Community Defined Health™: Thinking From the Inside Out

Janalou Blecke and Lisa Hadden

Abstract

Health-related decision making is traditionally based on institutional health indicators such as morbidity and mortality rates. Our approach, however, only tells a community's story. The Center for Health Professions in Saginaw, Michigan has developed a Community Defined Health "™ process that captures the human capacity of caring, citizen engagement, and quality of relationships—in essence the intangible assets of a community. We assert intangible assets are as valid as institutionally defined health indicators.

The HIV patient had been seen regularly by his family physician for over ten years. Because the physician knew him so well, the patient was identified as a volunteer to meet with a team of medical and nursing students about what keeps him healthy. When the student team presented their information, the physician was astounded to hear things about his patient that he had never captured in a chart or through many visits.

The physician experienced a profound realization that all the years of treating this patient had taught him nothing about the patient's interactions with the community or the nature and quality of his relationships with others. As a result of this experience, the physician has made a stronger commitment to the Center for Health Professions (CHP) where he is a faculty member. CHP is a community-based, non-profit organization in Saginaw, Michigan, which offers a curriculum for medical and nursing students who learn how to co-produce health in partnership with residents of the community.

The notion of a community co-producing health is a radical departure from the realities of today's health care system currently enmeshed in surviving the Balanced Budget Act, managed care, and rising levels of consumer dissatisfaction. While health care organizations repeatedly profess "healthy communities rhetoric" in vision and mission statements, they struggle with ways to gain grassroots involvement and community stakeholder buy-in regarding staying healthy.

For a community to stay healthy, a new understanding of health is required. Rather than a traditional definition of absence or avoidance of disease, health must be defined in terms of quality of life issues and maintaining well being. Such a definition guides the work of the Center for Health Professions.

As a community-based organization, CHP is dedicated to the dual mission of combining asset-based community development and health professions education. Asset-based community development, or ABCD as its practitioners call it, is an approach to community building that identifies and mobilizes the assets, capacities, and strengths of individuals, volunteer associations, and institutions. Combined with the education of health professionals, ABCD brings a broader definition of health and healing to the task of assessing a community. While these two entities seem disparate at first glance, each is inherent to determining a complete picture of a community's health. However, communities typically are not accustomed to being asked to articulate

their definition of health, and likewise health professionals typically are not prepared to view people as co-producers of health. Opportunities for communities and health professionals to build capacity together in co-producing health are inhibited by the "outside-in" approach of the traditional health care system.

Moving from Outside-In to Inside-Out

The outside-in approach is driven by "needs thinking." Needs thinking is steeped in the tradition of conducting needs assessments and basing an entire picture of a community on its deficits, weaknesses and problems. In terms of communities and health care, needs thinking creates a dependence on health professionals as the creators of well being, and therefore of our health. It reinforces a mental map by residents that encourages them to characterize themselves by their weaknesses and neediness. Health then becomes a commodity dispensed through the proprietorship of professionals from the insurance industry, as well as from those with clinical skills, or persons from academe.

We have learned that the opposite approach, or thinking from the "inside-out," has a different outcome. Through this approach the community's definition of health can be articulated and serve in partnership with health professionals so that together they co-produce health.

Inside-out thinking values the core of the community, where the importance of connections and relationships among individuals is essential for day-to-day living. It is represented by three concrete levels: individuals, volunteer associations, and institutions. The connections and relationships between these three levels form the basis of well being. When inside-out thinking operates successfully, networks of relationships among individuals are built and rebuilt, forming a resilient community fabric. This tightly woven fabric gives community members a stable base from which to move into association life. Association life is where the real work of the community gets done, but it is often the most overlooked resource. Associations are voluntary groups of varying sizes committed to working toward a particular community benefit, e.g., church groups, block clubs, support groups, and cultural organizations.

Inside-out thinking views the institutional layer of the community as having assets and resources to support initiatives emerging from the individual and association layers of the community. Rather than institutions imposing their policies and expectations upon the community, they contribute to building the capacity of the community by honoring self-defined goals and actions of individuals and associations. These three layers: individuals, associations, and institutions constitute the complete picture of a community.

