR. Dr. Hatcher has quite a few years at the local, state, and federal level. He’s been here at CDC for twenty-two years and I got to know him through some of the work we did back in PHPPO in the previous location here at CDC when we were developing the MAPP tools. Many of you might be familiar with the MAPP Community Health Improvement Planning Tool. He’s also spent time at the state level in Texas, as well as San Bernardino County. Our voices from the field today will include Tres Hunter Schnell, New Mexico’s Performance Improvement Manager and she also now holds a dual role as also the Director of Accountability and Policy, and we’re also joined by two individuals from Oklahoma; Joyce Marshall, of course is the Performance Improvement Manager, but joining Joyce, is Neil Hann, the Chief of Community Development Service with the Oklahoma State Department of Health and Neil will be speaking about some of the community engagement work they’ve been doing in Oklahoma. Michael, the floor is yours.

Michael Hatcher: Good afternoon everyone, I’m delighted to be with you today and have a chance to chat with you a little bit about community engagement. And what I’d like to do today is work with you so that you have an understanding of the principles of community engagement and specifically those in the text, *Principles of Community Engagement*, and how those apply in general to other work that you’ve been involved in I’m sure for a number of years yourself; describe the continuum of community engagement as well as discuss the relationship of engagement in collaborative decision making and examine the engagement practice and organizational management in performance of essential public health services.



The *Principles of Community Engagement* document was released in 1997, the first edition of that document. Recently we have worked with the National Institutes of Health, and in 2011 released the second edition. In both of those editions, the definition of community engagement is the process of working collaboratively with and through people affiliated in the geographic proximity, etc. The focus here is the real broad sweep of community engagement.

Now, I just want to touch base with you briefly on the principles themselves. These principles, again, have been in play for the past fourteen years, so they may seem very basic and second nature at this particular point. But when they were first released in 1997, they really shaped the overview of how people thought about working in and with communities. In some regard, they've changed the way we talk about working with and in communities in that, in 1997 the terms usually used were: community involvement, community organization. Today the prevalent term is community engagement. Even if we look into health systems and hospitals, we now have directors of community engagement in those facilities. Part of the reason for that is that the NIH Research Translation Group has really adopted them and incorporated them into their research work with communities to bring clinical testing and perceptions into the community with that work. So be clear about the populations and the communities you want to engage. Know the communities and know them in ways of the economics, the political, the history, the experience that they've had with you as an organization as well as others. Go into the community, those words are really relevant; go into the community to build trust. Later on in the presentation I want to come back to this, because this is a factor of how you approach the community. If you choose to go in, that signals one approach. If you choose to bring them to you, it may signal another.

Accept that collective self-determination is the responsibility and the right of the community members. So the democratic process is in play when you start engaging the community. Partner with the community is necessary to create change. I refer back to something that happened here in Atlanta ten or twelve years ago. There was a project that they wanted to improve a community here in Atlanta and they brought massive resources from the outside into that community to change the community. But the problem was that community was not fully engaged and once those resources were withdrawn, that community went back to the same conditions it was prior to that massive influx of resources.

Recognize and respect community cultures and other factors of diversity. Sustain the results of mobilizing community assets and develop capacities and resources. Without that community involvement and without that engagement sustainability is a real issue. Be prepared to release control of the community and be flexible. And this is where we really think about the empowerment side. If that community wants to go in a specific way and they have the capability to do that, we've got to work with that. Community collaboration requires long-term commitment.

That being said on the principles, I hope you don't think I'm preaching to the choir, but I did want to lay those out and just talk about them. And I hope that they are part of your culture and part of the way that you think about working with the communities today. If that's the case, then the years that these have been at play have made a change in the way that we think about community work.



We have a first poll here. If you would, please respond to this.

Liza Corso: So for the folks who may not be seeing this by webinar, just so you know, that the poll is asking, 'How do you engage communities you work with?' And the options are, 'Select the ones you use most often.'

Michael Hatcher: The options of response were: 'meet with community and present information on public health issues and recommend needed actions; hold a community meeting or forum and gather community input; form a coalition to analyze public health problems and collectively plan implementation interventions; or plan a series of activities to address health issues and engage the community to participate in delivery.' In the poll we have the largest response in forming coalitions followed by hold a community meeting in a forum to gather community input. These are all very appropriate ways to engage the community and I want to talk with you a little bit about that if we can move past this poll.

