

Collaborative Leadership

Assessing the Environment

Facilitator's Guide

Collaborative Leadership

ASSESSING the ENVIRONMENT

Purpose

Provide tools and techniques for assessing the community and organizational environment for collaboration readiness and capacity.

Learning Objectives

1. Increase the conceptual understanding of Assessing the Environment and its interrelationship among the six Collaborative Leadership practices.
2. Identify the skills and qualities associated with the Collaborative Leadership practice of Assessing the Environment.
3. Examine the concept of Assessing the Environment as a practice of Collaborative Leadership.
4. Increase conceptual understanding of systems thinking and its relationship to environmental assessment for collaboration.
5. Increase awareness of cultural perspectives and how they affect the collaborative process.
6. Compare and contrast a variety of environmental assessment tools.
7. Create a Personal Learning Plan to increase competency in Assessing the Environment using outcomes of self-assessment and awareness of resources for extended learning.

Summary of Activities

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Equipment and Supplies

- LCD or overhead projector
- Chart paper
- Markers

Curriculum Materials

Participant Guide: Assessing the Environment

Slide Set: Assessing the Environment

Preparation

Copy *Participant's Guide*, one per participant.

Copy "slide set" handouts, one set per participant.

Read the "Introduction and Overview" section of the *Collaborative Leadership Learning Modules: A Comprehensive Series*.

Read "Understanding the Context of Collaboration," pp. 59-72, *Collaborative Leadership*, by Chrislip and Larson. (See Readings and Resources: ***Fundamental Concepts; Participant's Guide*, p. 20**); Review *Understanding the Context of Collaboration, Participant's Guide*, pp. 5-6).

Read *Introduction to MAPP* (Mobilizing for Action through Planning and Partnerships), four pages, <http://mapp.naccho.org/FullTextIntroduction.asp>.

Become familiar with the *MAPP Model*, <http://mapp.naccho.org/MappModel.asp>.

Read *The Four MAPP Assessments*, three pages, http://mapp.naccho.org/4_mapp_assessments.asp.

For Activity 8G, select one vignette for each of the four MAPP assessment tool groups (see *MAPP Assessment Tools: Sample Vignettes, Facilitator's Guide*, pp. 13-25).

Obtain and review APEXPH organizational assessment tool, <http://www.naccho.org/project747.cfm>.

Obtain and review SWOT analysis, http://ctb.ku.edu/tools/en/section_1049.htm.

Become familiar with the Collaborative Leadership Web site learning resources, www.collaborativeleadership.org.

Display Slide 1 as participants enter room.

1. Welcome and Program Introduction

- Review information contained on Slide 1.
- Introduce yourself and any other facilitators.
- Conduct a participant introduction activity.

Slide 1

Complex Problems → Collaborative Leadership → Effective Solutions

**The Turning Point Leadership Development
National Excellence Collaborative**

Vision: Collaborative leadership is used to its fullest potential to achieve policy and systems change that maximizes the public's health.

Mission: Increase collaborative leadership capacity across sectors and at all levels.

Other Turning Point National Excellence Collaboratives:

- Modernize public health statutes
- Create accountable systems to measure performance
- Utilize information technology
- Invest in social marketing

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2. Introduction to Collaborative Leadership and the Six Practices

Learning Objective: Increase the conceptual understanding of Collaborative Leadership and the interrelationship among the six Collaborative Leadership practices.

- Review *What is Collaborative Leadership?* (Slide 2).

Emphasize that “leadership” in this context is a verb, not a noun. This definition presents leadership as a process shared by all the members of a group.

Slide 2

What is Collaborative Leadership?

- The processes, activities, and relationships in which a group and its members engage in collaboration.
- Collaboration is defined as “exchanging information and sharing or pooling resources for mutual benefit to achieve a common purpose.”

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- Review *What is a Collaborative Leader?* (Slide 3).

Emphasize that “leader” is a role that may be shared among members of the group.

Slide 3

What is a Collaborative Leader?

Someone who safeguards and promotes the collaborative process.

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Slide 4

Who is a Collaborative Leader?

| Skills | Capacities |
|---------------------|--------------------|
| Conflict management | Uncertainty |
| Developing trust | Taking perspective |
| Communication | Self-reflection |
| Decision-making | Ego control |
| Creating safety | |
| Assessment | |

C. Review *Who is a Collaborative Leader?* (Slide 4).

Explain that these skills and capacities were identified through research with academia, key informant interviews and literature reviews.



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Slide 5

Why is Collaborative Leadership Important?

- Most public health problems are complex, interdependent, and messy.
- These type of problems require a systems approach with diverse input and multiple perspectives.
- Many sectors need to “own” the solution for it to be successfully implemented.

D. Review *Why is Collaborative Leadership Important?* (Slide 5).

- Provide examples of public health problems: teen pregnancy, water quality, chronic diseases, and communicable disease control.
- Issues are not clear-cut, nor are the solutions.
- Root causes are unknown or so massive that one agency or sector within a community cannot effectively deal with problems of this scope independently.
- Stress the need to collaborate in order to share information and resources to enhance the capacity of another to achieve a common goal or good.



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Slide 6

Six Practices of Collaborative Leadership

E. Introduce *Six Practices of Collaborative Leadership* (Slide 6).

1. Make the following points:

Because collaboration is challenging, it takes special skills to create and sustain it.

There are a number of critical skills and capacities collaborative leaders should possess.

Many are not unique to Collaborative Leadership.



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F. Review *Six Practices of Collaborative Leadership* and how the six practices were chosen (Slide 7), based on the information from page 3 in *Introduction and Overview*.

Slide 7

Six Practices of Collaborative Leadership

- Identified by the Turning Point Leadership Development National Excellence Collaborative
- Research included:
 - Literature reviews
 - Individual interviews
 - Focus groups
 - Expert panel debates
 - Attendance at leadership development training programs

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G. Define and explain each practice (Slide 8, *Participant Guide*, p. 1-2).

