Strengthening, Mobilizing and Capacity Building in the Community: Lessons Learned

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“If we were doing things right, all communities would be healthier than they are.”
Health Officer - Genesee County, Michigan, 1990s

*My thoughts:
1. Missing Link – Sociobehavioral Influencers/Health Disparities – is the tremendous force and energy of the community to solve their own problems - both in HP/DP activities but more importantly in producing evidence-based approaches to healthy communities (research)
2. Academic/Community Partnerships or Institutional/Community Partnerships - institutions also bring important skills, resources to this issue, but often they have controlled the entire process, the CB empowerment approach corrects this.

Outline: My Career and Experiences in this Field: Lessons Learned

Overview of Paradigm Shifts in Working with Communities
Comparison of Two CBPR Partnership Projects - ATL, DC: Lessons Learned
Strengthening Community Empowerment in Alabama

Outline: Why Partnerships?
- Improve disparities in Health
- Limitation of Community Participation
- Limitation in addressing future public health risks

Why Partnerships?

Possible Benefits of Partnerships - Research
- Enhance data quality & quantity
- Move beyond categorical approaches
- Improve research definition & direction
- Enhance translation and sustainability of research findings
- Improve the community’s health, education and economics by sharing knowledge from projects

Why Partnerships?

Possible Benefits of Partnerships - Research
### Contrasting Two Approaches

**“Community betterment”**
- Examines community wants
- Gatekeeper broker for services from others
- Seeks agency change primarily
- More short term

**“Community empowerment”**
- Examines community responsibility, unmet needs and strengths
- Gatekeeper - facilities shared power & action
- Seeks overall change
- More long term

### Kellogg Foundation Partnership Characteristics

- Multidisciplinary Approach
- Community-based – increased presence-empowered-organized, visionary, strong leadership and governance*
- Shared Governance and control of funds/Sustainability
- Shared Evaluation/Dissemination of Results/Increased Translation

### 9 Key Principles of CBPR

1) Recognizes community as unit of identity
2) Builds on strengths & resources in the community
3) Facilitates collaborative, equitable involvement of all partners
4) Integrates knowledge & intervention for the mutual benefit of all partners

*Barbara Israel, U of Michigan SPH*

### 9 Key Principles of CBPR – cont.’

5) Addresses social inequalities
6) A cyclical & iterative process (evaluation continuous)
7) Addresses health from both a positive & ecological (holistic) perspective
8) Disseminates findings & knowledge gained to all partners
9) Involves a long-term commitment by all partners (i.e., trust building)

*Barbara Israel, U of Michigan SPH*

### LEAP Partners (Kellogg Foundation) – HPDP

- 2 Academic Institutions: MSM (PMR), EUSPH (MPH)
- 2 Health Departments: FCHD & CCBH*
- 3 Communities: UJHH, RGH, & KV*

*No Matching funds (Budget- 1 million over 4 years); * community empowerment*
LEAP Governance*
- Initial – PI/Director – EUSPH, 1-2 reps from each partner on Executive Committee responsible for all aspects of project
- Final – PI/Director – CCBH (not a strong prior relationship with community)
- Final - 1-2 reps from each partner Advisory Board & Implementation Committees: PODs based on geographical location
*Project Manager at initiation of project, moved to partner role towards end of project

WRACC Project Partners (Kellogg Foundation) – (GME)
2 Academic Institutions: GWU- SOM (Peds+, OB/GYN) & Health Science Program (MPH)* & GMU School of Nursing (NP)
1 Hospital System: Inova Health Systems* (FP)
7 Community Clinics: 4 in DC, 3 in VA**
*Provided matching funds (Budget - 3 million over 4 years)**community empowerment

LEAP Evaluation
- Initial – Evaluator – MSM/EUSPH
- Final – Evaluator – KSC – School of Business, Economics
- PH competencies assessed (direct observation, interviews, survey); activity evaluations also performed
- Findings: Community projects delivered in a culturally competent and effective manner, positive experience for student participants, long-term impact on HC uncertain

WRACC Governance*
- Initial - 2 Co PIs – both representing 2 academic institutions (One had good strong prior relationship with community, the other did not)
- Final – 2 Co PIs (turnover high)
- 1-2 Reps from each partner on Governing Board, responsible for overall management of program, including budget
- Committees responsible for implementation of program: Curriculum/Education, Evaluation, Governance & Policy Development
*Ass. Co-PI at mid point of project, Co-PI towards end of project