A Process for Co-Producing Health

By virtue of living it and creating it every day, individuals become legitimate practitioners of health. The inherent wisdom contained in the community's assets shapes its health. Identifying and mobilizing a community's assets to produce health, however, requires a process that shifts thinking from a person as consumer to a person as producer. This shift occurs through participation between community members and health professionals as co-learners constructing new knowledge about what creates and sustains health.

Constructing new knowledge about a community's health is a primary focus of CHP. How do we do this? Through a program called Community Defined Health™. Three essential ingredients comprise the process in this program: Asset-Based Community Development, Health Professions Education, and Community Action.

The ABCs of ABCD

Asset-based community development (ABCD) is derived from the work of John McKnight and Jody Kretzmann, co-directors of the Asset-Based Community Development Institute at Northwestern University in Evanston, Illinois. The main premise of ABCD is that a community is built on its assets, which shape the strength of its underlying fabric. Identifying and mobilizing these assets is the first step in building community capacity. Community capacity harnesses human potential, the raw material for making connections and taking action. Focusing on assets and capacity building portrays the community as self-reliant citizens who co-solve problems, and who are capable of co-producing health. Conversely, focusing on needs and deficits frames the community as pathologic, in need of "fixing," and assumes reliance on outside resources and services to solve problems. The wisdom of the community, its collective experiences, and the quality of relationships are lost in a needs orientation.

Moving Health Professionals Out of Needs Thinking

Health professions education is immersed in needs orientation. Health professionals typically know a community by health indicators and standards represented in morbidity and mortality statistics. The epidemiological picture of conditions and problems such as infant deaths, cardiovascular disease, accidents, sexually transmitted disease, and teen pregnancy forms the knowledge base for most practitioners. Monitoring charts and graphs representing the status of these is considered state-of-the art practice. This is congruent with, as well as supported by, government policies and programs steeped in needs orientation depicting communities as medically underserved areas or critical health shortage areas.

This is not to say that understanding disease and access to health care are not important issues. It is to say, however, that this understanding is incomplete. It is incomplete because it tells only a part of a community's story. We suggest to health professions students that there is more to knowing a community. Learning to know a community from the inside-out is not difficult information to acquire and will add meaning and enrichment to what is already known. This additional knowledge consists of answers to such questions as:

- What creates and sustains health in the community?
- What are the health issues as defined by residents?
- What are the health assets as defined by residents?
- How do residents perceive the health of their community?

Experience in asking these questions is gained through a learning activity offered by CHP in the curriculum for health professions students. Teams of third-year medical students from Michigan State University and fourth-year baccalaureate nursing students from Saginaw Valley State University visit families in the Cathedral District neighborhood in Saginaw, Michigan. The visit lasts for approximately two hours during which families and students have a dialogue regarding, but not limited to, the above questions. This activity satisfies curricular requirements at both universities regarding community and family assessment. It also provides a vehicle for neighborhood families to express their view of what keeps them healthy.

After the interviews, the student teams meet individually to flesh out the health information of their respective families and develop a presentation for their fellow teams. The presentation includes information on the family Genogram (a family health history map), an Ecomap (a map of important family social support systems), and the issues (barriers or impediments to health) and assets (those things that create and sustain health)—all of which are defined by the families. To conclude the learning activity, teams are reconvened in a meeting called a "reflection

session." During this session, CHP walks students through an exercise that identifies neighborhood issues and assets related to health. Students are cautioned and guided during their presentations to represent the issues and assets expressed by the family, through the eyes of their family, and not through a clinical interpretation.

At the conclusion of the reflection session, an entire wall is covered with information organized by the students but based on the priorities and insights of the families in the neighborhood. A picture emerges of how a neighborhood defines its own health as represented by these families. During the course of a year this learning activity is repeated in three cycles and involves approximately sixteen families and forty-two students.

The Community Takes Action

The student reflection sessions end with messages students wish to send to the neighborhood. Examples of comments include:

- Thank you for allowing us to come into your homes.
- We enjoyed the self-sufficiency of the neighborhood.
- There is incredible richness in this neighborhood.
- We are amazed at how your assets far outweigh your issues.
- We were able to see "real-life" (health) defined.
- Students and neighbors make good teams for health.
- Focusing on assets empowers people to deal with issues.
- Health care can be looked at as community development.

