# Chapter 1

Chapter 1

## Assumptions

This chapter defines the basic philosophy behind the Community Health Improvement Partnership process. It is critical for those deciding whether or not to embrace and implement this process to know the reasons why citizens need to be involved in deciding the fate of their local health care system and their own collective health status.

The Community Health Improvement Partnership process relies on some fundamental principles of democracy. Underlying all the strategies employed in this model is the assumption people have a right to participate in public affairs that affect their lives. Naturally, the more costly or irreversible the decision, the more citizens will demand an opportunity to participate. To leave them out, organizations run the risk of community polarization, alienation, and, potentially, outright opposition.

### Assumption 1: Organizational Ownership and Implied Responsibilities

Community-based health care organizations provide an excellent example of how the principle of "public affair" is applied. Every organization, once created, has survival as its basic motive. Survival of an organization is based on ***legitimacy***. Legitimacy means, "to give legal status or authorization to." All organizations depend upon at least the passive support of their clients in order to function, and none can expect to endure once it has lost that minimum loyalty embodied in the term legitimacy. As long as a health care organization satisfies the minimum expectations of the politically active or potentially active members of its community, there is little chance of internal upheaval.

Legal status or authorization is given to an organization through the state. This applies to for-profit, non-profit and public

organizations. All organizations delivering health care or having responsibility for protecting the health of the population are either for-profit, non-profit or publicly held. These three types of ownership differentiate themselves by whom they are responsible to and who holds them accountable for their actions.

***For-profit organizations*** are created by incorporating or by acquiring some type of business license through the state. The organization is accountable to the owners, partners, or shareholders. The most common example of a for-profit health care organization is the private practice physician. Hospitals, home health, ambulance services, and other health delivery organizations can also be for-profit.

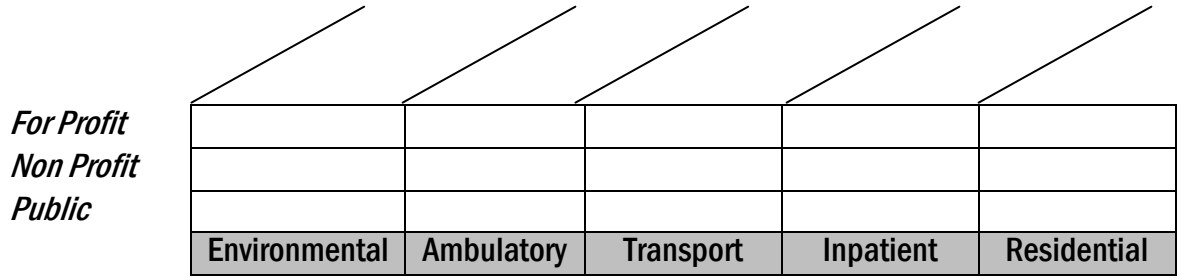
***Non-profit organizations*** are incorporated through state law. They have been declared tax-exempt because they fill some type of socially accepted or charitable need that for-profit organizations have not found profitable enough to serve. Non-profit organizations have a community-based board of directors who have been entrusted with the care of a community resource (exemption from paying taxes) and represent the community's interests. The non-profit organization is accountable to its board of directors or trustees, which, in turn, is accountable to the community. The bottom line for non-profit organizations is community service. However, do not confuse "non-profit" with no profit. Non-profit organizations are allowed to make profits. They simply must reinvest these profits in community service or to the community's benefit. Profits cannot be used for the personal gain of anyone associated with the organization. Whereas, the profits earned by for-profit entities can be used for personal gain and benefit.

Federally designated Community Health Centers are a common example of a non-profit health care service delivery organization. The community entrusts the boards of these centers to serve the primary care needs of the local medically underserved population. If they receive federal funding, as most do, they are also entrusted with the use of federal resources targeted at fulfilling this need. If the community feels the federally funded center failed to adequately serve the primary care needs of the medically underserved, the community can take away two financial resources – tax exemption and federal grant dollars.

***Public or government organizations*** exist because either the state provides the service or the state allows counties and cities to provide the service through their charters. Counties, taxing districts and cities get their legitimacy from the state to exist. Public organizations are accountable to the elected officials governing them, who are, elected, in part, based on their ability to govern the public organizations in the public's interests.

Figure 1-a presents a model of the basic building blocks that comprise a health care delivery system. The left-hand side of the model defines the ownership status. The bottom delineates the settings in which the services are rendered. The settings for the delivery of care are broad and require some further definition.

**Figure 1-a: Settings and Ownership**
**The Basic Building Blocks**
**Health Care Delivery System**




*Source: Affordable Coalition for RuralHealth, Center for Rural Health, University of North Dakota School of Medicine, 1987. --*

The first setting is labeled "environmental." An environmental setting generally consists of those services we do not consume directly but from which we still derive a benefit. For example, when we draw a glass of water from our faucet, or purchase prepared food, someone has responsibility to ensure the water or food product is safe. We do not often think about it, yet it is indeed there. The monitoring of air quality, public safety, occupational safety, tracking communicable diseases, measuring the incidence of disease, and conducting informational education campaigns such as those provided by The March of Dimes and American Heart Association can all be considered "environmental." Environmental health is commonly grouped under the umbrella of public health.

The second setting is "ambulatory." Ambulatory simply means the ability to walk -- as opposed, for example, to being driven. The services delivered in physician's office, outpatient surgical center, specialty clinic, and rehabilitation therapy are typical health care services delivered in an ambulatory setting. Other examples include school-based health care, mental health counseling and routine public health services, such as immunizations and well child examinations.