Slide 8

Six Practices of Collaborative Leadership

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- **(AE) Assessing the Environment:** Understanding the context for change before you act.
 - The capacity to recognize and understand other perspectives.
 - Facilitating connections and identifying clear and beneficial change for all participants.
 - Setting priorities and identifying barriers and obstacles.

- **(CC) Creating Clarity:** Defining shared values and engaging people in positive action.
 - Commitment to a cause that transcends the self.
 - Recognition of a spiritual reality or imperative, ethical and moral standards that provide guidance.
 - Developing a shared vision based on common values.
 - Helping people develop confidence to mobilize (take positive action).

- **(BT) Building Trust and Safety:** Creating safe places for developing shared purpose and action.
 - A two-way street—in order to build trust, you must be trustworthy.
 - Necessary for open expression of ideas, questions, and raising doubts.
 - To be successful this takes communication skills—those skills that enhance trust and promote respect.
 - A previous history of working together successfully in limited capacities allows partners to develop trust and respect for one another.

- **(SP) Sharing Power and Influence:** Developing the synergy of people, organizations, and communities to accomplish goals.
 - Participants in the decision-making process need to be empowered in order to contribute fully.
 - The energy of participants focused on a goal generates power; power is not a finite resource.

- **(DP) Developing People:** Committing to bringing out the best in others and realizing people are your key asset.
 - Maximizing the use of other people's talents and resources.
 - Building power through sharing power.
 - Giving up ownership and control.
 - Coaching and mentoring to create power in others that increases leadership capacity for the whole group.

- **(SR) Self-Reflection:** Being aware of and understanding your values, attitudes, and behaviors as they relate to your own leadership style and its impact on others.
 - At "the heart" of all the other practices: Self-reflection is internal while the others are external.
 - The ability to gain insight from one's own experience or action to try to assess the significance of what has happened.
 - Personal CQI—Continuous Quality Improvement: the capacity to engender a never-satisfied attitude that supports setting goals for personal development and learning.

H. Explain the Collaborative Leadership model (visual representation):

1. The collaborative process is triggered by a complex problem (left arrow), which enters the system through either Creating Clarity (CC) among a group or Assessing the Environment (AE) through a formal needs assessment process.
2. These practices are interactive and dynamic, often influencing each other in unplanned ways.
3. They are necessary to finding and implementing an effective solution (right arrow).

3. Module Purpose and Objectives

Learning Objective: Increase understanding of the purpose and learning objectives of this module.

A. Refer to and review *Module Purpose and Objectives (Participant's Guide, p. 3)*.

4. Assessing the Environment Skills: Self-Assessment

Learning Objective: Identify the skills and qualities associated with the Collaborative Leadership practice of Assessing the Environment.

- A. Distribute *Collaborative Leadership Assessing the Environment: Self-Assessment Exercise, Participant's Guide*, p. 4, and ask participants to complete it by reflecting on their own skills related to assessing the environment—understanding the context for change..
- B. Ask them to rate their Behavior Frequency for each item.
- C. Tell them that they will use the information from self-assessment when completing a learning plan at the end of the workshop.
- D. Debrief by asking: “Based on what we’ve been discussing in this workshop, how does this feedback (self-assessment) relate to being a Collaborative Leader?”

5. Conceptual Overview: What Is Assessing the Environment?

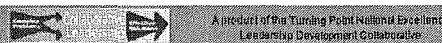
Learning Objective: Examine the meaning of Assessing the Environment as a practice of Collaborative Leadership.

- A. Review *Context of Collaboration*, Slide 10 (see Chrislip and Larson’s *Collaborative Leadership*, pp. 59-72).
- B. Refer to *Understanding the Context of Collaboration, Participant's Guide*, pp. 5-6 for more discussion.

Slide 10

Context of Collaboration

- Identify the problem type.
- Identify stakeholders.
- Assess extent of stakeholder agreement.
- Evaluate community's readiness and capacity.
- Identify where problem can be most effectively addressed.



6. Systems Thinking

Learning Objective: Increase conceptual understanding of systems thinking and its relationship to environmental assessment for collaboration.

- A. Introduce the topic by saying that systems-thinking is fundamental to Collaborative Leadership.
- B. Read the following analogy:

“A cloud masses, the sky darkens, leaves twist upward, and we know that it will rain. We also know that after the storm, the runoff will feed into groundwater miles away, and the sky will grow clear by tomorrow. All these events are distant in time and space, and yet they are all connected within the same pattern. Each has an influence on the rest, an influence that is usually hidden from view. You can only understand the system of a rainstorm by contemplating the whole, not any individual part of the pattern.” (Excerpted from *The Fifth Discipline* by Peter Senge, pp. 6-7)

- C. Refer to *The Five Whys, Participant's Guide*, p. 7, and invite participants to read along with you as you read the story aloud.

- D. Ask participants for a few responses to the story, guiding discussion toward systems thinking.
- E. Tell participants that they will use this same technique on an issue where both problem and solution are not clearly defined (e.g., teen pregnancy, water quality, chronic disease).
- F. With participants, choose an issue and write it at the top of a piece of chart paper. Ask, “*Why is this happening?*” You will probably get several answers. Write them on the chart paper with plenty of space around them.

| |
|--------------|
| Issue Here |
| Because..... |
| Because..... |
| Because... |
| Because..... |

- G. Repeat the process for every statement on the paper, asking “Why” about each one. Write them near its “parent” question.

| |
|--------------|
| Issue Here |
| Because..... |
| Because..... |
| Because.... |
| Because.... |
| Because..... |
| Because..... |
| Because.... |
| Because... |
| Because.... |
| Because.... |
| Because..... |
| Because.... |
| Because.... |

- H. As the process proceeds, the answers will begin to converge; several separate symptoms may be traceable back to a few sources. Draw lines between them. A web-like structure will start to emerge. (Activity adapted from “The Five Whys,” *The Fifth Discipline Fieldbook*, pp.108-110.)
- I. Summarize by addressing the following points:

- Systems thinking recognizes patterns of interaction among elements that are separated by space and time.
 - You can only understand the system by looking at the whole, not just any individual event within the pattern.
 - Linear thinking often focuses on short-term presumed causal events, missing the bigger picture.
- J. Say: *“What if I had used the very first answer to the first “Why” question as my root cause and made a decision about a solution to the problem?”* (I would have failed to explore the issue completely, missing several important factors.)
- K. Systems thinking under girds the environmental assessment model used in collaborative leadership development because it attempts to look at a wide array of elements that make up a pattern of influence.
- L. Say: *“Look at all the potential factors related to the problem. Does any one person have enough information about each factor to make an effective decision about the solution? No, each factor suggests different people with different knowledge and skills working together to solve the problem.”*

7. Cultural Perspectives

Learning Objective: Increase awareness of cultural perspectives and how they affect the collaborative process.

