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The Colorado Public Health/Parks and Recreation Collaborative: A Model for Bringing Together Multi-Sectoral Professionals

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Abstract

The five conditions of collective impact are explored as they frame the development and foundation of a multi-sector collaborative between public health and parks and recreation. The history of the Colorado Public Health/Parks and Recreation Collaborative's (PHPR) evolution is described. A review of the literature provides insight into the application of multi-sector collaboration for a collective impact on childhood obesity. Strategies and tools are described to establish new networks and provide insight for replication.

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The Colorado Public Health/Parks and Recreation Collaborative: A Model for Bringing Together Multi-Sectoral Professionals

“A rapidly growing body of evidence establishes that protecting and restoring access to nature in different spheres of people’s lives, among those of all ages, social groups, and abilities, can alleviate some of the most important problems in public health, including obesity, stress, social isolation, injury, and violence.” (American Public Health Association, 2013)

Introduction

Today, a considerable amount of discussions on population health are focused on collaboration and the need for multi-sector collaboration to enhance collective impact and community health outcomes. This paper describes efforts and the use of conditions of collective impact to bring public health and parks and recreation professionals together for collaborative work focused on healthy eating and active living.

History

Obesity prevention is currently one of Colorado’s flagship priorities in *Shaping a State of Health* (2015–2019). There are more than 1 in 4 children in Colorado overweight or obese, with approximately 14.8 percent of children ages 2–14 years old obese (CDPHE, 2014). Obesity prevention has been identified as one of Colorado’s *Winnable Battles* (CDPHE, 2013) and a statewide goal is to reverse the upward obesity trend. A winnable battle is important as a large portion of the population are affected or at risk, it also involves a large degree of health disparities, imposes a large economic burden or risk on quality of life, and is consistent with state or federally mandated programs to improve and protect the environment and public health. In addition, the identified health issue is supported by existing evidence-based practices or best practices programs and there is a community level of readiness for change.

Children spend a considerable amount of time in community centers, parks, and taking part in recreation activities during out of school time, whether it be in after-school or summer programs. Primary prevention (i.e., before symptoms occur) is the major method that can be employed to eliminate a future health problem (Cohen, Chavez & Chehimi, 2010). Selecting obesity prevention while aligning efforts and partnering with professionals in these environments, seemed to be a logical step to foster and support a culture of health in Colorado. Working with multi-sector partners in public health

and parks and recreation to build community engagement, was a new and unattempted avenue of collaboration.

In 2013 a number of like-minded organizations in Colorado were working to eliminate childhood obesity through a variety of modalities. Public health was looking at risk populations, implementing evidenced based programs, trying to connect with the community, and talking about increasing physical activity opportunities, healthy eating, and active living. Parks and recreation departments were providing programming for youth, and intimately connecting with the community providing food and safe places to play, as well as, planning and building parks and open spaces. However, Parks and recreation departments were not fully recognizing its role in health. Awareness of efforts to affect childhood obesity amongst the professions seemed minimal. Each profession had a place where they were comfortable trying to make a change in the obesity epidemic. What was not happening was communication and collaboration between the two groups of professionals. There was a profound disconnect between the language, the approach, perception of the problem, but not about the ultimate goal—eliminating childhood obesity in Colorado.

In early 2014, a small group of inter-disciplinary professionals came together to start approaching this opportunity on a grand scale by asking questions and inviting additional people to the table who were interested in joining an emerging parks and recreation and public health collaborative. The initial step taken was to identify individuals who were already engaged in efforts to eliminate obesity at multiple levels (state, county, municipal, and non-profit, as well as, school health and wellness). By spring of 2014 monthly conference calls were initiated to share efforts, expand the scope of partners (e.g., Live Well Colorado), and increase the knowledge of population health initiatives (e.g., Healthy Eating and Active Living [HEAL]).