The third setting is "transport." Transport involves moving people to services, between services, and bringing services to people. The obvious example in this category is emergency medical services provided through an ambulance. However, transport also includes helicopter and fixed-wing transport services, vans for the physically challenged, meals-on-wheels, and mobile clinics.

The fourth setting for delivery of care is "inpatient." These services require an overnight stay in a licensed facility. It may include hospitalizations for medical or surgical problems, inpatient psychiatric services, drug and alcohol rehabilitation, and skilled long-term facilities such as Veteran's Affairs hospitals.

The fifth setting is "residential." The health services in this category can be thought of as those provided in a community or community-like setting as opposed to an institution. The services may include: safe houses for abused women and children, group homes for the developmentally disabled, home health, nursing homes, residential care facilities, and durable medical equipment.

The above list is not exhaustive. However, we encourage you to use the model and begin filling in all of the health services delivered in your community in each of the appropriate blocks. Later in the workbook, we'll examine the settings in more detail as part of the Health Resource Inventory step in the CHIP process. But for now simply think about all of the organizations that affect the health of your community. You will probably find the same institution providing services in a number of different settings. For example, your hospital may have outpatient clinics/surgery, long-term care and run the ambulance service. Therefore, the hospital would be listed in the blocks labeled ambulatory, transport, residential and inpatient. Remember to determine the ownership status of each of the organizations as well. Is it a for-profit, non-profit, or publicly held?

## Assumption 2: Health Care as a Public Affair

According to Public Affairs Education, Report of the Cooperative Extension Service Committee on Policy, "a human affair becomes a public affair when the consequences of an act by an individual or group go beyond the persons directly involved and when there is an effort by others to influence the consequences. The resolution of a public affair is usually a public policy."

The non-profit or public hospital provides an excellent example of how the principle of "public affair" applies. If the local hospital board decides to increase revenues through raising taxes or decides to create a new service or discontinue an existing service, its decision affects those who live in and have a stake in the community.

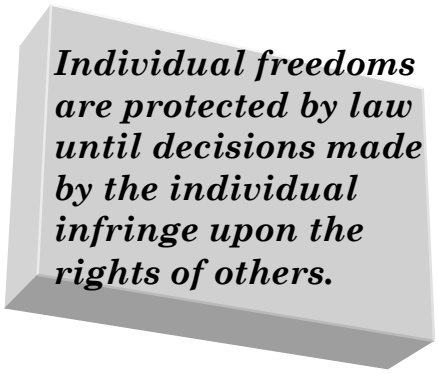
***The higher the cost, and the more irreversible the decision, the more citizens need and will demand an opportunity to influence the decision.***

The actions of the hospital have a "spillover effect," which is one of the two conditions that must exist to fit the above definition of public affair. The other condition is the attempt to influence. The spillover effect can be viewed in broad terms. Should the hospital require tax dollars, local citizens will have less money to spend on other goods and services. Closure of a particular service may cause someone additional pain or suffering. The selection of starting a new service may cause other needed projects and programs to not be implemented. The higher the cost, and the more irreversible the decision, the more citizens will demand an opportunity to influence the decision.

Because the decisions have an affect on others outside the hospital, those people will attempt to participate in the decision making. These attempts to influence may take many forms. There may be a "citizens committee against the hospital tax" or "spend more on primary care versus the "new" cardiac surgical service." Note that the two conditions of public affair will have been met. There is an

attempt to influence and a spillover effect.

The United States Constitution and the Bill of Rights protects the freedoms of the individual. These protections are guaranteed until those decisions made by the individual infringe on the rights of others. In a simple example, you have the protected right to keep your home in a messy condition. Your right to sloppiness is protected. If, however, your unsanitary home attracts rodents and diseases that cross your neighbor's property and affect them, you infringe on their rights. The resolution of this mythical dilemma is the establishment of public policy probably in the form of sanitation codes, rules, or guidelines.




The rights of people to become involved in public policy decision making in the hospital, or any health care organization, is clarified when we examine the sponsorship/ownership of the hospital. If the hospital is organized as a public hospital -- district, city or county owned, or as a private non-profit, the implied purpose of the hospital is to serve the defined community.

If the hospital is publicly owned, the reasons people have a right to participate are obvious. The people "own" the system. In the case of the non-profit hospital, the hospital's tax-exempt status carries with it an implied obligation to meet the needs of the people it is established to serve. The Internal Revenue Service, which monitors non-profit organizations, has determined that non-profit status implies more than meeting the needs of individuals regardless of ability to pay. The IRS mandates the non-profit organization must provide a "substantial community benefit." Therefore, the citizens themselves should participate in describing their perceived needs. Once described, the private non-profit hospital should attempt to meet those needs.

The case of for-profit private health care businesses and organizations is less clear, but it still meets the condition of a public affair. If a private physician decides to retire or shorten office hours, that is his or her private business. The spillover is the physician's patients have less access to his/her service. If the lack of availability and access are enough of a burden, the citizens will respond. They may

attempt to talk to the physician about a replacement or urge the physician to stay open longer hours. If the physician does not respond, the citizens may begin to organize their own response to what is now "their problem."