Facilitator’s Note: It is best to give limited information about the purpose of this activity beforehand.

- A. Tell participants that they are going to participate in an activity that examines their knowledge of others (or some other vague introduction).
- B. Refer participants to *Find Someone Who....*, **Participant’s Guide, p. 8**. Review instructions with participants. Say: *The object is to find individuals in the room who would agree with one of the descriptive statements on the worksheet. The rules of the activity limit you to asking only a single question one time to one specific individual. If you get a yes response, please put the individual's initial in the appropriate block. If you get a no response, check off the question and move on to another question and individual. Again, you can ask only one question of each participant. You may ask each question only once, and you may not ask more than one question of any one individual.* (This will encourage participants to give more thought to whom they ask what question.)
- C. Give participants 10 minutes for this activity.
- D. Debrief by asking the following questions:
- How many *yes*’s did you get? What does that mean?
 - How many *no*’s did you get? What does that mean?
 - Were any of the questions uncomfortable to ask? Why? Did you choose not to ask any? Why?
 - Were any of the questions uncomfortable to answer? Why?
 - How did you decide whom to ask what questions?
- E. Summarize by making the following points:
- Biases are not inherently bad; we all have them.
 - Awareness of our biases and the assumptions we make as a result is key.

- In order to accurately determine the factors associated with a problem, we need to bring the right people with the right knowledge and skills around the table.
- Each person brings his/her own perspective on the problem, specifically, and in general.
- To work together effectively, it's important to be aware of these different perspectives and what assumptions each brings with it.

8. Environmental Assessment Tools

Learning Objective: Compare and contrast a variety of environmental assessment tools.

A. Ask: "How many of you have conducted or participated in a community or organization assessment?"

B. Explain that:

Assessment tools are a collection of questions designed to collect information about a specific environment.

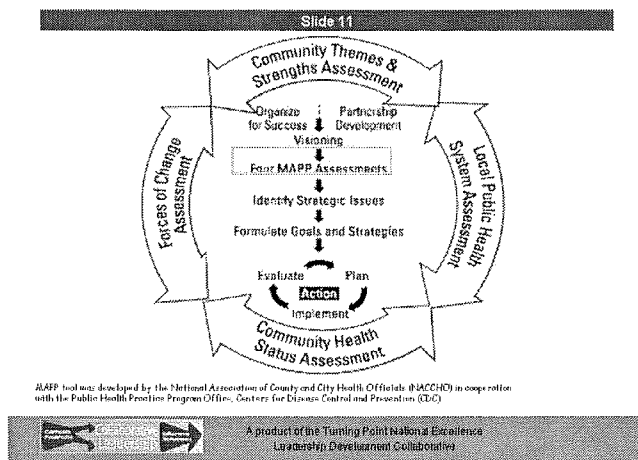
There are many tools to systematically assess a community's readiness and capacity for change.

It is also important to assess organizations in terms of their readiness and capacity to participate in collaboration.

Select tools that fit your needs based upon the kind of information you need to collect.

C. Say: "For our purposes today, we're going to become familiar with a tool that is specifically designed to help communities assess needs through a collaborative process. It's one of many assessment tools. For more examples, see the Readings and Resources section of the Participant's Guide, on pages 19 and 20."

D. Review *MAPP Model*, (Slide 11).



Explain MAPP (Mobilizing for Action through Planning and Partnerships):

- Was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the CDC.
- Is a community-driven and community-owned approach.
- Helps communities improve health and quality of life through community-wide strategic planning.
- Employs four comprehensive assessment tools to gather information about community needs and assets to drive the identification of strategic issues.

E. Tell participants that they will be exploring the four assessment tools, which form the foundation for the MAPP process.

Referring to *MAPP Model*, **Slide 11**, explain that prior to implementing the assessments, Partnership Development needs to take place (Step 1). The Model shows Visioning as Step

- 2; however, some groups start with assessment and then move into visioning. Both approaches can work.
- F. Divide group into four teams, assign one assessment tool to each team, and refer them to the appropriate page in their Participant's Guide. Refer participants to *The Four MAPP Assessments, Participant's Guide, pp. 11-18*, for background information on each of the four assessments.
 - G. Distribute the appropriate MAPP Vignette (choose a separate vignette for each of the four MAPP assessment tools), giving one vignette to each group. (The vignettes are in the *Facilitator's Guide, pp. 13-25*.) Instruct them to read the vignette, review their assigned assessment tool, and answer the three Guide Questions at the end of the assessment tool description in the *Participant's Guide*. They will be preparing a three- to five-minute overview of their vignette and how their tool was used in that community, incorporating responses to Guide Question #1 (What kind of information does the tool provide?)
 - H. Give teams 20 minutes to prepare their presentations.
 - I. Display the *MAPP Model (Slide 11)*, and ask each group to present its tool.
 - J. At the end of each presentation ask team to briefly respond to Guide Questions #2-3 (2. Is the implementation process feasible in your community? 3. How important is this tool to your understanding of the Collaborative Leadership practice of Assessing the Environment?).
 - K. Mention that often organizations want to do internal capacity assessments before embarking upon a community process.

The APEXPH has been designed for health departments, but may be adapted to other organizations. For more information, contact NACCHO (see *Readings and Resources* in the *Participant's Guide*).