In the fall of 2014 the PHPR tackled the objective of how to bring together public health and parks and recreation professionals. The professional conferences (e.g., Colorado Public Health Association (CPHA), Public Health in the Rockies (PHiR), and Colorado Parks and Recreation Association (CPRA) annual conferences) were identified as the place to start. Attendance and collaborative presentations at these conferences prompted the decision to create a statewide professional summit to further explore common topics of interest and to physically introduce professionals from each field to one another.

PHPR members felt the summit first and foremost ought to be participatory and cutting edge. The opportunity to network, be face-to-face with different professionals, break down communication barriers, tear down silos, and build relationship bridges was essential. In addition, it was key to identify topics that appealed to both public health and parks and recreation professionals and that effectively incorporated tenets and values respective to both professions.

It was important that there were valuable takeaways for attendees to share with their organizations, such as, conversation starters for collaboration aimed at reducing the obesity level for Colorado kids.

In February of 2015 the PHPR hosted the first Public Health/Parks and Recreation Collaborative Summit: For the Sake of Health. Sixty-five people attended the Summit: 20 from public health, 31 from parks and recreation and 14 others from varying professions. Following the Summit 94% of participants indicated they would like more events like this. Participants also reported that they had met an average of four potential partners and that they would follow up with the partners they met, take materials back to their organization, and encourage others to attend future events like the Summit. Taken together these various activities over the past two years launched multi-sectoral teams that have gone on to provide the structure for the Colorado Public Health/Parks and Recreation Collaborative (PHPR) and its subsequent work.

Review of the Literature

Calls for multi-sectoral collaboration to address a range of health problems—both pressing and complicated—are in abundance. Approaches such as Health in All Policies, Public Health 3.0, and Healthy People 2020, for example, reflect an appreciation for not only the social and environmental determinants of health, but also the limited capacity of any one sector to tackle effectively the conditions driving poor health outcomes and health inequality. In this respect, the rationale for Health in All Policies is instructive:

Health in All Policies is a response to a variety of complex and inextricably linked problems such as the chronic illness epidemic, growing inequality and health inequities, rising healthcare costs, an aging population, climate change and related threats to our natural resources, and the lack of efficient strategies for achieving governmental goals with shrinking resources.... Addressing them requires innovative solutions, a new policy paradigm, and structures that break down the siloed nature of government to advance trans-disciplinary and intersectoral thinking (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013, p. 17).

Similarly, public health practitioners recognize that several trends necessitate an “upgrade” to Public Health 3.0. These trends include elected officials and civic leaders’ increased awareness of the significance of community health, behavior-related causes of death and illness, diminished public health budgets, and public health’s move from direct service provision to primary prevention and promotion following the passage of the Affordable Care Act. Among the key components of Public Health 3.0 is an emphasis on “broad engagement with partners across multiple sectors,” including business and the general public (De Salvo, O’Carroll, Koo, Auerbach, & Monroe, 2016, p. 622; Office of the US

Assistant Secretary for Health, 2016). Likewise, according to Healthy People 2020, the promotion of physical activity, as with its other objectives, requires “traditional partnerships” with education and health care, as well as “non-traditional partnerships” with transportation, urban planning, recreation, and environmental health.

The current emphasis on multi-sector partnerships has prompted parks and recreation to re-consider its own mission. As Dolesh and Bashir (2016) remark, “Ten years ago, if you asked parks and recreation professionals if they were part of a system of health providers, you would have been met with a blank stare of incomprehension. If you ask the same question in 2016, you would find almost universal agreement that parks and recreation are all about health”. Studies that have shown the positive health effects of exposure to green space (Mitchell & Popham, 2008) further underscore this important shift in perception. Others who advocate for greater collaboration between public health and parks and recreation departments also note the alignment of their activities and responsibilities—for example, environmental health protection and land management practices, respectively (Merriam, 2016). In the case of the Colorado Parks and Recreation Association (2012), the commitment to population health finds expression in its core values of health/wellness and collaboration/partnerships in addition to its vision statement, “A dynamic, proactive organization that creates healthy residents and livable communities by promoting excellence in parks and recreation”. To be sure multi-sectoral activity promises mutual benefits, but they are not guaranteed. Collaborations frequently confront an array of challenges related to resources; commitment; turf; conflict; respect, understanding, and trust; diversity; communication; and facilitation (Hogue, 1993).

