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A Conversation Forward Community Capacity Assessment Tool (CCAT) to Catalyze Action

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Understanding and Building Community Capacity Through Conversation: A Conversation Forward Community Capacity Assessment Tool (CCAT) to Catalyze Action

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Abstract

Community capacity refers to the potential people and infrastructure have to develop initiatives that address community priorities. Understanding and building community capacity should be a parallel track with any health promotion initiative to support sustainability. Tools that assess community capacity are frequently implemented as a fast-and-easy measurement to assess the impact of community initiatives. These assessment tools are often created from validated measurement domains and questions to capture the essence of capacity at the community level. However, the piloting of such tools during the Alberta Healthy Communities Approach (AHCA) initiative from 2016-2019 found that tools that emphasize measurement often fail to facilitate and capture essential conversations. As a result, in 2019-2023, we developed and piloted a new conversation-forward Community Capacity Assessment Tool (CCAT) to assist with facilitating often complex community conversations about community capacity and to catalyze local action. The CCAT was created and implemented with an integrated knowledge translation approach that incorporated feedback from community members, implementation practitioners, researchers, and existing academic literature. The 17 communities that implemented the CCAT during the AHCA from 2019-2023 found the focus on conversation supported stronger knowledge translation of capacity concepts and domains and catalyzed action to build community capacity as a parallel element of action planning and implementation.

Keywords: healthy communities approach, multisectoral collaboration, community capacity, rural communities

Comprendre et renforcer les capacités communautaires par la conversation : un outil d'évaluation des capacités communautaires (CCAT) pour catalyser l'action

Résumé

La capacité communautaire fait référence au potentiel dont disposent les personnes et les infrastructures pour développer des initiatives qui répondent aux priorités communautaires. La compréhension et le renforcement des capacités communautaires devraient être une démarche parallèle à toute initiative de promotion de la santé visant à soutenir la durabilité. Les outils qui évaluent la capacité communautaire sont fréquemment mis en œuvre comme mesure rapide et facile pour évaluer l'impact des initiatives communautaires. Ces outils d'évaluation sont souvent créés à partir de domaines de mesure et de questions validés pour capturer l'essence de la capacité au niveau communautaire. Cependant, le projet pilote de tels outils au cours de l'initiative Alberta Healthy Communities Approach (AHCA) de 2016 à 2019 a révélé que les outils qui mettent l'accent sur la mesure ne parviennent souvent pas à faciliter et à capturer les conversations essentielles. En conséquence, en 2019-2023, nous avons développé et piloté un nouvel outil d'évaluation de la capacité communautaire (CCAT) axé sur la conversation pour

aider à faciliter les conversations communautaires souvent complexes sur la capacité communautaire et à catalyser l'action locale. Le CCAT a été créé et mis en œuvre selon une approche intégrée d'application des connaissances qui intègre les commentaires des membres de la communauté, des praticiens de la mise en œuvre, des chercheurs et de la littérature universitaire existante. Les 17 communautés qui ont mis en œuvre le CCAT au cours de l'AHCA de 2019 à 2023 ont constaté que l'accent mis sur la conversation favorisait une meilleure application des connaissances sur les concepts et les domaines de capacité et catalysait l'action pour renforcer la capacité communautaire en tant qu'élément parallèle de la planification et de la mise en œuvre des actions.

Mots-clés : approche des communautés en santé, collaboration multisectorielle, capacité communautaire, communautés rurales

1.0 Introduction

Community capacity refers to the collective ability of a community to address its priorities by mobilizing its people, leaders, organizations, and other resources (Labonte et al., 2002). Whether it be to build capacity for climate change (Ziervogel et al., 2022) or resiliency to trauma (Gilmer et al., 2021), community capacity is essential for actioning change. Community capacity building is reliant on social learning, where both assessment and critical reflection are used to evaluate underlying values and concepts (Raymond & Cleary, 2013). This learning process can be transformative (Raymond & Cleary, 2013), where individuals understand their own assumptions and the actions that uphold them (Reed et al., 2010).

Additionally, community capacity is built when multi-sectors collaborate to identify and mobilize skills and knowledge, prioritize, plan, and implement action (Cunningham et al., 2015). Building community capacity is often accomplished alongside health promotion activities. Community capacity-building enables sustainable skills and resources for health promotion in various settings and sectors over time (Labonte et al., 2002). It can also improve community actions and have a greater impact on individual and community-level health, social, and economic indicators that can be sustained after the completion of a program or initiative (Labonte et al., 2002).

It is essential to measure community capacity to assess skills and resources currently available to support community action planning as well as potential areas of improvement. Assessing community capacity provides the opportunity to identify and address aspects of leadership, resource mobilization, skill-building opportunities, and existing culture and communication. The conversations that go alongside community capacity assessment provide foundations for engaging diverse partners and participants, leveraging resources, skills and knowledge building, and creating a shared vision for collaborative decision making. To this end, we aim to describe the development and implementation of the CCAT and its use as a conversation-forward tool.