Organizations can also use the simpler SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis. For more information, go to Community Toolbox (see *Readings and Resources* in the *Participant's Guide*).

Facilitator's note: Mention that if participants want to access information on the MAPP Web site, they will be asked to complete a simple, one-time registration.

9. Develop a Personal Learning Plan: Assessing the Environment

Learning Objective: Increase competency in Assessing the Environment using outcomes of self-assessment and awareness of resources for extended learning.

- A. Say: "*Collaborative Leadership development is a personal growth process involving a change in mindset and habits. And there are proven methods for making these kinds of changes.*"
- B. Display and review **Slide 12, Methods for Change**. Say: "*Also, there are resources to support you on your journey.*"

Slide 12

Methods for Change

- Exposure to different ideas
- Exposure to different cultures
- Experience/Practice
- Self reflection (e.g., logs, journals)
- Mentoring/Coaching
 - 360-degree assessment, shadowing
- Peer support

- C. Refer to and review *Readings and Resources, Participant's Guide, p. 19.*
- D. Describe the learning resources on Collaborative Leadership Web site (www.collaborativeleadership.org).
- E. Refer participants to *Personal Learning Plan, Participant's Guide, p. 22.* Ask participants to review their self-assessment Behavior Frequency score to set learning goals and plan for achieving them.
- F. Work through an example with the participants, if appropriate.
- G. Remind participants that they are engaging in self-reflection, one of the collaborative leadership practices that is at the heart of any personal change process.
- H. Refer to *Module Purpose and Objectives, Participant's Guide, p. 3,* and summarize module.

MAPP Assessment Tools: Sample Vignettes

Community Themes and Strengths Assessment

The following four vignettes illustrate how communities have been engaged in public health processes:

1. Alameda, CA
2. Chicago, IL
3. Clarkston, GA – Windshield Survey
4. Clarkston, GA – Photovoice Concept

Local Public Health System Assessment

Two case examples — 1) St. Louis County, MO and 2) East Tennessee Region, TN — provide insight into how the Essential Services and other public health frameworks have been used at the local level. A third vignette — 3) Chicago, IL — offers an overview of how a local public health system assessment can be conducted.

Community Health Status Assessment

The following case vignettes provide examples of how three communities undertook a broad-based, community health assessment and how it helped to drive their planning process:

1. Miller County Example,
2. Peoria Example
3. Chicago, IL, Example.

Forces of Change Assessment

How communities have included Forces of Change in their planning processes:

1. Miller County Vignette
2. East Tennessee Vignette
3. Chicago, IL, Vignette.

Community Themes and Strengths Assessment

1. Alameda County, CA, Vignette

The Livermore neighborhood encompasses a 12-block area within Alameda County. A unique partnership has been formed among the residents of Livermore, the Livermore Community Policing Unit, and Alameda County Health Department (ACHD). Using Community Themes activities (public meetings, surveys, and informal discussions) and a community-driven process, the partners have begun to work together to identify and solve local problems.

Residents and the Community Policing Unit initiated the partnership after a series of drive-by shootings occurred in the neighborhood. The police department responded initially with a traditional policing approach to the problem through an enforcement sweep. The gang- and drug-related activities were minimized, but the partnership work had just begun. The police department provided a street barbecue and clean-up day with free dumpsters for the neighborhood. Residents were pleased with the efforts and offered to work with the police on future safety issues.

The police saw the potential for establishing a community-based effort and invited ACHD to participate. Shared goals were identified: 1) conduct neighborhood-based activities that would increase the community capacity for decision-making; and 2) organize to improve the overall health of the neighborhood. All partners shared the commitment to broad health outcomes, non-traditional problem solving with the community, asset-based approach to change, and community-building strategies.

Residents were invited to a public meeting at the local middle school. The police and health departments introduced key staff, crime issues, and the goals of a partnership with the community. A brief written survey was conducted to determine areas of concern. Residents were identified from sign-in sheets and invited to a follow-up meeting. The Neighborhood Coalition was soon formalized. The group selected a resident chair and police and health department representatives provide staff support. A visioning process was conducted to identify how residents would like the neighborhood to look in five years. This provided the basis for the assessment and planning process.

The coalition is currently designing a neighborhood assessment. The commitment of its members is demonstrated through attendance at weekly planning meetings that are held in the homes of members. Residents will be recruited and trained to conduct a door-to-door survey. This is a participatory process that transfers skills and information to residents in the design of the information-gathering tools, the implementation, and the development of a written plan that holds all the partners accountable.

One success story already has occurred. The coalition approached an apartment owner about noise, reckless driving, street drinking, and litter. The coalition was successful where previous actions by the police and others had been unsuccessful. The complex has remained quiet and clean. The power of collective action was felt by all the members. Community changes come from the neighborhood level. The outcomes of neighborhood work will affect multiple areas of health and will be replicated in other areas throughout the county.

Community Themes and Strengths Assessment

2. Chicago, IL, Vignette

While focusing its efforts primarily at a systems and policy level, the Chicago Partnership recognized the need to engage partners at the community level to inform the development of a strengthened public health system. With a “community” of nearly three million persons, this presented some challenges. The Partnership decided to engage in contracts with four existing, more geographically focused community-based partnerships, each with the necessary expertise for reaching into their respective communities that the larger Chicago Partnership, as systems representatives with broader foci, lacked. Each local partnership would conduct a series of three community forums. The first set of forums was used to inform the assessment process, while the subsequent meetings were used to generate input on strategic issues and strategies.

At the first series of public forums, community members (both residents and local service providers) shared their perceptions regarding: (a) priority health and public health issues, (b) barriers to the delivery of local public health services, (c) elements for successful community-based health improvement efforts, and (d) systems-level changes needed to support local public health improvement efforts. A member of the community-based partnership led each forum and was also responsible for reporting the findings to the partnership staff.