For-profit hospitals have obligations to meet certain rules and regulations if they accept Medicare and Medicaid. Employers and insurance companies also exert substantial influence through the purchase of services. In other words, for-profit organizations are most influenced by consumerism, competition and the forces of the free market system as opposed to public policy, which exercise much greater influence over non-profit and public organizations.

Figure 1-b on Page 11 adds to the basic building blocks the environments that influence health care delivery organizations. These environments include demographic, epidemiological, financial, personnel, technological, regulatory and political. Many of these environments are pathways for citizens to attempt to influence the decisions of private, non-profit and public health care organizations. All of these environments have an impact on the way these organizations conduct business.

## Assumption 3: Making Public Policy Decisions

When confronted with a problem or opportunity that clearly falls under the guidelines of a "public affair," a public decision must be reached as part of the solution.

Most public decisions are handled through representatives of the community or the shareholders. We select our representatives to public office or have community members serve in non-profit organizations, or shareholders elect a board to make decisions on behalf of the community or shareholder's. It is the premise of representative democracy. The *Federalist Papers* examine the concept of "representativeness" in great detail. The idea is based on the belief that if a pure democracy existed, where every citizen has a vote on every issue, chaos would be the order of the day. Therefore we select people, who are held accountable either through direct election or

selection processes and who make decisions in our best interest. The *Federalist Papers* suggest we should elect a candidate not because he or she believes in the exact same issues as we do, but because the candidate has the ability to reason and solve problems on everyone's behalf -- not simply our own. As such, routine decisions regarding organizational operations and activities are delegated to the governing boards. Consequently, most public decisions are made in city councils, county commissions, state legislatures, Congress, and boardrooms across the country.

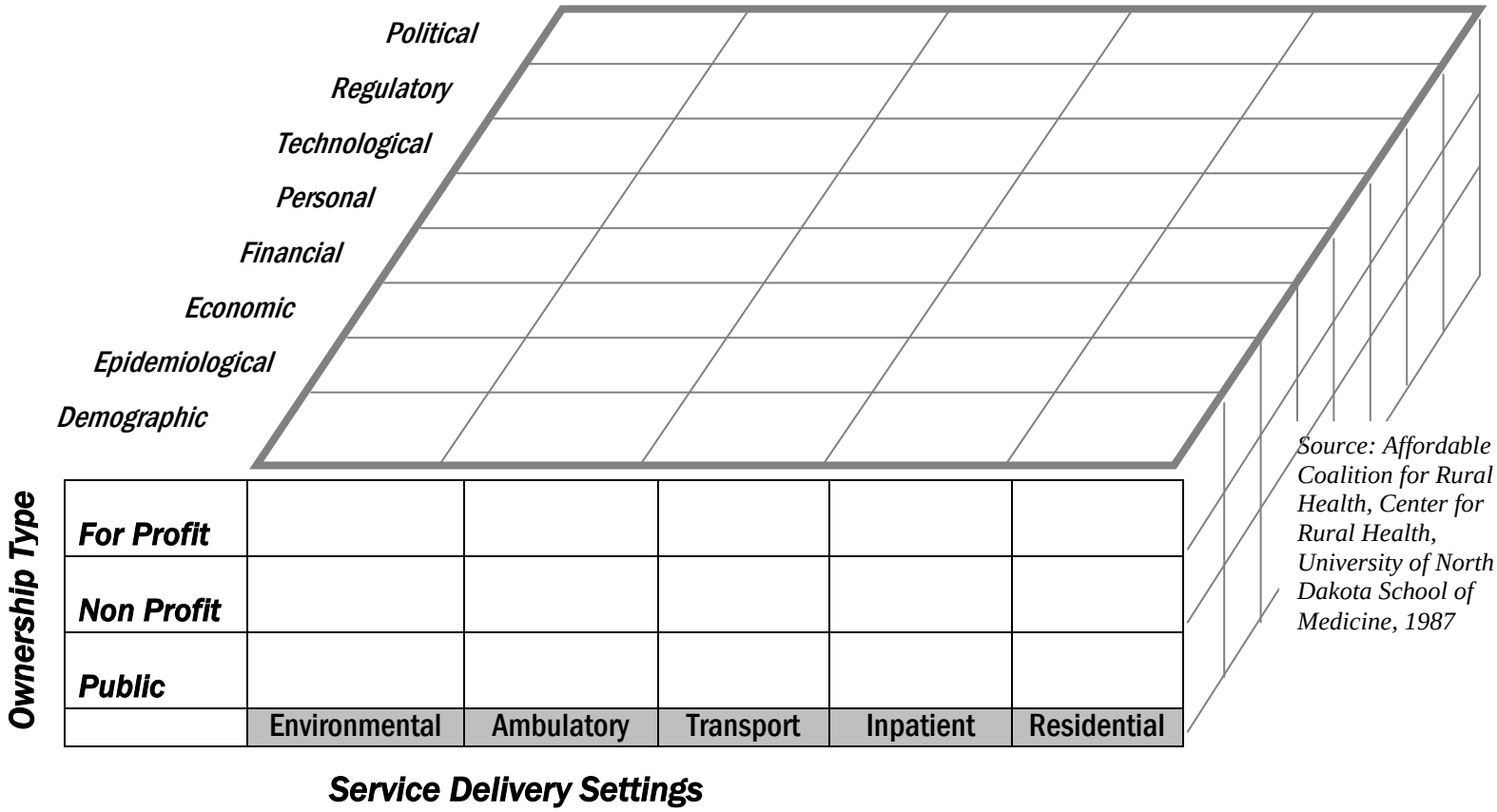
Many boards, commissions and councils are hesitant to make policy-level decisions without first seeking direct public input. The most common form of public input on decisions occurs in the privacy of the polling booth. The public policy question is stated, and people express their opinions by voting for or against the issue. Should the hospital be allowed to sell $2 million in bonds for capital improvements? Yes or No?

