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## A Brief Report on a Facilitated Approach to Connect Cooperative Extension Southern Region State-Level Health Specialists

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## A Brief Report on a Facilitated Approach to Connect Cooperative Extension Southern Region State-Level Health Specialists

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## **A Brief Report on a Facilitated Approach to Connect Cooperative Extension Southern Region State-Level Health Specialists**

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*Improving the nation's health will require collaboration among many stakeholders and systems, including representatives from Cooperative Extension Services (CES). This paper describes the process of establishing a multistate collaboration and discusses initial outcomes of a third-party facilitated participatory planning meeting. State-level specialists with expertise and responsibilities in "health" promotion participated. Satisfaction with meeting format; feasibility, acceptability, and appropriateness of the proposed approach to public health impact; and general meeting feedback were collected through a survey and cultural artifacts (e.g., notes, worksheets). Preparation and attendance costs were captured. Seventeen of the 20 attendees (85%) responded to the survey and reported the process was satisfactory and the proposed plan for moving forward was feasible, acceptable, and appropriate. The meeting cost was \$1,011 per attendee. The process mobilized a multistate Extension collaborative to promote health but revealed potential cost-benefit challenges. Leveraging resources is necessary to plan, implement, and measure collaborative public health efforts. Future data on outcomes will show if the process leads to intended objectives. If successful, this approach can be replicated across CES for stronger impacts.*

**Keywords:** capacity building, outcome and process assessment, preventive medicine

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## Background

To improve the health of the nation, multistate collaboration in Extension is necessary to share expertise, knowledge, and resources (NIFA, 2014). These collaborative efforts are especially needed to address the escalating prevalence of chronic disease in the Southern Region of the United States (Cooper et al., 2000; Jacobson, Gange, Rose, & Graham, 1997; Mokdad et al., 1999). Within Extension, university-based specialists typically work in content areas centered on their academic background, the academic unit in which they are housed (e.g., human environmental sciences vs. public health vs. exercise science), and personal program/research interests. Specialists identify, implement, and evaluate interventions as well as provide training and resources to community-based educators and volunteers. Thus, they are a bridge from research to community members. However, time and resource constraints and efforts to attain tenure and promotion in their respective units may limit specialists' scopes of work. Engaging in strong dissemination strategies among health specialists may speed awareness of available interventions, test the adaptations of interventions in the field, and impact public health (de Montigny, Desjardins, & Bouchard, 2017; Hiatt et al., 2018; Janecka, 2017).

The value-added of such work on professional networks (Franz et al., 2010; Manteiga et al., 2017), in-person think tanks (Shaw, Russell, Greenhalgh, & Korica, 2014), and other participatory approaches (Nicolaidis et al., 2011; Rosales et al., 2017) for addressing complicated problems is well reported in the literature. It is recommended that the forming, storming, and norming (Tuckman, 1965) of these groups may be best established through a third-party facilitator who can serve as an intermediary (Wastchak, 2013), provide structure and external leadership, and avoid biasing discussion.

These participatory approaches are positively perceived due to their focus on equity, capacity building, and public health impact. However, information on the resources required to engage in participatory approaches is less understood (Bergeron et al., 2017; De Las Nueces, Hacker, DiGirolamo, & Hicks, 2012; Grills, Robinson, & Phillip, 2012; Harden, Johnson, Almeida, & Estabrooks, 2017). Furthermore, limited information exists on the process and outcomes of a professional network for health promotion specialists.

This paper describes the two-year process, preliminary outcomes including costs, and lessons learned in establishing a Collaborative network of health specialists in the Southern Region of Extension. This process can be used in other pragmatic settings to organize, goal set, and evaluate health promotion efforts and serve as a model for replication in other Extension regions.

## Historical Context for the Collaborative

### Year 1

State leaders of the Southern Region invited health specialists to organize themselves and meet face-to-face at the Extension Southern Region Program Leader Network meeting in Nashville, Tennessee, in August 2016. The goal of convening was to meet other individuals with similar positions within their state, promote regional grant writing, and engage in other professional activities, such as the pursuit of tenure track with Extension position, publications, enhanced scholarship. Fifteen participants across eight states and eleven institutions met for approximately 3.5 hours. Several *Liberating Structures* (Lipmanowicz & McCandless, 2014) activities facilitated networking and idea generation to guide work moving forward: Impromptu Networking, Lightning Talks, Exploring Purpose, Generating and Sifting Ideas (please see citation for more details on how to conduct these activities). At the end of this session, five main areas for collaboration were generated related to curriculum, evaluation, training, marketing/communication, and new approaches (Table 1).