Staff analyzed the findings from the forums both individually and collectively. The findings were then organized in a manner that reflected both issues unique to a specific community and those that were more common. During the forums that were convened in four different parts of the city, there was great diversity among the issues raised. However, common themes were also evident. For example, participants at most or all of the forums identified substance abuse, violence, cancer, hypertension, diabetes, and asthma as being among the most pressing health status problems facing their respective communities. Also frequently noted were access barriers such as transportation, language or other cultural barriers, and poor health care coverage. Broader issues were also identified, pertaining to the complexity of the public health system, community mistrust, and limited funding for critical services. Participants also offered suggestions for system improvements, including greater community involvement in local planning, better communication, policy changes, greater collaboration, and stronger public health leadership.

The findings were presented to the Chicago Partnership at its September 1999 meeting. Partnership members discussed the findings, noting similarities between the communities’ perceptions and the health status data. It was also noted that the suggestions for systems change were very consistent with the Partnership’s vision. In one case, members noted that the perceptions of the community (that there were not enough community health centers) were inconsistent with their collective knowledge of the numbers, distribution, and capacity of the system. Members concluded that the issue might be related more to access than availability.

Community Themes and Strengths Assessment

Clarkston Health Collaborative – Windshield Survey

3. DeKalb County, GA, Vignette

On November 18, 1995, twenty-two people conducted a windshield survey of the census tract which encompasses Clarkston, GA, a small city with a culturally diverse population of about 5,395 in central DeKalb County. DeKalb County, the second largest county in Georgia, is also its most densely populated and culturally diverse county. The goal of the survey exercise was to initiate an asset-based community health collaborative and to create a foundation for people from within and without the Clarkston community to work together by using the strengths of the community to address its problems. The DeKalb County Board of Health (BOH) and the Atlanta Regional Commission (ARC) had earlier approached the leadership of Clarkston, who then expressed interest in launching the effort.

The participants divided into five teams (one for each section of the census tract) comprised of: a “tour guide” who knew the area the best, one or two other Clarkston residents, and one or two stakeholders from outside Clarkston but associated with the BOH or ARC. While driving every street in their area, participants discussed what was going on in Clarkston and made observations about housing patterns, businesses, schools, parks and recreational facilities, schools, faith institutions, transportation patterns, public service locations, and medical providers. During the hour and a half of the windshield survey, participants engaged in a lively exchange and it was obvious that both people from within and without Clarkston learned new things about their survey area.

All five teams returned to city hall, where they shared their observations and developed a preliminary list of strengths and opportunities that would be brought to the formal launch of the collaborative on December 12th. Key observations included the fact that this community has enormous diversity not only in the race/ethnicity and age of its population but also in housing stock and economic status. There has been some reinvestment in the community but many opportunities for improvement remain. Faith institutions are numerous and often dedicated to being responsive to the newly arrived refugees and immigrants. Many other assets were identified. Major challenges for the community included: finding ways to include all groups in the effort, significant problems of substandard housing, the need for sidewalks, and the need for more recreational facilities accessible to youth.

The exercise created a sense of working together and provided an excellent foundation for the work of the Collaborative that is active now in its fifth year. What begins well has a chance for ending well. The Clarkston Health Collaborative has operated successfully without major new funding for the first four years and in May of 1999 received a substantial two-year grant from a local foundation to continue its community transformation. The Clarkston Community Center has received additional support for beginning the renovation of the old high school.

Community Themes and Strengths Assessment

Clarkston Health Collaborative – Photovoice Concept

4. DeKalb County, GA, Vignette

Clarkston is a small city in central DeKalb County with vast cultural diversity. The population of the city of Clarkston is 5,395; however, the greater Clarkston community was estimated to be 15,942 in 1994. Clarkston was originally approached by the Atlanta Regional Commission's premier health initiative — arising from the region's Vision 2020 initiative — because of its rich diversity in age groups, ethnic/racial groups, faith institutions, housing stock, and because its health status data offered many opportunities for improvement. In addition, Clarkston represents a microcosm of what the Atlanta region, as a whole, will experience within a few decades.

The Clarkston Health Collaborative (CHC) facilitates communication and promotes collaboration throughout the community. The mission of CHC is to establish a platform for community development in order to facilitate meaningful dialogue among diverse individuals and groups so that they may effectively create the conditions that foster healthy people in healthy communities. With the leadership of the DeKalb County Board of Health (BOH), the group was formed in 1993 to guide a demonstration of community development that could lead to improved health and well-being among local residents. For three years, CHC has committed its efforts to listening to the community's needs. However, because adults primarily attend the CHC meetings, CHC found that it lacked information on adolescent needs and perceptions. So, the BOH implemented the Photovoice concept (developed by Caroline Wang) on behalf of the CHC.

The Photovoice concept provides a method for describing the community from the viewpoint of those who live there as opposed to those who govern it. Furthermore, it takes into consideration that what outsiders may think is important may not match what the community feels is important, and how outsiders perceive the community may differ from the way the community perceives itself. Using this framework, no person's perception is considered wrong and all are acknowledged as important. In Clarkston, the Photovoice concept was used as part of needs assessment, asset mapping, and evaluation.

Through partnership with Clarkston High School, the BOH asked the teachers to recommend eight students, and then hired the students to implement the Photovoice concept. The students discussed and identified their concerns for about two weeks. After this exploration, they were given a camera and unlimited supplies of film. Traveling around Clarkston, they took pictures of what they felt was important to them. Finally, they sorted out the photographs and produced a PowerPoint presentation and a book that reflected how they view their community.

The findings were presented to CHC and the BOH Board of Directors in August 2000. The youth identified five main concerns: violence, inadequate health facilities, smoking among youth, community services not being distributed equally among the different ethnic groups, and the environment (e.g., pollution). The assets they identified within the community were diversity and the fire and police departments. At the end of the Photovoice program, the students felt more empowered with an increased awareness of the community in which they live. They were also more willing to volunteer to make their community a safe and healthy place.