Even in cases where Congress, legislatures, councils and commissions do make public policy over issues in which they have authority without seeking direct input, citizens have an avenue of reproach. They can simply wait until the next election and replace members of these groups with someone else.

The act of voting is an example of the ***Advocacy Model*** of public decision making. Americans have come to rely on this model to resolve most public issues. The principle behind the Advocacy Model comes from the root word "advocate." The meaning of which is to "plead in favor of." The "in favor of" can be applied to denial as well as approval. In the bond sale example, if you vote "yes," you are pleading in favor of allowing the sale to occur. If you vote "no," you are pleading in favor of denying the request to sell bonds.

Americans use the Advocacy Model for many decisions that need to be made. We use the model to elect representatives to public positions. Two or more candidates vie against one another, and the public selects which one gains the right to represent. The judicial system also relies on this model. The prosecution and defense are the advocates, pleading in favor of the plaintiff or the defendant, and the judge or jury decides which one wins.

## Figure 1b: The Basic Building Blocks Health Care Delivery System




*Source: Affordable Coalition for Rural Health, Center for Rural Health, University of North Dakota School of Medicine, 1987*

Americans use this decision-making method because of its tradition and acceptance. The advantages are evident. The decision is final. The hospital will be allowed to float the bonds, the defendant is determined not guilty, or candidate Jones wins the election. There is a definitive winner and a loser. Whether you agree with the decision made by the public or not, the issue is settled and is implemented.

The Community Health Improvement Partnership uses a different method to make decisions, the ***Process Model***. The CHIP model says, "let's create a win-win situation" where common ground and concerns can be reflected in the choice.

Why is this important? Because those who lose under the Advocacy Model do not always support the decision once it is implemented. For example, let us say that 51 percent of the people voted to fund school-based health clinics for teens. This means that 49 percent of the people lost. Are those 49 percent of the people likely to say, "well, I lost the election, I had my opportunity to participate in a public policy decision, so therefore, I will change my allegiance and support the full implementation of the school-based clinics?" Of course not!

***Community Health Improvement Partnership attempts to build consensus and find common ground before implementing activities.***

The Community Health Improvement Partnership attempts to build consensus and find common ground before implementation of planned activities occurs. Perhaps the 49 percent of the people in the previous example thought school-based clinics were going to be too aggressive in sex education and contraceptive education. The question is, was there room for consensus so a larger percentage of the population would support the program? What teen health issues, other than birth control, are agreed to as being needed?

## Assumption 4: Involving People in Consensus

The Community Health Improvement Partnership utilizes a Process Model for public policy decision making. The Process Model implies the public has been involved in the establishment of the policy agenda, researched the alternatives and gained consensus before the issue is put to a public vote or directed to health care organizations to implement. The goal of the Process Model is to reach a decision citizens of the community will support and commit to over time. It eliminates the feeling of "losing."

## Assumption 5: Involved People Take Ownership in Issues and Solutions

Citizens who have a role in identifying health problems, and developing solutions and determining how that strategy will be paid for, will use and support that system. They will demonstrate support through direct utilization, involving themselves in volunteer activities, and giving money. Further, as leaders implement critical decisions that affect the overall health care system, citizens will not undermine the efforts.

## Assumption 6: Informed Citizens Will Make Good Decisions

If citizens are to participate in a "public affair" decision, we hope they are armed with enough information to make a wise decision. Informed and educated citizens and health care consumers are a major premise of the Community Health Improvement Partnership. The Process Model demands this. The Process Model follows a traditional planning approach with the planning activities occurring at the community level instead of in council chambers, commissions and boardrooms.

## Assumption 7:
## People Are Dissatisfied With Current Public Policy Process

Even if boards of health care organizations are doing an excellent job and have become educated and informed on issues, this does not ensure community support. Boards may represent the community, but often times they are not "representative of" the community they serve. A board may have determined through exploration of alternative solutions that a health problem might be resolved with a capital improvement program as cited in the bond example earlier. The board decides to put the proposed solution to a public vote, but it is voted down. The defeat may rest in the fact the "public" was not involved in the identification of the issue, development of alternatives that were reviewed, in analyzing the social and economic impacts of those alternatives or in the selection. All the average citizen sees is the proposed solution. They are not informed or educated about "why" the solution was needed, much less selected. This type of decision making is referred to as "planning in a vacuum."

The Process Model demands that the community be involved in defining the problem, generating alternatives, measuring impacts and making decisions. By involving the community, the health care organization has reduced the possibility that what is suggested will be rejected by the community as a whole. What may have been submitted for community approval under the "planning in a vacuum" process would be exposed and defeated as an inappropriate alternative before it went to a public vote using the Advocacy Model.

## Assumption 8:
## Citizen Involvement

One of the biggest barriers to conducting the Community Health Improvement Partnership process is community leaders do not believe the community wants to or is willing to participate, or has knowledge of the issues. Past efforts may have fallen short of expectations and continue to haunt leaders. The Community Health Improvement Partnership addresses the concerns of leaders and citizens alike and has proven successful in many communities. The key is understanding

why citizens have rejected past community involvement efforts.