2.0 Scholarly Context: The Alberta Healthy Communities Approach

The Alberta Healthy Communities Approach (AHCA) is an initiative developed, piloted, and evaluated with rural communities with Cancer Prevention and Screening Innovation (CPSI)—an interdisciplinary unit within Alberta Health Services (AHS), the single provincial health authority in Alberta, Canada.

Across two phases, AHCA engaged a total of 35 communities from 2016-2023. For this initiative, rural was defined as a population of 15,000 or less.

CPSI developed and piloted the AHCA through a five-step implementation process: (1) engage and create connections, (2) understand your community, (3) prioritize and plan, (4) implement and evaluate, and (5) sustain and share (Chaisson et al., 2022).

Figure 1. Alberta Healthy Communities Approach 5-step process.

There are a variety of measurement and data tools to support AHCA implementation available at https://albertahealthycommunities.healthiertogether.ca/building-healthy-communities/alberta-healthy-communities-approach/. In this paper, we focus on Step 2 of the process, "understand your community," and the development and testing of a new CCAT.

Community capacity can be perceived as both abstract and complex since it encompasses various aspects and layers of the community and its resources. When communities are starting their journey, understanding capacity can seem daunting. However, increasing community capacity can have a significant impact on community development. Decades of research have evaluated concepts, drafted capacity domains, and constructed assessment questions to be able to measure community capacity and evaluate the outcome of programs and initiatives (Lempa et al., 2008). It was essential to the development of the AHCA stepwise process and Step 2 to identify a community capacity assessment tool that could be mobilized by communities to measure community capacity and focus on community-relevant responses to address health disparities (Kwon et al., 2012).

In practice, community capacity assessment tools support community teams and the broader community to better understand their local community context and, specifically, to identify and address social and public health-related problems with an intentional direction based on their community capacity. A community capacity assessment tool designed for facilitating dialogue can help identify assets, strengths, and opportunities for growth in community capacity that supports action on local health and social issues. The identification of available resources for mobilization and specific areas to increase capacities will enhance action planning. In essence, the AHCA Step 2 both measures community capacity and builds 'research capacity' (Dancy et al., 2009) by educating community leaders and members on how to understand their community through research and evaluation assessment tools. Some tools, such as the Public Health Agency of Canada's (PHAC) 'The Community Capacity Building Tool' (Public Health Agency of Canada, 2005), focus on evaluation to measure change over time, specifically for the impact of grant funding. Other tools have a stronger community focus, ensuring that the tools are useful in fostering community dialogue and action, such as the Assessing Community Capacity for Change (Bopp et al., 2000), or the Community Capacity Assessment (Alberta Health Services Central Zone, 2000) tool.

Further, knowledge creation through information sharing and data collection is central to building community capacity that can be actioned (Ziervogel et al., 2022). The development and implementation of the CCAT are grounded in Community-Based Participatory Research (CBPR). CBPR is an equitable, collaborative approach to research that includes community members, organizations, and researchers where community capacity-building and sustainability are the key outcomes (Hacker et al., 2012). The barriers to current capacity building assessment tools are the knowledge translation of evidence-based research into community action. As was identified following Phase 1 of the AHCA, the definition of the domains, types of questions, and in-depth knowledge required for research methodology does not allow for equitable access to a research tool. As the AHCA was to be implemented throughout Alberta, a new assessment tool was required.

2.1 Local Context: The Need for an Adapted Community Capacity Assessment Tool

Phase 1 of the AHCA sought to understand the proof of concept of the AHCA and implementation testing in Alberta. This included evaluating and assessing for quality improvement to understand the implementation mechanisms of the AHCA. To do so, we collected preliminary evidence of effectiveness from 15 rural communities across Alberta to assess how the AHCA can increase community capacity and improve supportive environments. Further, we collect evidence of real-world context for the effectiveness, impact, and value of how the AHCA supports building community capacity for action on important health areas in communities.

To measure real world effectiveness during our proof-of-concept phase, the PHAC 'Community Capacity Building Tool' was chosen because of its historical application in grant funding initiatives to measure short-term outcomes and community capacity (Maclellan-Wright et al., 2007). The PHAC tool assesses the following nine domains: participation; leadership; community structures; external support; asking why; obtaining resources; skills, knowledge and learning; linking with others; and sense of community.

The PHAC tool was implemented twice as pre-and-post measures (roughly two years apart) with the 15 rural communities participating in Phase 1 of the AHCA. In addition to the pre-and-post scores, we evaluated the use of the PHAC tool through surveys, after-action reviews, temperature check-ins, and mid-and-end point focus groups. Data was also collected from the seven implementation practitioners supporting the 15 communities in mid-and-end point focus groups and quality improvement/feedback loops of practitioner experience throughout the AHCA.