**Table 1. Summary of Topic Areas from First Meeting of Southern Region Health Specialists**

<b>Curriculum</b>	<ul style="list-style-type: none"> <li>• Need to identify common curricula for implementation; consistent data collection and evaluation and reduce redundancy across state lines</li> </ul>
<b>Evaluation</b>	<ul style="list-style-type: none"> <li>• Need to establish the impact (and strength of evidence) for current health promotion efforts</li> </ul>
<b>Training</b>	<ul style="list-style-type: none"> <li>• Community-based educators have competency gaps</li> <li>• Public health approach is new for Extension. Need community-based educators to understand and address social determinants of health</li> <li>• Need for community-based educators to have cultural competence and apply social justice across program areas</li> </ul>
<b>Marketing/Communication</b>	<ul style="list-style-type: none"> <li>• Focus of work may be unclear without consistent language/terminology</li> </ul>
<b>New approaches</b>	<ul style="list-style-type: none"> <li>• Leverage a number of opportunities to collaborate with Extension community development as well as other partners</li> </ul>

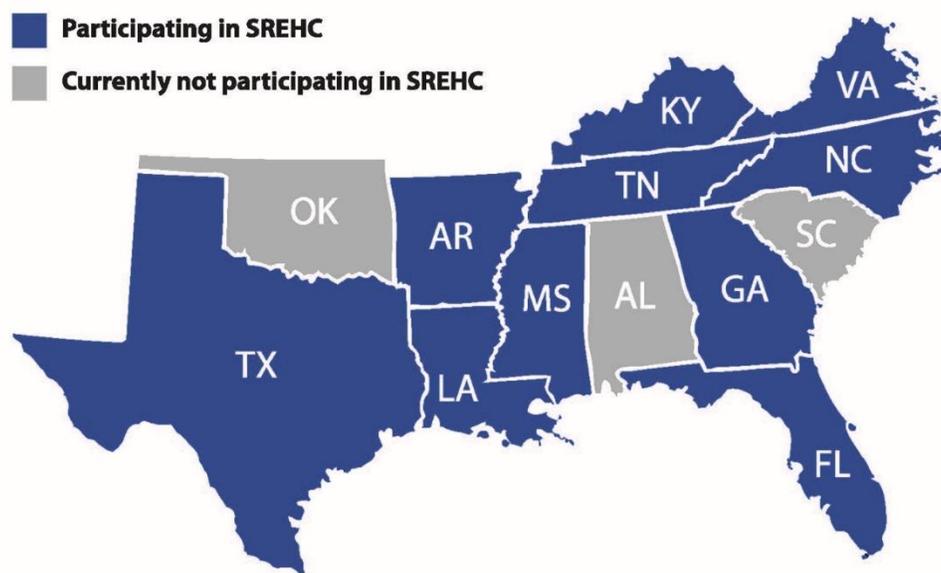
The group collectively agreed that to move forward: (a) It is important to organize the group and facilitate collaboration; (b) Gaps in expertise represented in the initial group need to be identified, and (c) The group should continue to convene (web and face-to-face). Attendees had the opportunity to participate in a brief presentation to highlight programmatic work and collaboration opportunities, but only two participants presented their specific work (e.g., information was not representative of health promotion across entire states or the region).

### Year 2

In year 2, a planning committee ( $n = 5$ ) was established in May 2017 to develop an agenda for a 1.5-day (Day 1: 7.5 hours, Day 2: 6 hours) workgroup meeting. The third-party facilitator was

informed of the history and goals of the group (see Table 1) and was hired to apply the adapted version of the Vision to Action Planning™ (Andress, 1991) approach. The committee met virtually six times and established a meeting location, agenda, and objectives. Meeting agenda and printable materials are available from the corresponding author upon request. Thirty-four individuals were identified through a health specialist listserv and personal invitation by national Extension leaders; 20 attended, representing 10 of the 13 Southern Region states (see Figure 1). The objectives of the meeting were to (a) increase knowledge of health education programming and applied research in the Southern Region, (b) determine the future of the group through strategic planning, (c) foster regional collaboration by forming workgroups to address priority issues, and (d) develop action plans to address priority issues.