Okay, let me back up just one second. When we were speaking about the publication, *Principles of Community Engagement*, I wanted to just basically show you the web page where this material is online. If you are not familiar with it, the chapters that are in the second edition of this book are the literature review; a review of the principles; examples of those principles being applied; a chapter on managing organizational support for community engagement; challenges that are faced in community engagements; value of social networking; program evaluation; summary of overview and concluding remarks for the book. For those of you that aren't seeing the slides, those were the chapters within that. This is available both in English and Spanish. And the quickest way to find it is through ATSDR, community engagement, and it should pop up relatively quickly in your browser search.

Now, back to the poll. If we look at this continuum of community engagement, this is one that's been used in various ways across different ways that people talk about engagement. But if we think about the diversity of a community and how we engage the community, we work across this continuum. On those communities that we have not necessarily built partnerships and trust with, we work on the outreach portion. On those where we need some quick responses, we need to start understanding their needs, their viewpoints, consultation is a role of engagement. Involvement, collaboration, and shared leadership, these are all levels of the engagement process and a way to think about when you're planning community engagement and looking at the segments of the community that you want to engage, you can evaluate what relationship you already have with those communities and think about where you want to start in the engagement process on a particular topic or issue. So I wanted to point that out. This is in the *Principles of Engagement* literature review, so you can find more information on that there.

Okay, we'll just skip this poll. The next chart is basically the chart that looks at the community participatory research approach. Again it looks at contextual issues across the board through the dynamics of engagement to the kinds of outcomes and so forth that are accomplished. I present these because I want to talk about them a little bit more in just a couple of minutes. Now before we get into



dissecting and looking at how to perhaps assess the capacity in the work that's being done, I want to talk about a framework you may consider in your organizational approach to community engagement.

This is reflected in chapter four of the *Principles of Community Engagement*. If we look at this from a practice perspective, the way that practice can be managed is broken into four elements. The first element is: know the community, its constituents, and its capabilities. If we reflect back on that element, to the *Principles of Community Engagement*, that touches upon principle two, six, seven, and nine. The second area that we have is establish positions and strategies to guide interaction, touching upon principles of community engagement one, four, six, eight, and nine. Now with these two elements, the first is really again the intelligence gathering piece of this. What do we know about the community? What do we need to understand? What are their needs from the socio-economic information? And if you've got behavioral information in terms of behavioral risk factors, you can apply all of this and looking at what you know about the community: their desires, their social determinants, and so forth. But in engaging the community, there's two ways that you can think of a position. The position that you may have, may be an open position, where you say, 'I'm here to work with you on areas of health that are of interest to you.' So you come into the conversation without a set agenda. The other is a more closed position, where you say, 'I would like to work with you on cardiovascular disease.' So you limit the scope and you set parameters of the expectations in the way you approach the community. Some of the issues that I have seen over the years is it's sometimes we don't set those expectations and help communities understand why we're there and what to expect from us. For any of you that have been around long enough to remember the PATCH model that CDC used years ago. It came in with a perceived open agenda, but as it went towards intervention, it narrowed it to the area of chronic disease and that always didn't meet the expectations that the community first had and it created some hurdles that had to be moved beyond.

Do we have time to take this poll? Okay, let's take this poll real quick. When you establish an agency position on a health concern, which strategy type in this list below should be used in your community engagement effort? Is it authoritative, competitive, cooperative, disruptive, or none of the above? Okay, it looks like most of you are indicating cooperative, so let's go to the next slide, and let's talk about this a little bit.

Oh, that's an early poll I've got one more slide. The polls should be towards the end. Excuse me for this. The last two elements in the practice of community engagement are build and sustain networks to maintain relationships, communications, and leverage resources. That relates to practice areas three, seven and nine. And then the final is mobilize communities and constituencies for decision-making. That cuts across principles of community engagement four through nine. So each of these relate to multiple engagement principles, but they group those in a way that we really have a management cord to deal with it. In thinking about the intelligence gathering, a lot of that may be in a unit that is your surveillance unit and, your social demographics, etc. The position and strategy development may be in your policy arena, it may be in your planning functions. Your building and sustaining networks is really how you engage with the community, the communication tools you use, your communicators, your health



educators that are on the ground that maintain those relationships. And then the mobilizing aspect of this is actually where you bring the science of intervention to the process of mobilization and there's many tools that can be used in this particular aspect of it, but the one that I can refer to that I'm sure you're all aware of, MAPP, is an excellent tool in the process of mobilizing. So there's one other tool on the social intervention that is the partner tool. It's the Robert Wood Johnson tool that is a way to analyze your networks and we will make sure that you have that link so that you can reach that. And I know that some of our Oklahoma partners may be familiar with it as well.