A basic premise of participating in public policy decisions is to have access to the process itself. Unfortunately, many people feel cut off from the process. According to Harper's Index in 1990, 91 percent of Americans say the group with too little influence in public policy decision-making contains people like themselves.

## Assumption 9: People Feel Excluded from the Process

In response to perceived levels of public apathy, it has become a political necessity for agencies to extend themselves to involve the public. Over the past few decades, people have experienced many changes brought on by forces outside of the community itself. Whether it is absentee ownership of major businesses, federal timber or agriculture policies, unfunded mandates or increased global competition, people are feeling a loss of control in their community and in their lives.

The same holds true in the health care field. Medicare payments, Medicaid policies, health professional shortages (or gluts) and the regulatory environment all have impacts on the local health care system. Many feel the only way they can influence issues is to express their opinions to statehouses or Congress.

Organized coalitions of health care providers like medical societies, hospital associations, and rural health associations enhance and protect the views of their constituents in the policy arena. These groups compete for the attention of policy makers with thousands of other special interest groups. These groups do their utmost to protect the industry they represent as a whole but are not designed to solve problems at the local level. This is a rational approach to state and national policy as well as administrative activities. However, it does nothing to alleviate the imminent closure of a rural hospital, the lack of access to primary care services, a high teen pregnancy rate, or a deteriorating emergency medical service system in any given community across the country.

Much of what contributes to a population's overall health has little to do with the regulations and payments for utilization of services. Communities have many options available to combat health issues not subject to confirmation from state legislatures and Congress. The real problem is many community members have either forgotten how to participate in the public policy process or are completely frustrated by the forms of involvement employed by agencies and organizations. Perhaps the strongest evidence of this is low voter turnout and high measures of public apathy.

***While expressing your opinion to legislators may influence some health issues, local health issues are best and most immediately influenced at the local level.***

There are a number of reasons why people feel frustrated by the current system of public policy decision making. According to "Citizens and Politics: A View from Main Street America," prepared by The Hardwood Group for the Kettering Foundation, the prevailing professional conventional wisdom on citizen involvement does not fit with what regular citizens say about their role in the process.

Conventional wisdom says Americans are apathetic about public policy -- they no longer care. Yet citizens say they do care about public decisions, but they feel they can have no effect on these decisions. They feel politically impotent. Instead of agencies and organizations reaching out to their publics to assess their needs and concerns, people feel they must go to the organization to express their views. The public is uncertain about how to approach organizations, and, if they do, they do not see their concerns being acted upon. Citizens do not connect themselves to the issues presented by agencies and organizations because of the way they are framed and talked about. While the issue may indeed be critical, citizens do not see their concerns reflected or see their connection to them.

Agency directors and boards often feel citizens do not take time to learn about issues. They believe if citizens availed themselves to all of the information, they would understand their decisions and support their activities. Citizens admit they need to be better informed. But the problem is not that they need more information, they need *different* information. In the health care field, professionals have developed a

language that most citizens do not understand. This "professional speak" serves to turn people away from the process. Rather than ask for clarification in definition, citizens shut up and leave meetings feeling inadequate, or even, somewhat stupid. The rise in "professionalism" in all sectors of the community has driven the wedge between the public and those who serve it.

There is a growing lack of faith and trust in our public officials. People do not perceive a strong leadership base exists to solve the problems that affect them. Many say the disdain citizens have expressed about leadership is so strong it deters extremely qualified individuals from serving on boards, councils and commissions. The Community Health Improvement Partnership provides an opportunity for citizens to experience the process and pursue their interest and willingness to assume leadership positions in their community.

Many citizens feel they must be part of organized coalitions and special interest groups because as an individual they have little power to confront these groups. The silent majority is often over-ridden by a vocal minority.

Perhaps the most critical issue is that most commonplace citizen involvement processes are too formal. Further, citizen involvement is usually requested after a decision has been reached by an agency or organization, which then uses "public comment" meetings as a way of selling ideas to the people. How many times have you seen plans for a public improvement project "drop out of the sky?" The proponents of the project jump on the "cold sandwich circuit" approaching various civic groups for comments. Citizens are made to feel like any suggestions they make may be too late and place a burden on the process. The citizens' perception is that the decision is already a finalized plan ready for implementation. They also may feel their suggestions will not be taken seriously because they lack expertise.

The Community Health Improvement Partnership utilizes approaches that break down the barriers to citizen involvement by attempting to get as close to one-on-one with community residents as possible. The Community Health Improvement Partnership reaches out to those who need to be involved in all stages of planning - the people themselves.

Everyone in your community has something to contribute to the discussion of local health and the health care delivery system because they are all personally involved in the system. The Community Health Improvement Partnership facilitates involvement of citizens in deciding ways to improve the health of the population, the level of health care services desired, and how the system of services programs, and projects should be financed.

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Chapter 2

Chapter 2

# Community Health Improvement Partnership Defined

The Community Health Improvement Partnership is a structured process designed to involve community members in developing ways to improve to the local health care delivery system and community health status. It is a structured process only in terms of the sequencing of events and activities. Issues which surface, generation of policy alternatives and actual implementation are not pre-conceived or planned. The community sets the agenda of what actually happens during the process.