**Figure 1. State Participation Status within the Collaborative across the Southern Region of the Cooperative Extension System**



### **Facilitated Planning Meeting Process and Outcomes**

The facilitated planning approach was based on an adapted version of the Vision to Action Planning™ (Andress, 1991). This is an approach where a third-party facilitator guides key stakeholders through five stages: (1) agreements, (2) preparation, (3) workshop (including information, vision), (4) action, and (5) evaluation. The work has evolved to meet Extension professionals' needs for 25 years; however, the elements remain the same.

#### **Stage 1: Agreements**

To establish an agreement regarding the purpose of the meeting, the facilitated session started with attendees writing three reasons for “Why are you here?” and “What do you like about the group?” on sticky notes. Using a rapid inductive approach (Beebe, 2001; Hamilton, 2013;

McMullen et al., 2011), the facilitator clustered the notes into similar responses to identify emergent categories and themes to propose mission and value statements. The resultant mission statement was: “To provide a venue to network, collaborate, and learn by sharing, growing, and finding the path forward for collective impact of Extension programming.” An initial values statement was crafted from “What do you like about this group?” to reflect: “We value collegiality, common understanding, openness and diversity, connections, productivity, and idea building.”

## Stage 2: Preparation

The next stage was related to preparing to work together. Participants reflected on strengths and concerns for the group to open discussions on expectations and role clarity. Table 2 summarizes major categories and themes for strengths and concerns of developing a specialist network, informed by participant responses.

**Table 2. Emergent Themes from Mission, Values, and Workgroup Building Sessions**

<b>Item</b>	<b>%</b>
<b>Why did you come? (Mission) (n = 57 MU*)</b>	
Collaboration	21%
Networking	19%
Ideas	7%
Impact potential	5%
Sharing	5%
<b>What do you like about the group? (Values) (n = 58 MU)</b>	
Collegiality	10%
Shared focus on health	9%
Networking	7%
Enthusiasm	7%
Openness	7%
<b>Strengths (n = 124 MU)</b>	
Diverse experiences	19%
Willingness to collaborate	11%
Impact potential	9%
Common interests	5%
Enthusiasm	5%
<b>Concerns (n = 106 MU)</b>	
Undefined focus	12%
Time	9%
Funding	8%
Competing interests	7%
Group cohesion	6%

### Stage 3: Workshop

The workshop portion of the process was to generate ideas, potential solutions, and finalize a vision. Using a handout provided by the facilitator, each attendee created a written vision for the Collaborative's work in the next three years. Three individuals collapsed the vision statements into seven themes: collaboration, impact, focus-fit, sustainability, innovation, programming, and support/resources. Then, attendees were asked to cast four votes for the visions they perceived as most important. The four themes selected were collaboration, impact, sustainability, and focus/fit (receiving 17, 12, 11, and 8 votes, respectively); innovation, programming, and support/resources received, 6, 4, and 2 votes.

### Stage 4: Action

Based on the results of the workshop, the group moved into taking action. The four major themes were used to develop four working groups: (1) *Impact*, (2) *Fit/Focus*, (3) *Collaboration*, and (4) *Sustainability of the Collaboration*. All attendees self-selected into a working group. For the remainder of the session, the working groups set goals, outcomes, and action strategies to address their group's vision. This stage also included a break from workgroup tasks. In this "break" time, each state Extension system provided a 5-15 minute update respective to their state system. On day 2, workgroup members reconvened to finalize strategies and share with the overall group. Workgroup planning session results are summarized in Table 3.