In the case of partnerships between public health and parks and recreation departments, pronounced differences in methodologies and terminology can be bridged through the five conditions of collective impact. Collective impact is defined as the “commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem” (Kania & Kramer, 2011). The five conditions that set collective impact apart from other forms of collaboration are a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and the presence of a backbone organization (Hanleybrown, Kania, & Kramer, 2012). Numerous communities and funders have embraced collective impact and applied it to a wide range of community development issues ranging from poverty reduction to teen pregnancy, infant mortality, early childhood education, and positive youth development.

Importantly, seasoned practitioners of collective impact readily acknowledge the demands inherent in implementing such an approach. In a recent issue of *Community Development* devoted entirely to a critical examination of collective impact, Walzer, Weaver, and McGuire (2016) contend that collective impact

“is not a one size fits all approach; rather it must be tailored to meet specific needs and desired long-term outcomes” (p. 157). Later, Weaver (2016) notes the “deceptively simple and intriguingly complex” (p. 282) nature of collective impact’s conditions, and argues, “scaling change on a complex issue, bringing together diverse partners, building a system leadership skill set, understanding and engaging a community that is ready to act are all challenges that take both time and an attention to the micro-shifts that occur in any type of community change effort” (p. 282) These same conditions, LeChasseur (2016) concludes, “stop short of providing guidance on how to handle power relations within communities and change efforts” (p. 235). Elsewhere, the writing of others echo LaChasseur’s concern, offering comprehensive critiques attuned to social justice and equity considerations (Wolf, 2016; Le 2015). For their part, Kania and Kramer (2015) encourage an explicit attention to equity to effect the transformational change that the five conditions of collective impact are designed to support.

Health equity is an overarching aim of the PHPR, and the five conditions of collective impact offer a conceptual basis for innovative intersectoral activity. However, collaborative members also recognize the value of complementing the collective impact approach with other models to advance equity statewide. These include a social-ecological model of health, which “requires practitioners to consider both the individual and her or his environment in preventing and treating poor health” (Grzywacz & Fuqua, 2000, p. 102) and an asset-based model of community development, which emphasizes communities’ strengths, gifts, and talents and thereby offers an instructive alternative to needs-driven, deficit-centered narratives” (Kretzman & McKnight, 1993). LaFasto and Larson’s (2001) research on teamwork and leadership provides additional insights. Their model highlights the importance of team members’ qualities (experience, problem-solving ability, openness, supportiveness, action orientation, and personal style); team relationships; team problem-solving; the team leader’s capacities (focuses on the goal, ensures a collaborative climate, builds confidence, demonstrates sufficient technical know-how, sets priorities, and manages performance); and the organizational environment. Several of these components parallel the characteristics of effective collective impact backbone leadership (e.g., “collaborative, relationship builder” and “focused, but adaptive”) (Turner, Merchant, Kania, & Martin, 2012).

Finally, PHPR members regularly refer to the collective knowledge and expertise of public health entities, such as the Colorado Department of Public Health and Environment,[1] the National Association of City and County Health Officials,[2] and the Centers for Disease Control and Prevention[3] for guidance in conceptualizing and operationalizing health equity. The integration of these varied sources of knowledge, expertise, and models with the five conditions of collective impact reflects the PHPR’s heightened awareness of the intricacies of health equity and population health promotion and sets the

stage for PHPR members' informed decision-making and sustainable activity. In the following section, the alignment of the PHPR's strategies and tools with the five conditions of collective impact will be discussed.

1. See Colorado Department of Public Health and Environment health equity model at <http://www.chd.dphe.state.co.us/CHAPS/Documents/Health%20Equity%20Model%20and%20Summary.pdf>.
2. See the proceedings of the 2016 National Association of City and County Health Officials Annual Conference at <http://www.nacchoannual.org/highlights-from-naccho-annual-2016/>.
3. See Centers for Disease Control and Prevention—Division of Community Health. (2013) *A practitioner's guide for advancing health equity: Community Strategies for preventing chronic disease*. Atlanta, GA: US Department of Health and Human Services. Retrieved from <http://www.cdc.gov/NCCDPHP/dch/pdf/HealthEquityGuide.pdf>.