## Community Health Improvement Partnership

The word "community" as used in the title can be interpreted in a number of ways. The Community Health Improvement Partnership has broad application depending on how one defines the word "community." Like making images of clouds, defining community can be an illusive, floating proposition subject to individual perceptions and interpretations. Consequently, defining community and gaining consensus around the definition often becomes a stumbling block for health development coordinators. However, you can pin down the cloud and avoid stumbling by determining just what "community" is the target of in your effort.

Most people would define community as an area or place in which a group of people share common interests goals and objectives, cooperate on common projects and feel a sense of loyalty and identification. This idyllic definition is one that we have come to embrace because of our history and experience as a nation. The yearning for this type of community still exists, yet in reality Mayberry does not.

Carl Van Doren in his book, The American Novel, captured the traditional view of community. He described it as "neat, compact, organized, traditional -- the white church with its tapering spire, the sober schoolhouse, the corner grocery, the cluster of friendly houses, the venerable parson, the wise physician, the canny squire, the grasping landlord softened or outwitted in the end; the village belle, gossip, atheist, idiot, jovial fathers, gentle mothers, merry children; cool parlors, shining kitchens, spacious barns, lavish gardens, fragrant summer dawns and comfortable winter evenings." Such an idyllic vision of community pervades American society, strongly reinforced by the entertainment industry. Even humorist Garrison Keillor's Lake Wobegon, for all its warts, is at its core the idyllic community -- "where the women are strong, the men are good looking, and the children are above average."

This is the ideal social organization that still defines our notions of community and the human, political, and social relationships that make up community. Although we may still seek this, or even think we have achieved it, any cursory examination will reveal the flaws in the belief.

The traditional definition of community links values with a physical place. The definition describes community as an area. By this, we conclude that values conform to some natural geographic or political boundary. We can draw a line around the "community" and all people and resources within that line belong to the community. Further, the definition suggests that all those inside the line share common interests, goals and objectives as well as feel a sense of loyalty or identification. This could suffice as a definition, except we often do not share common values and goals – even with our next-door neighbors. America is a very diverse collection of people, and a very mobile collection. One in five American families moves every year. As the population shifts, people carry with them their diverse values, dreams, expectations and codes of conduct along with their household belongings.

This helps to describe the human fallacy attached to our traditional definition of community. Community must be viewed as both an independent and dependent variable with respect to territory. The physical place is where the human community unfolds. But humankind has never successfully been contained within a place. The daily interactions of human beings spillover the boundaries of any area or physical place established for them. People go to wherever their needs are fulfilled, whether its business, social or health needs.

Community is often also considered in terms of the real estate and the physical properties the community has accumulated. This is especially true in western societies where material wealth is so highly valued. Look at any chamber of commerce brochure that describes a community and you will read descriptions of buildings and infrastructure. Yes, chamber brochures are typically designed to attract business, but as they compete with other communities, the selling points they use are comparisons of physical properties. The community is described as having a hospital, "X" number of doctors, recreational facilities, schools, arts centers, libraries, and "X" square feet of available retail or industrial space.

***We too often focus on only the community's physical attributes, paying scant attention to what really defines and sets the community apart – its members.***

The brochures rarely describe the people who live there, their ability to work together or the values they share. Many attribute poor retention rates for health care professionals in rural communities to this. The health care professional is recruited and attracted to the community by its physical attributes but later discover the values of those in the community are incompatible with their own.

Community has also been defined as a grouping of people who share common needs, interests or experiences. In this definition, you'll note the sense of "place" has been eliminated. These communities of people may not live in the same geographic area. An example is the community of physicians. Physicians around the world belong to this community as they share in the same profession and experiences. Cancer patients, regardless of where they live, may also be considered a

community because they share common interests and human experiences. This definition of community can be applied to many other groups as well such as ethnic, racial or religious groups.

Despite the evidence, we still seek the traditional community as defined above. To achieve this ideal two options are available. The first is to seclude yourself with others in some type of commune. Our country has extensive history in this area. Religious groups such as the Latter Day Saints, Quakers, Amish, and the Rajnesshies, Davidians and The Universal Church Triumphant have all sought the traditional notions of community by moving away from the elements and beliefs of societies which differed from theirs.

***Community development attempts to instill a sense of "community" in people by convening a gathering on common ground.***

The second method to achieving the ideal type community is to embrace the concept of community development. While community development may not result in the traditional community, it does provide a means to that end. Community development can be defined as a process, which attempts to infuse a proper sense of loyalty and identification in people to develop formal mechanisms encouraging cooperation in the pursuit of common goals. Put in another way, community development gives people an opportunity to find common ground and decide what they want to do together.

In his book, Community Oriented Primary Care, Paul Nutting, M.D., defines community through what is referred to as the "denominator issue." The denominator in the equation represents the entire population under consideration. When applied to a community development approach, such as The Community Health Improvement Partnership, the denominator may change depending on the specific issue. The denominator may be considered at three levels: client-based, service-based, or population-based.

The ***client-based denominator*** is typically limited to individual health care institutions or practices. The clients are those who seek services at a specific locale. For example, the community may be defined as all those people who have an active patient record in a medical clinic. If the physician at the clinic was to attempt a

community-oriented health intervention, she may select only those patients with whom she comes in contact.

***Service-based denominator*** communities draw across institutional or practice boundaries and include all those people who use or need a type of service. Maternal and Child Health services can be used as an example. While many individual organizations may provide Maternal-Child Health services, including private physicians, public health clinics, midwives, schools, hospitals and others, the denominator is all women and children who need information, education or services related to maternal and child health.