**Table 3. Summary of Workgroup Goals, Outcomes, and Strategies**

Workgroup	Goal	Outcomes	Strategies
<i>Impact</i>	Collaborative clearly articulates its impact on improving health outcomes in Extension programs	50% of Extension institutions use common indicators to document health outcomes	<ul style="list-style-type: none"> <li>• Within first 6 months, a definition of health indicators will be established</li> <li>• By end of year 2, an environmental scan of existing health indicators will be conducted</li> <li>• Within 6 months of completed scan, identify key health indicators that have value to stakeholders and institutions</li> <li>• By end of year 3, findings about common health indicators will be disseminated to the Southern Region Extension Health Collaborative for review</li> <li>• By end of year 3, Southern Region Institutions will identify a common indicator(s) that has value to stakeholders and their institution to include as a pilot in evaluation efforts</li> </ul>

<b>Workgroup</b>	<b>Goal</b>	<b>Outcomes</b>	<b>Strategies</b>
<b>Fit/Focus</b>	Increased recognition and value of health programming in Extension in the Southern Region	Provide Southern Region strategic plan/logic model	<ul style="list-style-type: none"> <li>• Partner with the Collaborative to determine the health program priorities in other states</li> <li>• Analyze environmental scan results</li> <li>• Conduct one-on-one interviews with individuals doing unique programs to gain input from partners</li> <li>• Share results of survey and interviews (potentially via webinar)</li> <li>• Hold a face-to-face meeting in 2019 to create strategic plan for logic model</li> </ul>
		Increased support for health specialists to succeed	<ul style="list-style-type: none"> <li>• Create materials with mission and vision to share with new health specialists who join</li> <li>• Create a webinar series to share programs</li> <li>• Quarterly zoom meetings of the Collaborative</li> <li>• Create a listserv for group communication</li> <li>• Hold annual in-person meetings</li> </ul>
<b>Collaboration</b>	To improve the efficiency and effectiveness of Extension health programs through collaboration	Increased number/adoption of collaborative health programs	<ul style="list-style-type: none"> <li>• Training to help community-based educators conduct health programs</li> <li>• Benchmark via survey of current collaborative programs to compare over every two years</li> </ul>
		Increased resources (monetary, FTE, volunteers) for health promotion	<ul style="list-style-type: none"> <li>• Share opportunities/information about certifications that provide monetary resources</li> <li>• Benchmark current health indicators, such as monetary resources, FTEs, volunteers, and compare every two years to determine change</li> </ul>
		Increased number of collaborations at regional and national level as a result of this collaboration	<ul style="list-style-type: none"> <li>• Benchmark what currently exists</li> <li>• Assessment to help determine what collaborations are needed—specifically from this group (monetary resources, program evaluation, implementation)</li> <li>• Research best practices in collaboration and share to help increase collaboration</li> <li>• Census/survey of Collaborative projects every 2 years</li> <li>• Submit proposal for multistate grant with members of this Collaborative</li> </ul>

Workgroup	Goal	Outcomes	Strategies
Sustainability of Collaborative		Increase number of active participants in the Collaborative	<ul style="list-style-type: none"> <li>• Finalize the name of the group</li> <li>• Create a sustainable organizational structure</li> <li>• Have representation from all Land Grants within the 13 states</li> <li>• Define “active” participation in the Collaborative</li> <li>• Collect responses regarding suggestions for structure and frequency of meeting via survey</li> </ul>
	The Collaborative is recognized as leaders in Extension health programming	Increase use of evidence-based health promotion programs available through the collaborative repository	<ul style="list-style-type: none"> <li>• Each state will compile a list of all health programs/ activities/ curricula that are currently being implemented</li> <li>• Develop a repository for evidence-based Extension health programs</li> <li>• Define evidence-based program</li> </ul>
		Increase support for collaborative from stakeholders (admin, program leaders, department, constituents)	<ul style="list-style-type: none"> <li>• Define stakeholders</li> <li>• Clarification of participants’ roles in collaboration (to include value to development and to state)</li> <li>• Disseminate outcomes of collaborations’ activities</li> <li>• Market/publicize activities of the collaboration</li> </ul>

### Stage 5: Evaluation

An electronic post-meeting survey was distributed via email in the form of a Qualtrics survey to obtain preliminary feedback on whether the planning meeting met its purpose. Seventeen responses (85%) were received within the first week. A reminder email was distributed, and no additional responses were recorded.