Strategies and Tools

Although the critical examination of collective impact in the literature was acknowledged by the team, the five conditions of collective impact were used as the foundation for framing work and activities of the collaborative. Table 1 delineates the strategies and tools used by the team to reflect each of the five conditions that distinguish highly structured combined efforts. It was difficult to address each condition in isolation of the other conditions as they often overlap. For example, strategies and tools used for continuous communication may also represent a mutually reinforcing activity. For the purposes of this article, tools and strategies have been defined and discussed related to one primary condition, of collective impact.

Table 1: The PHPR Collaborative's Strategies and Tools to meet the five Conditions of Collective Impact.

The Five Conditions of Collective Impact'		Colorado Public Health-Parks & Recreation Collaborative Related Strategies & Tools
Common Agenda	All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.	Various statements describing the Collaborative's focus/purpose/vision: <ul style="list-style-type: none"> • “Creating a healthy Colorado”—specific focus on “the role that built design, recreational programming, academia, and for/non-profit agencies play in effecting change towards

(cont'd)

		<p>healthy eating and active living and away from obesity and other negative outcomes often impacting low income populations” (2015 PHiR conference proposal).</p> <ul style="list-style-type: none"> • “We want communities who are healthy, active, happy, and safe” (2015 “Taking Stock” leadership retreat & 2016 Summit dotmocracy activity). <p>Note: utilized the 2016 Summit dotmocracy activity to gather feedback on Collaborative’s global vision, priorities, and guiding principles</p>
Shared Measurement	Collecting data and measuring results consistently across all participants ensures efforts are aligned and participants hold each other accountable.	<p>Examples of evaluation strategies (related to process and operation):</p> <ul style="list-style-type: none"> • Summit evaluations (online surveys and follow-up interviews = mixed methods approach) • 2016 Summit dotmocracy activity (a kind of evaluation as well) <p>Specific metrics to gauge success regarding interventions and health outcomes will be developed.</p>
Mutually Reinforcing Activities	Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.	<p>Examples of efforts to support the identification and pursuit of mutually reinforcing activities:</p> <ul style="list-style-type: none"> • “Speed dating” • Brokering—introduce individuals/organizations/agencies to one another • Collaboration Multiplier Tool—effective use of this tool/intentional interdisciplinary and geographic seating arrangements during 2015 Summit • Attending and presenting at PH and PR conferences (moving in one another’s professional circles)
Continuous Communication	Consistent and open communication is needed across the many players to build trust, assure mutual objectives,	<ul style="list-style-type: none"> • Onboarding of new members, including explanation of “how we roll”/communicate with one another (i.e., norms) • Monthly conference calls with leadership team

	and create common motivation.	<ul style="list-style-type: none"> • Frequent e-mails focused on resource sharing, event announcements, and information exchanges • LinkedIn • Bingo—use to introduce PH and PR terminology and build a common language
Backbone Support	Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.	<p>Creative/dynamic infrastructure:</p> <ul style="list-style-type: none"> • Jo's unique role • Leadership team (Important point: How we lead matters. We're not interested in taking credit; we want to broker connections and catalyze action.) • Summit attendees = larger network of cross-sector actors who engage in the work with the leadership team <p>Financial support:</p> <ul style="list-style-type: none"> • Question: Who has contributed? How much has been contributed? How have funds been managed?

¹Hanley Brown, F., Kania, J., and Kramer, M. (2012). Channeling change: Making collective impact work. *Stanford Social Innovation Review*, 1–8.