Okay, now in terms of position and strategy development, we have to go back to what is the reason that we're engaging the community. If we're engaging the community in an emergency response, we may want to use an authoritative approach. There may not be time to go through a deliberative process of determining what the right action is. The same is if we're engaging the community around a regulatory issue, we actually are applying an authoritative strategy. So all of the things that we do, all of the things we have contact with the community, whether we realize it or not, we're approaching that community with a specific strategy. A competitive strategy is most often used in trying to determine who gets what funds, but there's also competitive ideas that may be at play if you're going through a health oriented referendum, where you're trying to compete for ideas that may end up making impact on the community in a way that relates back to health. So if it's that kind of situation, then you're in a competitive strategy and you have to plan accordingly.

The position when we look at cooperative is one that we are very well seeded in. It may be contracting with organizations to get the areas that you want; it may be coalition building; or it could be co-optation, bringing in people that may not see things exactly the way you do but bring them in and help them be a part of your process and both of you will benefit by a little give and take through that. The last area is the disruptive strategy and this is probably one of the strategies that has been used extensively in the last decade in the tobacco-related world where there is direct attempts to curtail the market of the tobacco industry either through smoking regulations or other moves to limit who smokes and where they can smoke. I wanted to bring those out because quite often when we think about community engagement and we think about what we want to do with them, we don't really plan accordingly the strategies that will be at play and most of what we do are mixed strategies. For example, the tobacco work is both disruptive and competitive if we think about the work that's done in anti-tobacco advertising.

This particular slide is not to be read. I just wanted to put this up because if we start thinking about how to assess and look at the capacity and capability of our workforce, our organizational structure, we can look at the areas that we know so well in looking at core functions: the human resources, the information resources, the organizational structure, and the physical capabilities. What this particular slide is is a table that is in chapter four of *Community Engagement* that crosswalks the community coalition action theory to the principles of community engagement for each of the four practice elements of community engagement and then looks at, what are the skills that people need for, in this case, the strategy, the position and strategy development. What are the informational resources, what



are the organizational structures? So this offers a starting point for you to think about how you would want to look at and examine the capacity components of community engagement within organizations as well as look at the structure itself.

I've thrown in a couple of slides; I don't really have a whole lot to say on those, but if you go back to your February meeting, this is a slide that I recreated out of it, looking at the roles, looking at the optimal improvements, the fundamental tactics, and the aims. I think if we look at community engagement in this way, then we have the guidance of the principles, over in the roles, within the community engagement areas. You will have a handout, a couple of pages, where I went in and I've drawn out pieces of the essential public health services that I think there's opportunities to look at community engagement. I think our end aims remain the same. But our tactics, if we go back to the earlier charts that we looked at, the tactics of outreach, consultation, involvement, collaboration, shared leadership, and if we drop into the chart that looked at the community engaged prevention research, they look at things like individual dynamics, relationship dynamics, and structural dynamics. I think those are all tactics that can be examined in the work of really examining performance in this area. I've not created any new models, I'm just showing you these two particular charts that I presented earlier and how they play out.

Now in terms of outcomes, I saw three different levels of outcomes. We have outcomes related to interactions, and those are presented here on this chart, and those are taken from the earlier material. We have outcomes of system capacity in community engagements, whether that's policies and practices, power relationships, or empowerment, and then we have health outcome. I'm not totally in agreement with the health outcome statements when they look at transformed social and economic conditions. I think those are bases of improved health outcomes, but I'm not sure they are health outcomes in and of themselves, but I reflected back on that slide here so that you could see how I pulled from that framework to think about the aims and the measurements.

If we're running short on time then I don't have to spend much time on this. This is basically questions, whether you're looking at process evaluation, whether you're looking at outcome evaluation, but when you're thinking of how to evaluate community engagement, the basic questions: Are the right people, the right community members at the table? Does the process and structure of the meeting allow for the voice? How are members involved in developing the program? So these are all ways of thinking about, are we doing things right, and are we doing the right things. So without going into those in any further depth, I will end my portion of the presentation, and thank you for the interest that you have in this work, and for the important work that you do out there.