Local Public Health System Assessment

Using the Essential Services to Analyze Public Health Activities

1. East Tennessee Regional Health Office, TN, Vignette

The East Tennessee Regional Health Office (ETRO) serves a predominantly rural 15-county region, which surrounds but does not include Knox County. The regional office has oversight responsibilities for the 15 local health departments in the region, which serve a total population of 600,000. Each county conducts a community assessment and planning process which is overseen by local health councils. ETRO, which assists in these efforts, undertook its own internal organization planning process in 1997 to supplement local efforts and devise a plan for moving into the future. As part of this organizational assessment, ETRO used the Essential Public Health Services to analyze the internal activities.

After using a Vision Quest process to develop a vision, mission, and slogan for the organization and to identify four priority strategy areas, ETRO used the Essential Services to define common threads and areas across programs within the four strategy areas. Cross-disciplinary strategy teams attempted to redefine the Essential Services using “common language” developed by each team. For example, a strategy team focusing on case management and outreach redefined the Essential Services from the outreach point of view, keeping mind that all health department programs have an outreach component. This activity helped to build participants’ abilities to think in terms of the Essential Services and to lay the foundation for the performance measurement work that was subsequently undertaken in the counties.

The performance measurement tool was then used by ETRO to review the activities being conducted for each Essential Service across all health department levels (local, regional, and state). Using the performance measurement instrument, ETRO county and regional staff walked through each Essential Service and collectively discussed the activities being done in each indicator. To facilitate a dynamic discussion, only the model standards (or paragraphs describing the ideal community) were shared with all participants. The group discussed how health department activities matched with those included in the model standard. Only the facilitator had the objective (yes/no) questions (which directly related to each element in the model standard); these were used to prompt the discussion. For each indicator, the groups discussed the level of importance and current status (similar to the methodology in *APEXPH* Part I) and then used the results to identify challenges and opportunities.

The internal performance measurement process was conducted in anticipation of working through the same tool with local health councils and other community representatives. Although ETRO is still deeply involved in this process, it has already seen benefits from using the Essential Services. The Essential Services provided a good framework for ETRO to use in educating staff about public health activities, analyzing what is being done, and identifying areas for improvement.

Local Public Health System Assessment

Using Public Health Frameworks to Improve Activities

2. St. Louis County, MO, Vignette

The St. Louis County Department of Health (SLCDOH) serves a large urban and suburban geographic area surrounding the City of St. Louis. St. Louis County consists of 524 square miles of land, approximately one million persons, 92 municipalities, and 24 school districts. In 1997, SLCDOH embarked on the “In-Partnership” process to assist in more accurately and effectively assessing and serving the communities in the area. SLCDOH implemented a collaborative, community health-planning process with the Jennings community and a training process based on internal core functions, which included ongoing collaborative activities with distinct communities in the county. A key concept in both of these activities was a focus on the “community-oriented core public health functions,” or engaging the community in all aspects of the core public health functions.

To strengthen the ability of SLCDOH staff in empowering and engaging the community, approximately 50 staff were recruited to participate in an internal training. In partnership with the National Civic League, a series of training sessions was designed to progressively educate staff about both the core functions and skills required for empowering and engaging the community. As one step in the training, staff formed four cross-disciplinary teams focusing on poverty, communicable disease, healthy neighborhoods, and family health. Each team is working with a community identified by an assessment step to address a problem in their issue area. For example, the family health team narrowed its focus to address limited utilization of preventive care services among the 30- to 60-year-old individuals. This team is working with the community to explore how to promote increased use of preventive services and earlier detection.

Although the process is still underway, the benefits of these activities are already apparent. Identified progress has been made toward one of the primary goals of the project — to have staff “think differently” and more strategically and to change mindsets to focus on community needs based on assessment and community inclusion. Staff members have a better understanding of the public health infrastructure, interactive roles they play, and how their activities relate to assuring public health as a whole. The cross-disciplinary aspect of the teams was especially useful in building bridges and communications between employees and divisions. The staff and the community are learning to better understand each other and are strengthening the capacity of SLCDOH to respond to problems collaboratively.

The changing mindsets are improving the work being done by SLCDOH. For example, the Environmental Health Division has traditionally had a strong regulatory focus. The training process has helped to make inspections more community-friendly, adding the dimensions of learning experiences and community responsiveness. Additionally, SLCDOH has developed a public health orientation packet and instituted a mentoring program for new employees. Furthermore, a consultant with the St. Louis University has developed a survey related to the Essential Services to explore the activities, behaviors, and attitudes of employees. Although it had not yet been implemented at the time of the case study, it is apparent that this will be another useful tool for improving SLCDOH’s broad-based approach. This training initiative continues, with plans to repeat the cycle for another class of interdisciplinary and vertically integrated employees from throughout the department.

Local Public Health System Assessment

3. Chicago, IL, Vignette

The Chicago Partnership established a Systems Assessment Committee to identify the extent to which organizations in Chicago contribute to the delivery of the ten Essential Public Health Services. The Committee's first step was to determine those categories of entities that participate in the local public health system. In addition to public health and related governmental agencies, the committee identified community health centers, hospitals, policy and advocacy organizations, coalitions, educational institutions, social service providers, philanthropy, businesses, and the religious community. Committee members then generated a lengthy list of specific providers within each of these arenas. A survey was developed seeking to determine (a) which of the ten Essential Services agencies were providing, and (b) examples of the ways in which they delivered those services. The survey was sent to more than 150 agencies; 48 responses were received. Staff then organized the responses by arena and service, and completed a larger matrix reflecting all arenas and noting which services they provide. The Committee then met to review the findings.

Although the respondents represented only a fraction of the providers across Chicago, the matrix was nearly filled. This suggested that while Chicago has a lot of resources, a key issue may be how those resources are being used. It was also noted that while many agencies are carrying out public health services, some are doing so deliberately while others may be doing so incidentally. If identified services are truly going to benefit the local public health system, they must have the capability of being folded into the system so efforts can be more directed.

It was agreed that a more refined analytic framework was needed to better understand the contributions being made to the development of the public health system. For immediate purposes, however, the information obtained would be very useful to characterize the system as it currently exists.