Common Agenda

An initial step in delineating a common agenda was to identify individuals and organizations that could help develop strategies and create environments to create change. The core leadership team used collaborative presentations at one another's professional conferences to share the vision and mission of the PHPR and examples of beginning programs and projects. Attending and presenting at conferences created the opportunity to move within one another's professional circle. This was the first time health care professionals attended parks and recreation conferences, and that parks and recreation individuals attended state level public health conferences. This small step was extremely challenging as venues and professional programs expectations were very different, however, it created opportunities for discussion and dialogue on how to provide a collective voice to the different types of audiences present. Costs are associated with presenting at a conference as presenters are expected to register for the conferences they attend. In some cases, membership within the association is a requirement for a presentation to take place. Professionals from another field might not be members of the conference association and

will therefore incur fees which can be barriers that would hinder participation. It is our recommendation that these barriers be removed to foster multi-sector reports of collaborative work. Team efforts provided strategies to increase interest and engagement of conference participants. For example, attendance was taken, email addresses were gathered and the efforts of the PHPR were expanded statewide. Team members followed up with individuals and invited them to participate in core leadership team and partnership meetings.

With increased participation and enthusiasm to further develop a common agenda, a statewide summit was planned and implemented to bring parks and recreation department leaders and public health leaders from all levels together to increase the network and sustain the momentum to create change. The 2015 Summit: *For the Sake of Health* was attended by professionals who were present at previous state presentations and has expressed interest for inclusion in the summit. This free, invitational, space-limited conference resulted in approximately 30 parks and recreation individuals registering. The team then offered invitations to local health agency (LHA) representatives from those counties, and 20 attended along with 14 others from related professions. The Summit venue created a successful structure that has been replicated annually (*For the Sake of Community*, 2016; *For the Sake of Equity*, 2017) to foster continuous communication and reinforcing activities. Strategies to multiply collaboration and a joint network were emphasized at the summits.

Following the 2015 Summit, the leadership team, comprising public health and parks and recreation professionals, came together to take stock and consider the future of the collaborative. The leadership team held a full-day retreat, during which they reflected on the Summit evaluations, reviewed the collective impact literature and related tools, discussed the PHPR's readiness for a collective impact approach, and explored examples of local collective impact efforts (e.g., Early Childhood Colorado Partnership) for transferable insights. Later in the retreat, members contemplated the following question: "What are the quality of life conditions we want for the children, adults, and families in our communities?" This led to a fruitful brainstorming session aimed at the articulation of the PHPR's next steps as a collective impact initiative. All comments were recorded on chart paper, and then, the team coded the comments according to the components of a common agenda: vision, outcomes, strategies, and principles. By the conclusion of the retreat, the leadership team had forged a vision for the PHPR: We want communities who are healthy, active, happy, and safe. The initial operationalization of the vision, along with potential strategies (e.g., empowering community members to be advocates for their health) and guiding principles (e.g., data-driven decision-making and adherence to a social justice orientation), were then shared with the full PHPR membership during the 2016 Summit. Members' feedback was gathered through a Dotmocracy exercise described in the "Shared Measurement" section below.

Both the 2015 retreat and the 2016 Dotmocracy exercise marked critical moments in the PHPR's evolution. The retreat was instrumental in strengthening the relationships among the partners in the room because it allowed for the exchange of different kinds of expertise grounded in personal experience and disciplinary training. It also gave partners an opportunity to converse with one another as co-creators rather than as competitors for limited resources. The Dotmocracy exercise further democratized the decision-making process by soliciting input from those chiefly responsible for effecting change in their communities.

Mutually Reinforcing Activities

Mutually reinforcing activities are described as actions taken by stakeholders or collaborative members that are both differentiated and coordinated through a plan of action. In the beginning of the PHPR members were asked to share what activities their organizations were already engaged in regarding reducing obesity in communities in Colorado. These included Healthy Eating Active Living (HEAL) coalitions, youth sport and activity programming, nutrition classes, Walk with a Doc, 5-2-1-0 Let's Go!, and Parks Rx. The next question was how could we connect with each other through these already occurring activities and share or replicate the benefits with other members. The undeniable choice was to present examples of these programs/interventions occurring in collaboration at the professional conferences of both disciplines, as confirmation of what we could better accomplish together. The rationale for the choice to present at the professional conferences was to improve connection, communication, and collaboration amongst the two professions.