These comments, as well as a summary of the issues and assets, are reported at monthly meetings to the Cathedral District Neighborhood Association, a neighborhood grassroots group. Residents who attend these meetings are able to examine the information and conclude how health is defined in their neighborhood. Initial response tends to be a general discussion of a broad definition of health and working with health professionals. Typically the most immediate response from residents is, "We like this program because it busts stereotypes of folks in low-income, minority neighborhoods." They also say, "We like students getting to know us as a neighborhood first, before we are patients in an exam room."

These discussions have extended to action decisions. Some residents concluded that asset-based information would be positive testimony to be presented at City Council meetings. Now called a "Citizen Accomplishment Report," residents appear regularly before the City Council to inform members of upcoming events in the neighborhood and share newly defined assets. Another example of an action decision outcome is the development of a walking club. The walking club achieves three objectives. First, it offers regular exercise to those who like to walk. Second, it sends a powerful message to residents that the neighborhood is safe. Finally, the walking club provides a forum for neighbors to connect and build friendships.

A Community Defines Its Own Health

Community Defined Health(, which is comprised of the issues and assets as expressed by the neighborhood families and compiled by the students, represents a broader perception of health. This perspective encompasses the following determinants of health compiled by McKnight and Kretzmann from epidemiological sources: 1) individual behavior, 2) social support systems, 3) physical environment, 4) individual economic status, and 5) access to therapeutic resources. The first four of these represent community functions, as opposed to the traditional thinking of health

produced solely by the health care industry. The fifth determinant implies that having access to health care resources contributes to maintaining health.

The first four determinants are those in which the individual or the community exercises control or choice. The first determinant or individual behavior includes choices made in nutrition, exercise, rest/sleep, sexual expression, substance use, and stress management. The second determinant, or social support systems, includes the strength and quality of relationships with significant others, immediate and extended family, neighbors and associations, community at large, and institutions. The third determinant, or physical environment, involves structures such as housing, retail and manufacturing, life supporting resources (air and water), industrial pollutants, green space, and recreational opportunities. The fourth determinant, or individual economic status, involves purchasing power that includes the currency value of education, employment, and skills. The final determinant, access to therapeutic resources, involves health care systems, including primary, secondary and tertiary care, as well as all complementary and supplementary services.

The Center for Health Professions embraces a broad definition of health and believes that the issues and assets gleaned through the ABCD process represent health as defined by the community. To confirm this belief, we explored the relationship between the issues and assets and the above five determinants of health. We assigned each issue and asset category to the appropriate determinant of health based on the above definitions. The summary of the results is presented in Table 1.1 below. The left-hand column of the table represents the five determinants of health categories. The middle column represents the issues classified into the five determinants of health prioritized by the most frequent number of responses by category. The right hand column highlights the assets, again prioritized by the most frequent number of responses into the five categories.

Table 1.1 Proportion of Issues and Assets in the Determination of Health

DETERMINANTS OF HEALTH	# & % OF ISSUE CATEGORIES	# & % OF ASSET CATEGORIES
INDIVIDUAL BEHAVIOR	4 21%	1 14%
SOCIAL SUPPORT SYSTEMS	8 59%	3 14%
PHYSICAL ENVIRONMENT	3 15%	5 31%
INDIVIDUAL ECONOMIC STATUS	2 4%	1 35%
ACCESS -THERAPEUTIC RESOURCES	0	1 6%
TOTALS	17 99%	11 101%

Proportion of Issues and Assets in the Determination of Health

Based on the five determinants of health, the results of the issues are listed below by most frequent response of families.