There were two additional components to Chicago's system assessment. First, an extensive review was conducted of public health mandates, as reflected in the City Municipal Code. The review revealed the code played three roles: (a) laid out the administrative structure for governmental public health; (b) empowered the Department of Public Health and its board to establish standards for public health protection; and (c) authorized the department to actively enforce the rules and regulations designed to assure those standards. These mandates were then organized along the Essential Services; not surprisingly most fell under diagnosis and investigation of health problems, enforcement of laws and regulations, and policy and plan development.

The final component of the assessment was a mapping of existing community-based health improvement partnerships. It revealed that 16 of Chicago's 77 formally designated community areas are served by seven existing partnerships. Most communities are underserved.

Community Health Status Assessment

1. Miller County, GA Vignette

With a population of approximately 6,000 residents, Miller County, GA, is a small rural county, located in the southwestern corner of Georgia. In 1997, a coalition of community organizations and representatives in the county embarked on a community strategic planning process to improve the healthcare system. As part of the process, the coalition conducted a broad-based community health status assessment. To inform the planning process with accurate information about the health status of Miller County, a varied set of objective and subjective data was collected. Because the focus of the planning process was on the healthcare system — the local hospital, in particular— much of the data collection focused on information specific to health care services.

The elements of the data collection included:

- ✍ *Demographic and Health Status Reports* – These included population, economic, education, employment, health status, and crime data.
- ✍ *Claritas Marketing Database Information* – Claritas, Inc., a national marketing company, develops cluster health profiles about the lifestyle of communities (including commonalities such as age, ethnicity, race, education and income, consumer preferences, and neighborhood location).
- ✍ *Community Asset Mapping Results* – Available resources in Miller County were identified, including employers, lending institutions, healthcare, churches, civic organizations, and cultural groups.
- ✍ *Community Health Assessment Survey* – A survey was distributed to learn about resident perceptions related to: 1) the most important health issues; 2) issues for which services were the least adequate; and 3) the health problems of highest priority.
- ✍ *Key Informant Interviews* – Coalition members conducted open-ended interviews with 70 community residents to identify overall needs and perceived problems.
- ✍ *Telephone Opinion Survey* – A randomized telephone opinion survey to 260 Miller County residents provided information about the quality of healthcare in the county and perceptions about and use of the Miller County Hospital.
- ✍ *Economic Impact Study* – An economic impact study explored the direct and indirect impact the hospital has on the community.
- ✍ *Regional Asset Mapping* – A study was conducted to identify health services available within Miller County's potential market area.
- ✍ *Health Services Dollars: Patterns of Use* – This study was completed to describe how Miller County health care needs are currently being met and to identify opportunities for improvement. Claims data from Medicaid, Medicare, and Merit System employees were used.

Miller County collected a broad array of objective and subjective data that was used for well-informed decision making. The data collection efforts also show how the coalition collected traditional data, but also focused their efforts on areas important to the strategic plan.

Community Health Status Assessment

2. Peoria City-County Health Department, IL, Vignette

The Peoria City-County Health Department (PCCHD) in Illinois serves a total population of approximately 130,000. In 1992, in response to the Illinois Project for Local Assessment of Needs (IPLAN), PCCHD conducted an internal organizational assessment and a community assessment process.

In January 1993, the Board of Health appointed a 15-member Community Health Needs Assessment Committee (CHNAC) to assist in implementing the development of a community health plan. In May, the CHNAC met for the first time and approved the following statement as its purpose: “To identify, assess, and prioritize the health needs of Peoria County residents.” The final product would be a plan with strategies for addressing the community’s priority health issues.

PCCHD advised the Committee that data were available that related to the health department’s identified problems. A nominal group process was suggested and then selected as a means of identifying the perceived needs within the community. The health problems identified by statistical measures were then provided to the Committee, which integrated them with the perceived needs and prioritized community health problems. CHNAC recommended additional community input into the process. The Committee identified and surveyed 25 social service agencies for input into what they perceived to be the most important community health needs.

Using the data, the Committee perceptions, and the agency survey, CHNAC identified 12 health problems, conducted a prioritizing process, and produced the following four highest ranked community health problems:

1. Infant Mortality
2. Sexually Transmitted Diseases
3. Stroke
4. Cancer

The health officer and the Board of Health independently identified positive results within PCCHD, including an increased appreciation for other staff and programs and more confidence in their work responsibilities and environment. In the community, results included improved communication with partners, new services (family planning in a community hospital), and improved relations with the Board of Health.

Community Health Status Assessment

3. Chicago, IL, Vignette

The Chicago Health Profile was compiled largely by staff, with the Chicago Partnership determining the elements that would be included. At a February 1999 partnership meeting, members were presented with a preliminary list of data elements that might be included in the profile. They made additions to the list as well as questioning the need for some of the data elements. Agreed-upon elements fell into five categories:

- Demographic and socioeconomic indicators
- Health status indicators
- Health perceptions and health-related behaviors
- Social and environmental factors
- Health care delivery and access to care

A variety of data sources was used to obtain information in the above areas. These included: the U.S. Census, vital records and reportable diseases (maintained by the Public Health Department), hospital discharge data, adult and youth behavior risk factor surveys, violent crimes from the police department, and a recently-completed broad-scale survey of Chicagoans.

Once the data were collected, staff drafted a 37-page narrative report (with data tables attached) and distributed it at the partnership's June meeting for review and future discussion. Members were asked to contact staff over the next two months with any recommended changes. Staff then synthesized the profile's findings into a seven-page summary and presented this information at the Partnership's September 1999 meeting.

Among the profile's key findings:

Significant health status disparities exist by race/ethnicity and by gender.

The city experienced a 12 percent decrease in available jobs from 1992 to 1997, although the past two years have seen a slow growth in new jobs.

While mortality rates overall are declining, hospitalizations for related conditions were up.

Infant mortality rates continue to decline, despite no decreases in low birth weight births.

Having decreased significantly in recent years, most types of sexually transmitted diseases have increased in the past year.