For our first and subsequent Summits, the core leadership team chose to use seat assignments to create opportunities for intentional connection and collaboration. Table assignments and participants were critically analyzed and selected to foster increased communication between public health and parks and recreation leaders within specific regions of the state. Although some attendees were initially uncomfortable or even a bit resentful towards this action, the strategy was effective in creating new relationships and ultimately resulted in a positive evaluation. In addition, the assignments were given to create discussion and dialogue. The initial tool used was the Collaboration Multiplier, which is an interactive tool used to "help lay the foundation for shared understanding and common ground across all partners" (Prevention Institute, 2011). Newly formed table teams worked collaboratively on the mission of creating a healthy Colorado. Teams presented a report to all conference participants which provided ideas and strategies for continued future work, communication, and collaboration.

Another strategy used was creating a game, similar to “speed dating”. Conference time was provided to allow the introduction of new acquaintances and relationship building among Summit participants. This brokering activity provided awards/prizes to individuals who had met the most new individuals and who had made plans to follow up with them in the future. Our rationale for this activity was to give multi-disciplinary professionals the opportunity for face to face time.

Continuous Communication

In addition to the more typical methods of communication such as core leadership team meetings, partner meetings, monthly conference calls and information exchanges a tool was developed, *Acronym Bingo*, which would in turn enhance communication. It became clear that the use of acronyms was causing some problems with communication and that some individuals might not feel comfortable acknowledging a lack of understanding. For example, at one time, discussion was focused on DNR. What a disconnect! Health professionals were thinking “do not resuscitate” and parks and recreation professionals were talking about the Department of Natural Resources. Bingo boards were developed and the fun began, with prizes for the most accomplished. Later a cheat sheet was provided to all to facilitate and enhance communication. This communication tool is in continuous revision and used to introduce new members to commonly used terminology and helps to build a common language. The quality of relationships, the cohesion that exists, and the hospitality that is shown between members of the two specialties form the social capital of the organization and in sense the work of the community (Putnam, 2000).

The all-day retreat, which was mentioned above, was held to reinforce goals and the mission, as well as, review foundations and tools for new members and leaders. Work focused on the five conditions of collective impact and the 3–5 year goals of the PHPR. Validation and confirmation of goals were desired and a strategy was created to get statewide input into leadership goals and objectives at the 2016 Summit.

Shared Measurement

Online summit evaluations provide data related to structure and process of the programs and related activities, which provide work and activity for future programming related to the mission and vision. Precursory evaluations with questions such as: *After attending this event today, do you feel more inclined to take*

action to promote the integration of public health and parks and recreation? and Will you take any action based on this event? also provide emphasis for continued work.

In 2016, an evaluation event was included as an activity in the Summit: Dotmocracy Activity. This activity was planned to gather feedback on the PHPR's vision, priorities, and guiding principles. Statements were posted throughout the room on poster boards, and participants were provided different colored dots (yellow, green, blue, and red) to rank their belief in the value of the statement or the priority to be given to the statement or content. Facilitators asked for no discussion/talking during this time and then facilitated a critical analysis and evaluation of grouped dots for synthesis and further consensus building. Data from the Summit evaluations and Dotmocracy Activity provided evidence to support interest and momentum for continuation of the network and depth of work.

Implementation of joint local programming outcome measurement has also been discussed. Use of evidenced-based practice programs, such as 5-2-1-0 *Let's Go!*, a healthy eating and active living teaching program (Rogers & Fortier, 2000), and The OrganWise Guys, a company that "helps spread awareness about the importance of a healthy lifestyle to battle childhood obesity" (Lombardo & McNamara, 1993) provide opportunities for multi-site evaluations and community participatory research. These evidenced based programs provide tools to assist with data collection and evaluation. Purposeful selection of programming and tools increases the likelihood of successful replication to other sites. Attempts have been made to decrease as many barriers to replication as possible: cost, availability, copyright, and translatability across disciplines.