Liza Corso: Thank you, Michael. That was wonderful, and we appreciate the way you've also actually linked the work on community engagement to the quality aims presented by Dr. Peggy Honoré on our February call. We are now going to turn it over to our partners from Oklahoma, Joyce Marshall and Neil Hann. Neil, I believe you're going to be jumping in now?



Neil Hann: Yes, thank you very much. I'm pleased to be here this afternoon to talk a little bit about Oklahoma's community engagement process that we call Turning Point. And if I can have the next slide. Can I have the next slide, please? Thank you. Just to give you a little bit of background – this slide shows Oklahoma's age-adjusted death rates, and you can see from the 1980s, Oklahoma's tracking well with the rest of the nation in terms of decreasing our death rates. That leveled out in 1988, and actually for a period of time, Oklahoma was the only state in the nation where our death rates were increasing whereas every other state in the nation was decreasing. This obviously caused a tremendous amount of concern for public health leaders in Oklahoma. And so innovative ways or solutions were sought to correct this, and we found a solution, which was the Robert Wood Johnson / Kellogg Foundation initiative called Turning Point. Probably many of you remember this initiative that started nearly 14 years ago. The application for proposals urged applicants to rethink the delivery of public health, placing the emphasis on state and local quality partnerships and receiving from community partners their priorities for public health interventions. Next slide, please.

Oklahoma has had a long history of having a centralized system, and actually this has been in many respects a very positive thing. Because of the centralized system, we have a well-trained public health workforce that spreads clear across the state who operate out of 68 county health departments out of 77 counties. So we have excellent infrastructure, we have an excellent workforce, and yet during the '80s and '90s and into the 2000s, we really were not having an impact at all on our health outcomes. And when we looked at the possible reasons, it became clear that the missing element was direct involvement of communities in public health decisions. Simply put, unless communities are actively engaged not only in determining their own public health needs but also developing and implementing solutions, improvement in community health will not be realized. Next slide.

So this idea of rethinking the delivery of public health and placing the emphasis on collaborative partnerships and receiving from community partners their priorities for public health interventions really represented, at least for Turning Point, kind of a radical change in how we approached public health in Oklahoma. And even though funding from the Robert Wood Johnson and Kellogg Foundations was not guaranteed, our commissioner at the time decided to move forward with the application because he understood really the urgency we had in Oklahoma with needing the change and restructure how public health was delivered. And he said that even if we didn't get the funding, this was the quote/unquote "philosophy" Oklahoma needed to adopt, which was really working with community partners on identifying not only local needs but implementing local solutions. Next slide, please.

We started out in 1998 with three community partnerships; very different communities – one was in the Texas panhandle, or in the panhandle Texas County. A second one was in Tulsa, which is of course a very urban area, and then the third one was in Cherokee County, which had a large Native American population. And, as expected, all three of these partnerships developed very differently, developed very different priorities, and formed differently in terms of the structure of their partnership. But what it provided, these initial three, was really three models that other communities could look to, and gave



other communities the confidence that they could in fact develop their own community partnerships and really have a voice in public health decisions. Next slide, please.

Today we have over 70 community partnerships that we work with all across the state, and they're supported by 14 regional Turning Point consultants, which I will briefly mention in just a few minutes. Next slide, please.

So because of our community engagement process, we're seeing significant community health system changes. Turning Point continues to tailor Oklahoma's public health needs based on real perceived needs of community members who have joined public health officials as equal partners in making public health decisions. Next slide, please.

The Turning Point philosophy of community health improvement through collaborative state and local efforts really has taken root in Oklahoma, and we'd like to say that it's really part of the organizational fabric of the state health department. In 2000, the State Board of Health adopted Turning Point as the key philosophy to approach public health and prevention, and as a result, we've really seen many significant system changes across the state. Namely, all 70 of those partnerships are engaged in some type of strategic planning process, most using the MAPP process that is working toward community health improvement plans. We've also through the years seen the establishment of community health centers. We've seen the removal of unhealthy snacks and unhealthy drinks in school vending machines. Local health and safety ordinances have been passed. We've seen the establishment of new county health departments in counties that did not have one before. Community trails, farmers markets, community gardens, and the list goes on. Very significant changes all across the state. Next slide, please.