Most Chicagoans have some source of regular medical care; most of the insured are not covered for wellness services.

Members discussed the findings and their implications. The decreasing mortality rates (including infant deaths) and rise in hospitalizations, along with the lack of improvement in low birth weight births, suggested to members that although advances are being made in medical intervention, more work is needed in the area of primary prevention.

Forces of Change Assessment

1. Miller County, GA, Vignette

Miller County, GA, is a small rural county (population: approximately 6,000) located in the southwestern corner of Georgia. When faced with the possible closure of the local hospital in 1997, a coalition of community organizations and representatives initiated a community strategic planning process.

The potential hospital closure was a clearly identified catalyst for initiating the strategic planning activities, providing the impetus for convening partners, obtaining external technical assistance, and designing the process. Closure of the hospital would leave residents without a nearby hospital or emergent care system and represented a possible loss in jobs and economic and population growth for the county. In addition, several other forces were identified that contributed to health care delivery problems in the county. The onset of Medicaid managed care in the state had affected the rural health care system. It also became apparent that a broader “health care crisis” was occurring, in the guise of the rapidly decreasing number of local physicians.

The Miller County Coalition recognized that there were important forces aggravating those that prompted the process. At a strategic planning retreat, a broad range of forces was identified. Some were beneficial to the community, including: 1) a history of success with community-driven projects such as “Swamp Gravy” (a local theater production) and the Tarrer Inn (a restored historic inn); 2) the recent successful collaboration among community leaders, physicians, the hospital authority, and the public health director; 3) the enthusiastic community spirit; 4) the willingness of community leaders to learn; 5) the agreed-upon plan based on solid information and the support of the “Safety Net Project”; and 6) an internal desire within the state public health system (supported by the district health director) for increased strategic planning. The coalition also identified forces that threatened to derail the quest for a successful health care system. The most serious potential threat was the failure of the community to work together toward a common vision. Community leaders identified competition for scarce resources, fear of the unknown, lack of communication, hidden personal agendas, turf guarding, negative attitudes, and resistance to change as specific problems that might hinder success. The coalition also feared that leaders responsible for managing the health care system may not have the knowledge and preparation needed to make the new vision a reality, and that this lack of leadership may result in a loss of momentum.

These and other forces affected the process — either by posing obstacles or providing opportunities upon which to build. Many of these forces were recognized by the Miller County Executive Committee (which oversaw the process) or were illuminated by a survey that gathered community perceptions. These forces, and the fact that they were recognized as having an impact on the public health system, helped the Miller County Executive Committee move forward with their eyes open to the challenges and opportunities that lay ahead. The identification of Forces of Change was instrumental in shaping the process and its resulting action plans.

Forces of Change Assessment

2. East Tennessee Regional Health Office Vignette

The East Tennessee Regional Health Office (ETRO) serves a predominantly rural 15- county region. The regional office has oversight responsibilities for the 15 local health departments, which serve a total population of 600,000. Each county conducts a community assessment and planning process that is overseen by local health councils. ETRO — which assists in these efforts — undertook its own internal organization planning process in 1997 in an effort to supplement existing local efforts and devise a plan for moving into the future. As part of this organizational assessment, ETRO assessed the forces of change affecting its community.

ETRO undertook a 12-step process for conducting the assessment — one of which focused on external trends, forces, and contingencies. As part of this process, the agency director developed a survey instrument to gather input from ETRO staff and others. Two items related to forces of change were included on the survey:

1. Identify those trends/forces/contingencies in the external environment that could have the most significant impact on your organization over the next five years. You should focus on your organization's economic, social, political-regulatory, and technological-scientific domains.
2. Over the next five years, what are four of the most unexpected external occurrences that could happen outside of your organization that could have a significant impact on it?

After gathering individual responses to the survey, the director and a core group of staff compiled and analyzed responses. The forces identified as “most important” were: technology, changing demographics, and health care reform. ETRO recognized that these and other trends had prompted the regional organizational assessment and had brought the need for more planning into focus. (For example, a shift in primary care services was caused by the rise in federally-funded and private primary care centers. The 1994 implementation of TennCare, the state's Medicaid managed care program, also caused changes in primary care services as well as within the Tennessee public health infrastructure.) Lastly, a significant amount of funding was shifted from Tennessee's Department of Health to support TennCare. Since then, many local public health departments have refocused efforts on outreach and assurance of care (reimbursable services), as opposed to providing direct services.

ETRO is continuing with its organizational and community planning at both the county and regional levels, relying on the identification of these factors and forces to help both processes.

Forces of Change Assessment

3. Chicago, IL, Vignette

As one component of its analysis, the Chicago Partnership worked to identify forces and trends that pose potential threats or opportunities for public health in Chicago. At their May 1999 meeting, members were asked to take home and complete a simple three-column worksheet on which they could list forces and trends in public health and threats posed and opportunities related to each of these.

Members returned their completed worksheets by fax to project staff. In all, more than 75 forces and trends were identified. Without changing the text of the submissions, staff consolidated the input onto a single worksheet on which the forces and trends were grouped under 11 larger categories. This allowed the Partnership to identify forces where members had shared concerns (those appearing with greater frequency). While an effort was made to discuss the document in full at the Chicago Partnership's June meeting, the number of issues identified and the members' interest in broader deliberations prompted the scheduling of a three-hour meeting the following month. At that time, the Chicago Partnership analyzed and debated points raised in the document in great detail, offering additions in some areas and challenging assumptions in others. They also elected to consolidate some of the 11 categories. This meeting resulted in significant revisions to both the organization and substance of the document. In the end, the Partnership had identified eight categories of forces/trends:

- Lack of public health constituency
- Shifting funding streams and focus
- Governmental role in public health
- Health status disparities
- Health care system changes
- Emerging public health issues
- The aging population
- Economic development

Once there was consensus on the substance and organization of the worksheet document, staff drafted a 14-page narrative reflecting the full detail from the Partnership's July discussion. With the Partnership's review and subsequent revisions, the narrative was included in the final public health systems improvement plan.