***Population-based denominator*** communities include the entire population of a given geographic area. This area can be defined by the various institutions that comprise that continuum to be "those they feel a sphere of accountability to." The population-based denominator is the most commonly selected community denominator for community health development activities.

If community is defined as a "network of like needs and ideas" all three of the above listed denominator groups can be simultaneously applied, and The Community Health Improvement Partnership applies this definition to community. However, the process begins with a population-based denominator. Once the population has been assessed, interventions may be developed around all three denominators. This is defined further in the intervention stages later in the text.

## Community Health Improvement Partnership

"Health Improvement" should be interpreted in the broadest sense. It can include health care system improvement, which deals with any health care delivery organization. It can also apply to changes in the social and economic systems as they effect health including housing, environment, education, crime and employment among others. Health improvement also can be applied to individual behavioral lifestyle issues and should be considered a part of the definition. Because health improvement is broadly defined, the local decision-makers must recognize the process may take them into new areas of community concern.

## Community Health Improvement Partnership

"Partnership" is the means to achieving the end -- "Community Health Improvement." It is the conceptual framework for community involvement in the process and in decision making structure. Conceptually, "Partnership" describes the nature of the link between the health care system and the community. On the practical side, Partnership also refers to the group of individuals representing the interests of all key sectors in the defined community in the Community Health Improvement Partnership process. To avoid confusion we will refer to this group simply as the Partnership. The Partnership carries out the process in the community.

Gaining community consensus about the level of health care desired to meet community needs is the result of the community development effort. Determining the types of health services and programs, developing community health improvement strategies and fostering community willingness to support those services and strategies is achieved through the Partnership.

Individuals, small groups and communities have different styles and attitudes toward the process of decision making. Some like to make choices quickly and get on with it. Others continually seek more information, delaying the choice while looking for the perfect answer before moving forward. Some enjoy the process and are willing to state their belief regardless of critical review, while others are frightened to the point of paralysis. Obviously, neither of the extreme approaches alone is beneficial.

The Community Health Improvement Partnership process relies on the concept of ***collective rationality***. Collective rationality is defined as a choice reached by a group of two or more rational people, each acting in their own self-interest, and each having a say in the decision. This is different than "individual rationality" which is the choice a rational individual would make if they were the only person involved in the decision. Groups of people bring varying experiences and expectations to the problem solving arena. The diversity of opinions and ideas, if managed properly, typically produces better decisions.

Consensus decision making is based on the term "to consent" as to "grant permission." To arrive at consensus is to give permission to go along with the total group. It means to have your say, not necessarily your way, and when you leave the room you agree to support the decision made by the entire group. The implication is that individuals and coalitions can express their terms and negotiate the terms through which permission will be granted. When group members feel good about the manner in which a final solution is reached, they are more likely to carry out the action out in a positive way. This will occur even if the final solution is a result of compromise, conversion, or concession.

Some levels of decision making do not produce the best choices. When one side or person dominates the situation and others give in to the dominant person or group, decisions are not embraced by the whole. Likewise, compromise as a decision making tool produces an outcome only half as good as it could be. This is because each of the sides involved partly gives in on the decision, perhaps abandoning principle beliefs.

Ultimately a decision is implemented. In addition to implementation, the decision should be evaluated to ensure the desired impact is achieved. In evaluation, effectiveness is measured by whether or not the intervention achieved the desired results without causing additional issues. The test of time and hindsight reveal the strengths and weaknesses of the decisions. Regardless of the strengths and weaknesses, the Partnership ensures the decision is public.

The Community Health Improvement Partnership process is time limited. The entire process can be completed in anywhere between eight to 18 months, depending on the willingness of the participants to meet more frequently or the urgency with which a decision needs to be reached. Once this process has been completed, any number of local individuals and community-based organizations or groups can institutionalize it.

## Goals of the Community Health Improvement Partnership

The Community Health Improvement Partnership process

mission is to reach a community-based decision regarding health and the health care system. To accomplish this mission, there are six inter-related activity goals. The six goal activities listed below are not in any type of priority order. The success of the process depends on all of the goals being acted upon in an integrated manner.