WRACC Evaluation
- Evaluators: GWU – Department of Management and Health Policy (guided by committee)
- Gather data throughout project through site visits, interviews, document review, timesheets
- Parameters measured included training & clinical outcomes (community projects, team approach, policy changes & cost effectiveness)
- Findings: WRACC maintained or increased capacity of clinics with incorporation of multidisciplinary teams, primarily led by NPs

CBPR Scorecard
*Compare LEAP vs. WRACC
*Who does better based on 9 CBPR Principles? LEAP - 4/9- #1,2,6,7- C
WRACC - 8/9- #1-8-A
Lessons Learned

- Must have shared goals – Humility & willingness to learn from each other
- Prior experience and established good relationships make it easier to build on collaboration
- Setting realistic goals enables partners to stay motivated
- Effective communication essential to project success (i.e., listening)

Lessons Learned (cont ‘)

- Investing in evaluation helps produce tangible outcomes for sustainability
- Attention paid to PR keeps partners as well as potential partners and funding sources informed and engaged
- Projects of this type are very time-consuming and can be demanding for personnel-need patience
- In planning, geographical considerations must be considered

Lessons Learned (cont ’)

- Attention paid to governance can save enormous time
- Support from high levels of partnerships is desired for sustainability

Shifting and Sharing Power

- Shift and share power from institutions to communities (i.e., decision making at every level – finances, health priorities, acknowledgement of needed community expertise, training opportunities – adjunct positions, authors on research papers and journals, etc.)

Lessons Learned (cont ) – Hiatt, 2004

- Leadership – vision and coordination important
- Management of conflict important
- Define roles and responsibilities upfront
- Dissemination plan esp. publication protocol desirable
- Continually check partners commitment
- Constantly create new opportunities

Capacity Building in Alabama- Cases – Challenges in Building Community Capacity
CASE #1

- Retired nurse - Black Belt County, had a for-profit corporation – doing home health, etc. Started a parish nurse program – relatively new concept in Black churches, enlisted volunteer nurses – 25, started doing screenings, etc. Wanted to expand for data collection - prove it worked, expand services and geographical area. Controlling and aging wouldn’t groom new and expanded leadership, also having hard time with expansion with evaluation.

CASE 2

A visionary AA minister has a project that he has developed using a coalition of ministers to address health issues including mental health and aging. He has great ideas and is always looking for partners with funds to run his programs, however, he is not flexible with negotiating implementation and planning activities with his funding partners.

There are a few JoAnnes out there - Has the “IT” Factor for Community Empowerment (These are the persons we need to be developing, nurturing, encouraging in building our community capacity to eliminate health disparities)

The “IT” Factor:

- Pure Passion for the Community – servant, no ulterior motives
- Pure Passion for Health improvement – personal identification, close family member, health related field
- Pure commitment – in it for the long haul, long after we are gone
- Good leadership skills which pulls in others – organization not dependent on one person
- Well respected by the communities they serve - usually evident by how many people are involved with organization or community support
- Flexibility to new ideas and a willingness to work with others to expand their missions (not threatened by resources and skills of others)

There are many Joanne leaders (community empowered) in Alabama to address health disparities - some fully developed, some who may need assistance:

1. Francis Ford - Sowing Seeds of Hope - Marion, AL - partners with ADPH, Samford U SOA*
2. Lawrence McRae - McRae Prostate Foundation - Tuskegee and Selma, AL - partners with East Alabama Hospital, ADPH, MSM/TU/UAB CCC Partnership
3. Rev. Willie Smith - EIM Outreach Inc. - Montgomery, AL - partners with ADPH
4. Barbara Howard - partners with MSM/TU/UAB CCC Partnership as well as HDIRE
5. Mary Brooks - Women’s History Month Project - expanded into Bullock County Health Coalition-Union Springs, AL - partnering with Mayor’s Office, ADPH, TU, County School System, Bullock County Hospital, and others*
6. Others - I’ve been partnering with either through UA or MSM - work to build HW prevention capacity - Latoya Davis - West Alabama Medical Association, Rev. John Meeks - New Era Baptist Conference; Rev. Chris Spencer - Black Belt Community Foundation

*perhaps partnership with UA in future