So through the years we've learned a number of lessons, but I think three really stand out. First of all, there's no question collaboration works. Working together, sharing resources, and combining talent simply enhance the chances for achieving positive health outcomes. Collaboration results in outcomes greater than is possible when agencies, communities, and organizations work separately on parallel paths. The second lesson is giving up control and not being concerned about who gets the credit contributes to the success of partnerships. Although one agency or organization in a collaborative effort may be the first among equals, all of the partners are still equal, and it's the partnership that gets the credit for success, not one organization. And we have seen through the years that once all the partners within a collaborative partnership understand this concept, that partnership will thrive and really do amazing things. And then thirdly, I think one of the key successes in Oklahoma has been that we've had dedicated staff for partnership development. As I mentioned earlier, we have 14 Turning Point state consultants, and they're stationed locally at the local level, housed out of county health departments, and they provide support, in the background, to those partnerships. All partners in a collaborative effort are volunteers who have full time jobs and responsibilities, and even when those partners are completely dedicated and believe in the partnership philosophy to improve health outcomes, it's still difficult for a partnership to thrive without the dedicated staff. Next slide.



Final thoughts: Really, it's all about relationships, and here in Oklahoma, it's not the state people or the local people, but it's really us working together to build healthy communities. And that concept has really taken hold and I think that we can truly say that we have in all of our counties good collaborative relationships with many communities that are really equal partners with state health department officials making decisions about health improvement across the state.

And the final slide. I always like to end with this quote. It's from Mr. Ed Kirtley, who was one of the chairs of the Texas County partnership. And he said, "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 communities if priorities and solutions are developed and implemented locally." So with that, I'll end, and thank you very much.

Liza Corso: Thank you so much, Neil. It's really very impressive to hear about the work that Oklahoma has done and how you sustained this and spread it across the state in a very powerful way throughout the years. We were supposed to have Tres Hunter Schnell from New Mexico join us now, but she was unavoidably detained, so we're going to now segue into questions and answers and dialogue. So if the operator can open the lines, we'll take questions. But in the meantime, we do have one question that has come in on the computer, or by submitting a question online. And this is a question for Neil, although quite frankly I think either of you could be answering that, Michael or Neil. And that asks about, "What kind of dedicated staff for partnership development or community engagement is appropriate or needed, and how can this possibly be funded?"

Neil Hann: Well, I'll start. As I mentioned, we have 14 dedicated staff, and I actually have a director at Turning Point who supervises those staff. We started out initially with just me and one other staff person back in 1998 to staff Turning Point, but we quickly learned that really for those partnerships to be effective, staff was really needed just to do basic things like take minutes, to help the partnerships establish by-laws, to help with data interpretation, to help with data that was collected at the local level or data that was collected by the health department that needed to be interpreted for local needs. Staffing for just basic communication – getting out emails about meetings and notices about agenda items. So that type of work is extremely important because, again, particularly in rural communities, you have partnerships that are made up of people who have full time positions, and these same people that are on the health improvement partnership may also be on the local PTA, they may be on their church board of governance, they're on multiple other committees within that community, and they simply don't have the time to really manage the business of a partnership. And so staffing is important. The way we funded it? Most of our staff now are funded through state general appropriation funds, and that simply reflects the support from our leadership here at the state health department and the belief that they only way that we can really improve our outcomes on a statewide level is by engaging our local partners. And that's the kind of commitment that we have had, even with changing commissioners and



change in leadership. Any change in leadership, including new health board members, really see the value of that community engagement. They see the results that have occurred, and so we've continued to get not only support, but increased support throughout the years.

Michael Hatcher: I'd like to just add one thing. The table that I put up that looked at the crosswalk between the coalition theory and *Principles of Community Engagement* and the capacity components. That is one way to look at what you need not only in terms of people but also in terms of structure and so forth. The numbers there depend on the size of the organization. If it's a small county health department, you know you wear lots of hats. If it's a larger metropolitan one, then there's a breakup of ways that you can manage the engagement process. And it may not be one person. When I spoke a little bit earlier in terms of, "How do we know the community?" If you're in a large community, then quite often, especially at the state level, you have an organizational unit that looks at the surveillance statistics, the demographics, that brings in a lot of planning data to understand what a community looks like. You have your outreach and education people that may be doing the direct, hands-on. You have the management structure that helps establish those positions that you establish strategies and approaches around. So you've got to have someone that links to the community, but don't think that that person should be the entire resource because as an organization gets bigger or as you move from a small jurisdiction, I'm sure Neil can tell you, I'm sure they provide a lot of support to those working in the smaller areas to bring in some of those bits of information, whether its data or understanding on how to approach interventions and group processes and all that. So there's ways that you can dissect and come up with your own answer if you think about how to manage those processes.