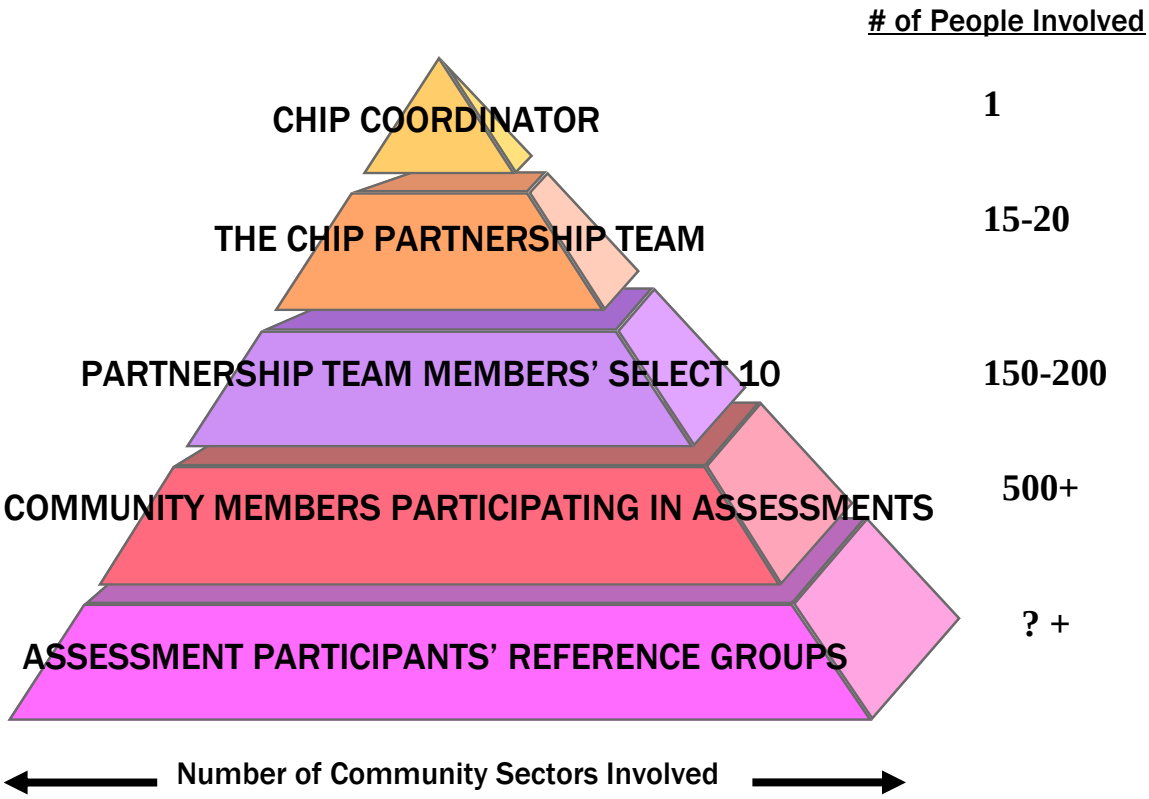
## Goal 1: To involve as many people as possible in the process of deciding the appropriateness of the local health care system and community health interventions.

This goal puts into practice theories of increasing citizen involvement in public policy development. Anyone who wants to participate should be given meaningful opportunities to give comments, solicit comments or be part of the planning partnership.

The involvement goal is accomplished through building a pyramid within the community for gathering information, giving information, and creating interactions. Figure 2a on the next page displays this pyramid. The apex of the pyramid is the CHIP Coordinator and the second level is the Community Health Improvement Partnership team or, simply, the Partnership.

Partnership members represent a variety of community sectors. Each Partnership member forms a third level by establishing opinion giving and feedback focus groups, which are, called the "Select Ten." The foundation of the pyramid includes those invited to participate as special members of committees formed by the Partnership and those citizens who are motivated to participate in the assessment and involvement methods used in the process.

## Figure 2a: Community Health Improvement Partnership Pyramid of Involvement




Using several techniques for increasing community involvement, the CHIP process strives to maximize public participation in local health care decision making. As you move down the pyramid, which represents the community, the number of local residents involved in the process increases. The number of sectors also increases as Partnership team members involve their sectors in the process and then reach out to other sectors through assessments and dialogue.

## Goal 2: To improve the health status of the local population

Any community development process is implemented to benefit the community in some manner. In this case it is to improve health status. Health status may be affected through creation of programs, resources or education. The health status issues, which are selected for intervention, are determined by the Partnership.

## Goal 3: To expand awareness of local health care issues, and to develop a local response.

Citizens need information about the health care environment in order to make rational choices. Community education techniques help accomplish this goal. The CHIP Coordinator and the Community Health Improvement Partnership receive training on understanding the health care delivery system. They are taught the dynamics of prevailing demographic, socio-economic and industry trends and their impact on the local health care system. Further, it is important to inform the community about the types and variety of health resources available in the community.

## Goal 4: To develop new local leadership

The Community Health Improvement Partnership is based on the belief that adults learn best by doing and that leadership ability is enhanced through life experiences. This process seeks to involve those who are not currently considered leaders in the community and mix those individuals with some who are leaders in their sectors. These participants are trained and given ample opportunity to put learned skills to work. Partnership members receive training to effectively conduct assessments, improve communication skills, and refine problem solving and decision-making capabilities.

## Goal 5: To educate the community on the importance of the local health care system to the local economy

All community health care decisions will have a measurable economic impact in the community. This impact is the "spillover" effect described earlier. The expansion or reduction of services either positively or negatively effects the community as a whole. Community members need basic estimates of health care dollar impacts to evaluate decisions through a cost-benefit approach.

## Goal 6: To create projects, programs and develop resources in response to community issues.

The final presentation of the health improvement plan to the community and sponsoring organization completes the Community Health Improvement Partnership process. The implementation of the plan is the responsibility of those individuals, organizations or groups whose overall activities are impacted. The plan may involve the structure of the health care system including sponsorship-ownership issues, coordination and collaboration (networking) opportunities as well as financing issues.

**Sources and References**

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Chapter 3

Chapter 3

# Community Health Improvement Partnership Process Overview

Time to roll up your sleeves. The first two chapters of this manual provided the conceptual foundation of the Community Health Improvement Partnership process. The rest of the manual concentrates on implementing the process in your community. CHIP incorporates a basic three-step process. These three steps are:

1. ***Organizing the Community***
2. ***Assessing the Community***
3. ***Developing and Implementing Community Responses***

Each step of the process includes an ordered set of activities to complete. These activities are outlined in Figure 3a on the next page. All the instructions, templates and tools for completing the activities included in each step are provided in detail in the remaining chapters and Appendices of this workbook.

## Figure 3a: Community Health Improvement Partnership Process Diagram