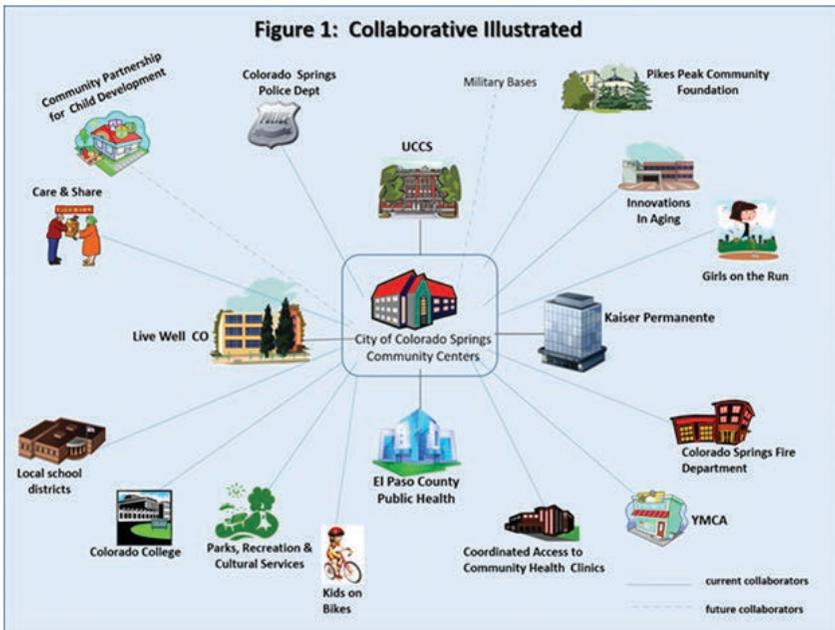
Use of the Omaha System of Information Management provides a framework for practice documentation and information management. The system includes an inter-professional Problem Classification Scheme, which consists of four domains: environmental, psychosocial, physiological, and health related behaviors (Martin, 2005). The Omaha System provides a Problem Rating Scale for Outcomes which has been piloted for specific programming in parks and recreation. In 2017, Colorado Springs' three community centers, each located within neighborhoods that service predominantly low-income, minority populations used the Omaha System within their respective summer camp programs. Improvement in individual knowledge, behavior, and status in areas of physical and mental health were targeted for the problem classification of health-related behaviors and more specifically social contact and growth and development. Over the centers' collective one hundred plus years of existence, numerous qualitative evaluations—including focus groups and testimonials—have been used to evaluate programs. This is the first formal effort to objectively establish the direct impact on health that these programs have for participants who are vulnerable and at risk of poor health outcomes.

(For more information see the Colorado Community Center Collaborative Illustrated in Figure 1)

Use of Likert scale ratings related to change in knowledge, behavior and status has provided initial data for review in El Paso County, which includes the city of Colorado Springs. In addition to having a strong representation on the PHPR, Colorado Springs is taking the lead on program evaluation. A *Healthy LifeStyle Screening Tool* has been developed based on the structure of the Omaha System to reflect outcomes related to the program 5-2-1-0 *Let's Go!* - five fruits and vegetables, two hours or less of screen time, one hour of physical activity, and zero sugary drinks (Rogers & Fortier, 2000). The evaluation plan includes replication over time in a longitudinal design. Current and future collaboration with the local school system is in progress to provide access to metrics such as high school diploma, career achievement, and community involvement. The long- term goal of the evaluation plan is to provide quantitative evidence of recreational programming as an investment in positive youth development and healthy behaviors.

The PHPR's evaluation plan begins with support for a foundational structure for shared measurement. Orientation to the Omaha System is planned for

Figure 1: Colorado Community Center Collaborative (CCCC) Illustrated. Shows current and future collaborators. Created by Brian Kates, City of Colorado Springs.



the 2018 Summit and use of above mentioned program pilots will provide an exemplar for presentation to members of the State Collaborative. The goal is to create a multi-county Evaluation Action Team to focus on evaluation and a joint participatory research agenda.