- **59 percent - Social Support Systems** had by far the highest number of issue categories assigned to this determinant and accounted for fifty-nine percent of all the issues reported by the students from families. These included categories related to inequity of services in the neighborhood compared to other places in the city such as concerns expressed by the families as to limited access to a grocery store, poor quality produce, erratic trash pick-up, and no pizza delivery.
- **21 percent - Individual behaviors** ranked the second highest issue category assigned to the determinants of health. These included threats from illegal activities with the actual concerns expressed by the families for this category related to drugs and prostitution in the neighborhood.
- **15 percent - Physical Environment** had the third highest rating named "aesthetic pollution" and expressed the actual concerns by families in terms of litter and noise. This included the amount of litter in vacant lots and the playing of loud "boom boxes" at odd hours.
- **4 percent - Individual Economic Status** had the fourth highest rating and included the long history of business disinvestment that had occurred in the neighborhood over the years along with the issue of "a working versus living environment." This last concern expressed by families included the incongruity of high unemployment by residents in the neighborhood juxtaposed against the presence of a large tertiary care hospital, with relatively few hospital employees living in the neighborhood.
- **0 percent - Access to Therapeutic Resources** - No issue categories were assigned to the determinant of access to therapeutic resources. (In other words, the families in the neighborhood did NOT see therapeutic resources as an impediment/barrier to achieving health.)

Similar to the process for the issues, the families' assets were assigned to the five determinants of health. Here, the picture looked quite different. The resulting determinants of health from the asset side (those things that create and sustain health) are listed below by most frequent response by families.

- **35 percent - Individual Economic Status**, which ranked the highest, included individual personal and professional skills and represents the largest category of assets expressed by the families. These included such skills as retail experience, estate planning, computer skills, baking, cooking, and sewing.
- **31 percent - Physical Environment** had the second highest rating of assets and included community assets such as gathering places. The actual assets expressed by the families were Saint Mary's (hospital) and the rich history of the neighborhood.
- **14 percent - Social Support Systems** ranked third in assets that determine health. These categories demonstrate evidence of change and perceived evolution of stability. The actual assets expressed by families included improvements in school systems and decline of gang activity.
- **14 percent - Individual Behavior** ranked fourth and included assets such as positive attitudes, strong values, and motivations. It represented the assets of self-sufficiency and cultural diversity.

- **6 percent - Access to Therapeutic Resources** represented the asset category of community health resources and included the assets of Saint Mary's and the Center for Health Professions.

When Thinking Shifts to Inside-Out

What does inside-out information reveal? First, both the issues and the assets are identified. Second, health is defined in the language of the people. Third, determinants of health related to the issues come from four community functions, most notably social support systems. Fourth, determinants of health related to assets also come primarily from community functions, most notably the human capacity currency of individual economic status. Finally, the asset-based approach helps people define for themselves what creates and sustains health in their community.

In summary, health-related decision making traditionally occurs under the aegis of institutionally defined health indicators such as morbidity and mortality rates. This approach, however, tells only part of a community's story. Through the community-defined health process, it is clear that knowing a community involves capturing its human capacity in the levels of caring and hope, citizen engagement, and quality of relationships—in essence the intangible assets of a community. We at CHP assert that intangible assets are as valid as traditional, institutionally defined health indicators. Based on our work in the Cathedral District neighborhood, results to date validate that neighbors view the determinants of health deriving more from the substance and quality of community life than from contact with the health care system.

Uncovering intangible assets provides a deeper, more meaningful way of knowing a community. We further contend that comparative analysis of community-defined health and institutionally defined health reveals that scholars, researchers and health professionals characteristically know a community through aggregate data and regard individual information as anecdotal. Community-defined health, on the other hand, demonstrates the opposite. The more individualistic and idiosyncratic the information, the more powerful the relationships among individuals in the neighborhood and community. Current practice in health care tends to disregard intangible assets in the form of community-defined health information, and does not recognize its value in decision making. It is essential, therefore, that in shifting the thinking of health professionals, community assets are not "clinicalized" and the beauty and uniqueness of the community is not denigrated. We have learned that people are more than just informants; they are the identifiers and interpreters of their own truth. They are active participants in the co-production of their own health and well being.

Lisa Hadden is President and CEO of the Center for Health Professions based in Saginaw, Michigan and can be reached at: Telephone: 517-776-8529, Fax: 517-776-8141 or haddenl@aol.com. Janalou Blecke, RN. Ph.D. is a consultant and curriculum development specialist for the Center. Dr. Blecke can be reached at: Telephone: 517-790-4130, or E-mail: blecke@svsu.edu. *The Center for Health Professions is supported in part by Saint Mary's hospital in Saginaw, Michigan, a member of Ascension Health System, and the Michigan Primary Care Association.*