Teresa Daub: Thank you, Michael. This is Teresa again, and Kelly, our operator, we'd like to open the lines now, please.

Kelly (Operator): Once again, to ask a question, please press star one. To withdraw your request, star two. Once again, to ask a question, please press star one.

Teresa Daub: Okay, if there are no questions on the line, we actually do have a few questions in the room. Harald, go ahead.

Harald Pietz: So my question was just some real world examples of do's and don'ts when you're holding kind of a broader community engagement session on what might be a sensitive topic. And there's a lot of material here. Just some practical wisdom of something you've experienced or witnessed to convey to the audience now, that might be a nugget to take with them.

Michael Hatcher: One of the things that I think is really important is for the community to understand why you're there. If you don't set those expectations, they form their own expectations. And if you don't say explicitly what you can do, what you can't do, then from the perspective of ATSDR, we do go into communities a lot, we do work with communities that are often at odds with each other because contamination issues are tied often to jobs, and those people that feel threatened with their jobs being taken away if the contamination issue is addressed are maybe quite hostile to people that are trying to point out the health impacts that are occurring. And the one thing that ATSDR has to always



communicate when they go in to do a health assessment is what they can do and what they can't do. They can make recommendations. They cannot regulate. They're not a regulatory... we're not a regulatory agency, so we can't say to the polluter that you have to do X, Y, or Z. What we can do is we can tell EPA that if this exposure path ... if there is an exposure path occurring, these are ways that it can be dealt with. EPA as the regulatory agency then takes the action that needs to be taken. But, again, often, people think that we can make those decisions, we can make compliance happen. So it's incumbent for us to say what we can and can't do up front and to be very mindful of the impacts that may have ramifications on the economy of the community if actions are taken.

Harald Pietz: Thank you.

Neil Hann: In Oklahoma, we probably don't have those kind of issues, difficult regulatory issues with our partnerships. All of our partnerships are really looking at local health improvement initiatives. And we don't come in really with any major expectations, other than providing that partnership with data and letting them interpret the data to determine what they believe their priorities should be for health improvement at the local level. We hope that they'll pick our key issues, which include child health improvement, obesity reduction, and tobacco use prevention efforts, and nearly all of them do pick those three flagship issues that are included in our Oklahoma Health Improvement Plan. But they also pick out of their own choosing some difficult issues, such as teen pregnancy and how to deal with high pregnancy rates with high schools, for example, in a small community. So those issues, we have found that our community partnerships are not afraid to tackle, and we don't have to prompt them. They make those decisions themselves. And again, what our role is is to simply be supportive, provide the data they need, provide some recommended evidence-based practices that they can implement as a community, that they can tailor specifically for their own needs within that community and give them the best resources we can in order for them to be successful.

Teresa Daub: Thanks, Neil, for adding that. Everyone, the lines are now open, so if there are any questions out there, any burning questions as we come to the end of our call, or any comments – please speak up now. Things from the field? Okay, thanks for your participation. I'll turn it back to Liza for final wrap up and announcements.

Liza Corso: Great. Thanks, Teresa. And I want to thank especially our speakers today, Dr. Michael Hatcher and Neil Hann for the wonderful presentations and discussion and of course I want to thank all of the performance improvement managers for participating on today's call. Before we leave today, we do have one more final poll. And the poll is, "How would you rate this webinar overall?" Our usual evaluation poll. And the poll is now open, so go ahead and cast your vote. Of course if you'd like to give us any additional feedback on today's call or suggest topics for future calls, please email us at pimnetwork@cdc.gov. We hope you'll plan to join us on July 26th for our next call. We'll be focusing on engaging leadership. Don't forget that you can also of course view and download these calls and materials on the PIM Network web site. We'll see you again in July. Thank you again, everyone, and goodbye.



Kelly (Operator): Thank you for participating in today's conference call. You may disconnect at this time.