Evaluating change in community or growth in advocacy capacity buildings has also been discussed. Future goals involve, providing the structure for continued work related to specific desired outcomes of changes in practice, policy reforms, and/or outcomes, and community impact (Kabel & Curry-Stevens, 2013). Plans are being discussed for the next leadership retreat to plan procedures and structures for sustained momentum. This is a work in progress and there is much work that still needs to be done.

Backbone Support

This condition describes the need for an external separate organization to take the lead and facilitate coordination. Unfortunately, this is the weakest link or condition of collective impact, as no external staff support exists. There has been no formal external funding to support this collaborative. Work related to launching and managing a collaborative dedicated to multi-sector collaboration is daunting. A member of the PHPR has taken on the leadership role to convene and manage the multi-sector activities with input from partners in establishing initiatives at the state level. A group of stakeholders with entrepreneurial passion and strategic patience come together and align with strong principles of joint leadership and management. Reflection on leadership is built into process. Core leaders of the PHPR relate individual interests to wider system level relationships, and discussion reflects on how we lead and less on the need to take credit for results or outcomes. Financial support through donations and in-kind structural support have been received, and a checking account has been established to facilitate funding and use of funds for annual summits. Two individuals have been designated to serve as treasurer and manage the fiduciary responsibilities. A creative and adaptive infrastructure that responds to the current needs as well as financial considerations helps to enhance momentum. This collaborative continues to expand its capacity to create the future (Senge, 1990). This condition of backbone support may need more specific attention as evaluation and collaboration research are considered with potential funding opportunities.

Conclusion

As Einstein once said “We cannot solve our problems with the same thinking we used when we created them.” So it only goes to say that leaders must think

differently to solve big problems and engage with people who think creatively to see other perspectives, opportunities, and solutions. The PHPR was created to address healthy eating and active living in Colorado. To attack a problem as big as childhood obesity, a variety of professionals with unique perspectives and ideas have put their heads together. Childhood obesity did not occur overnight and neither will the solution, but coming together from multiple sectors has provided professionals an opportunity to expand their network for future problem solving.

The majority of PHPR participants represent organizations tackling obesity from some perspective, but resources (money and manpower) are limited. After having candid conversations, decoding language, crossing bridges, and focusing on a variety of aspects related to obesity prevention, it was discovered that the professionals had common interests and goals. Professionals within the PHPR constantly share information, resources and opportunities trying to find ways to help each other. Silos have been torn down, turf has been overturned, and as a result, the world of health has become more interconnected and manageable.

The PHPR includes professionals who not only represent many public health, parks and recreation, and not-for-profit interests, but are also open to collaboration, comfortable sharing and speaking up, willing to make bridges, and have conversations outside of comfort zones. There are currently 30 professionals on our regular communication list who all participate as they are able and serve as a resource and contributor. A remarkable feature of the collaborative infrastructure is the various levels of practice and leadership that are represented, with participation of staff, coordinators, directors, local public health and official state consultants. The PHPR has public health professionals involved in nutrition, built environment, community engagement, and health planning, as well as, parks and recreation professionals involved in youth services, sports, wellness, facility management, and therapeutic recreation. There are also professionals from non-profits associated with health and school wellness.

In discussion with several collaborative members, the question has been raised about why this seems to be working. What has made this click when other collaboratives have ended? We began our conversations about a topic we all cared deeply about, ending childhood obesity, we were all pursuing different ways to combat the epidemic so it gave us common ground to discuss and to gain trust with one another. Bringing together similarly motivated professionals is more productive and creates collective impact on the issue of childhood obesity. The openness manifests in learning from each other, collaborating with each other, and realizing that sharing resources, efforts, and ideas is more productive and impactful on the issue than each of us pursuing our interventions separately.

Trust has been established around the work of obesity prevention and has opened the door to have more controversial and challenging conversations

(e.g., sugary drinks in public venues and park access equity). The Colorado Public Health/Parks and Recreation Collaborative is now a confident, growing group of professional's intent on inclusion of all those who want to pursue and achieve the vision of making Colorado a group of communities who are healthy, active, happy, and safe through this multi-sectoral collaboration.

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