Ten items were adapted from the Training Satisfaction Scale related to the content and usefulness of the meeting, all on a 5-point Likert scale (1 = *completely agree* to 5 = *completely disagree*; Beidas, Edmunds, Marcus, & Kendall, 2012). Example items included, “The processes were realistic and practical” and “The processes used enabled us to take an active part in the meeting.” The training satisfaction sum score indicated that participants strongly agreed or agreed (1.45 ±.57) that the training was satisfactory. In response to the additional item added to the scale for this work (i.e., “The workgroup meeting merits a good overall rating”), participants strongly agreed (1.35 ±.49).

The survey also included an adapted version of a validated feasibility, acceptability, and appropriateness scale, with four items per construct on a 5-point Likert scale (1 = *completely disagree* to 5 = *completely agree*; Weiner et al., 2017). Example items include “The 4-

workgroup approach seems feasible” and “The 4-workgroup approach seems fitting.” Participants agreed or completely agreed that the 4-workgroup approach was acceptable ( $4.41 \pm .039$ ), appropriate ( $4.56 \pm .039$ ), and feasible ( $4.30 \pm .036$ ).

To gauge initial perceptions of the proposed Collaborative structure, additional items were developed for this work. On a 5-point Likert scale, individuals were asked to state their level of agreement that they could engage in the Workgroup structure as proposed. For example, “I can meet annually in person” and “It is important to me that I am an active member of this workgroup.” Most respondents agreed or completely agreed that they could meet in person annually (94%), that they could meet quarterly online (88%), that it is important to be an active member of their workgroup (94%), that this work was important and they could actively contribute (82%), and that it is important to be an active member of the Collaborative (94%).

Open-ended responses were gathered related to three challenges and three strengths of the working group meeting, and any other feedback. The top four challenges of both the in-person planning meeting and resultant Collaborative were concern for time commitments/lack of time to keep this work moving forward, lack of facilitator on day 2, need for role clarity and to finalize scope of work, and need for clear structure of the group. Strengths were related to values including, but not limited to, organization, networking, diversity, and enthusiasm. As one participant noted, “Learning about what other states are doing was extremely helpful. It seems that the group has a more defined identity as a result of [the facilitator’s] activities. Meeting in person forced me to be more engaged in group conversations.” Additional feedback was that having a third-party facilitator was imperative and that the group needs a “fast, easy win to show that these efforts have a return on investment.”

### **Costs of This Approach**

Cost data were captured for meeting planning personnel time, participant registration fees, facilitator fees, meeting materials (printing, markers, etc.), and participants’ flight and lodging. Participants’ time was not included in cost estimates; all specialists had FTE for Extension, and the sessions were held within the workweek. Meeting supply costs were included in participant registration fees. Funding sources for registration and travel costs varied by university and included university administrative support and specialists’ overhead/grant dollars. Financial support for year 1 and year 2 meetings was solely provided at the university level; no regional-level funding was provided. Registration (\$190) and lodging (\$353.36) were fixed costs for all participants, whereas transportation costs were variable with some members driving or flying—approximately \$350 per attendee. For the facilitator, expenses accrued were airfare (\$485.00), lodging (\$353.36), meals (\$69.66), mileage (\$36.12), and parking (\$30). Facilitation expenses of \$100 per hour were incurred for planning and facilitation before and during the meeting, respectively, for a total of \$1,050. In addition, \$335.16 covered an administrative assistant’s personnel time to coordinate the event (collect and monitor registration, payment processing,

printing, collating, etc.). This cost was based on 24 hours of time at a rate of \$10.50 per hour plus a 33% fringe rate. In total, the regional planning meeting cost was estimated to be \$20,226.50, or approximately \$1,011 per attendee ( $N = 20$  attendees).

## Lessons Learned

### Satisfaction with and Feasibility of the Facilitated Process

Process data reported here indicate the facilitated approach was well received; the proposed working groups seemed feasible, acceptable, and appropriate to move this group forward; and concerns remain for the Collaborative structure and impact. Notably, the top concern before and after the meeting was time. This is unsurprising given the demands of community and academic work. However, to be responsive and improve real-world translation, protected time is needed to collaborate, deliver, and evaluate the impact of health interventions in an empirical way. All four workgroups can address this need. As seen in Table 3, the workgroups independently developed specific and measurable goals. For example, the *Fit* workgroup aims to develop a clear definition of health to which specialists and health educators may align their efforts. The *Impact* workgroup will identify measurable impacts on health (e.g., standardizing health behavior measures in Extension programming) as well as evaluate the degree to which the workgroup structure is sustainable.

### Remaining Concerns for Impacting Health Across the Nation

Participants also mentioned that Extension administration needs to be aware of these efforts, the time invested, and the outcomes produced. This is, in part, due to the financial investment that underpins support for in-person meetings. In fact, an in-person meeting may have been cost-prohibitive for some health specialists to participate in this work in the first place. This cost-benefit challenge may remain as the Collaborative moves forward to promote health in a systematic way. These barriers—time, cost, competing interests—were reflected as the top three challenges attendees shared related to continued quarterly web-based meetings and annual in-person meetings. To demonstrate return-on-investment, the Collaborative needs to track outcomes and outputs and disseminate benefits of the working group to multiple stakeholder levels. This will be calculated through increased peer-reviewed manuscript submissions, funded grant applications, and translated health promotion programs.

### Replication of this Process for Other Collaborative Efforts is Warranted

Strengths of this work include details from process, funds, and participant perceptions. There is a dearth in the literature related to process and specifics of *how* and *why* an approach (in this case, a facilitated meeting) may impact dissemination and implementation outcomes (Proctor et al., 2011). For example, many manuscripts refer to “full-day” trainings, with limited information on the facilitation process. However, the nuanced details of this report and the materials

available (agenda, worksheets) may aid in replication for faster public health impact (Glasgow, Vogt, & Boles, 1999; Wilson, Strayer, Davis, & Harden, 2018). Future work is needed to determine the degree to which the plan proposed by the Collaborative is followed, any adaptations to the plan, and if this plan produces outcomes of interest such as increased use of evidence-based interventions across Extension and/or increased number of collaborations across the states in the region.

### **Limitations**

This brief report is not without limitations. First, aside from the facilitator, all authors and respondents were members of the Collaborative. Another limitation was the post hoc collection of cost data, so no results related to participant perceptions of the cost-benefit of attending were collected. In addition, the cost of each specialists' time was not included in the cost description. However, these data may be a useful inclusion to understand the full costs of an in-person planning meeting in future efforts both for this Collaborative as well as a cost to be captured a priori in other work. Another limitation of this work is the potential lack of generalizability outside of the Southern Region. While previous research suggests that this region, and the Extension professionals working within it, value this type of approach (Franz et al., 2010), this process may not be feasible within other regions or other systems. As recommended by Damschroder et al. (2009), future work is needed to explore the context of Extension, the professionals within the system, the processes by which health promotion interventions are adopted, and characteristics of health promotion interventions that are deemed appropriate for implementation.

### **The Facilitated Process Should be Generalized to Other Regions**

As representatives of the Southern Region, we acknowledge that future collaborations (either by region or for the nation) may undergo the same process, but develop different visions, missions, and working groups. For example, in stage 3, when writing individual vision statements, a different region may land on different priorities. Ownership and buy-in are vital for the success of this work. Therefore, new collaborations should undergo a similar process but not necessarily buy-in to the same outcomes and visions that we established. Indeed, the group will meet again in August of 2019, and the working groups may be reordered depending on productivity and progress related to outcomes described in Table 3. The pieces of this work that we deem generalizable are related to incorporating a third-party facilitator, capturing cultural artifacts from the meeting, and developing working groups to ensure that the "work" continues outside of the planning meetings.

### **Conclusion**

Extension is poised to address health through evidence- and practice-based interventions, but efforts could be improved through collaboration among state representatives who can

complement strengths and expertise, leverage human and monetary resources, and systematically measure impact. This participatory approach to determine a path forward for health in Extension in the Southern Region was determined to be feasible, acceptable, and appropriate to begin visioning this effort. Future data on outcomes will determine if the process leads to intended goals. With the data presented here, other systems and settings may replicate this approach for a collaborative effort for health promotion.

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