Comparing the results, all communities recorded an increase in the nine domains of community capacity (evaluation data not yet published), suggesting that the AHCA supports building community capacity when communities work through the stepwise process.

Feedback from the perspective of community members captured the appropriateness of the tool for measuring community–level work—which is the "perceived fit, relevance, or compatibility of the innovation or evidence-based practice for a given practice setting, provider, or consumer; and/or perceived fit of the innovation to address a particular issue or problem" (Proctor et al., 2011, p. 69). The feedback identified that, generally, the PHAC tool was not 'useful' due to two themes. First, the PHAC's assessment questions per domain were too specific to program measurement and outcomes rather than measuring the current level of community capacity broadly. This limitation did not encourage community members and partners to explore the potential opportunities to build capacity. Second, while the PHAC tool supported the facilitation of a conversation about building community capacity, the limitations of the first theme made the implementation of the tool more difficult to align with the community context. To better adapt to the various levels of readiness and community context, a more conversational and thought-provoking tool was needed.

A review of evaluation findings, community feedback, and implementation practitioner experience identified the following recommendations: (1) expand the PHAC tool to revise and add domains of importance to the community that can be applied to broad or specific actions; and (2) design a tool that, through its implementation, supports discussion and conversation. Implementation practitioners identified inherent limitations with the PHAC tool, including a predominant focus on granting and project-based initiatives, while not supporting broader conversations about opportunities to build capacity.

Health promotion and community development scholars argue that community capacity is more complex. Unfortunately, these conversations may be absent from community work without an experienced practitioner and the appropriate resources and tools to facilitate a conversation that supports the community to move past assumptions and current narratives. An adapted community capacity assessment tool is needed to expand on the traditional definitions of community capacity, enhance applicability to unique community contexts, and emphasize discussions and conversations rather than focusing only on evaluation outcomes. To fulfill the needs of the AHCA and the community, we worked together with both our community and organization partners to create the CCAT that encourages deeper community capacity and produces results that can be integrated into community planning.

3.0 Methods: Developing the Community Capacity Assessment Tool

3.1 Conceptual Approach: Integrated Knowledge Translation

Integrated knowledge translation (IKT) is founded on the development of true partnerships with diverse partners and participants rather than simple engagement (Wensing & Grol, 2019). Throughout the knowledge translation process, partners and participants work together to share decision making, co-learn, and co-create (Nguyen et al., 2020). This active collaboration allows for a more efficient translation of the generated learnings into practice than traditional academic research methods that generate knowledge externally to real-world realities. Through an IKT approach, the various realities, perspectives, and contexts provided by the diverse informants are actively shaping the result (Nguyen et al., 2020). Partners and participants are also 'knowledge brokers' who facilitate and promote the exchange and dissemination (Dobbins et al., 2009). Additionally, instead of the participants just actioning the information that the health organization provides, co-creation, in the case of the CCAT, refers to the community's active participation to create mutually beneficial outcomes (Ertz, 2024).

An IKT approach encourages the recognition of the unifying role of the implementation practitioner to bring together multiple streams of evidence, including research, knowledge brokering, operational experiences and real-world practices (Albers et al., 2020). Click or tap here to enter text.This co-design process ensures community capacity reflects the lived experiences of community members and contributes to the creation of a more relevant and useful product for the user. Further, this enables a 'knowledge to action' process, where evidence-based research is translated to promote awareness and implementation of the research knowledge (Graham et al., 2006). Graham et al., 2006, note an action cycle process that includes (1) a group identifying a problem or issue that needs attention, (2) adapting the research knowledge to the local context, and (3) developing knowledge transfer strategies to promote awareness of the knowledge. Table 1 reflects the application of this process to create the CCAT.

3.2 Partner and Participant Engagement

In the co-creation of the CCAT for AHCA Phase 2, the CPSI implementation practitioners acted as knowledge brokers with rural communities, facilitating exchanges of knowledge and experiences among the participants. The seven practitioners have over 70 years of combined health promotion experience. In addition, the CCAT needed to align with the AHCA. This included ensuring that the CCAT captured the broader, lived experiences of partners and community members to reflect the social determinants of health while reflecting the AHCA process and broader conceptualization of community capacity. The implementation practitioners were critical of the CCAT creation to ensure it was appropriate for rural communities in Alberta. The CCAT thus brought together best practice evidence, practitioner experience and community knowledge in the adaptation of a community capacity tool.

3.3 Combination of Literature and Practice

The development of the CCAT went through several stages (see Table 1).

Table 1. *Integrated Knowledge Translation (IKT) Stages to Develop the CCAT*

Stage	Description
1. Identify the problem	• Review of feedback from AHCA Phase I identified a need for an adapted tool. • CCAT creation process began in October 2018. • Thematically analyzed AHCA Phase I evaluation data from 15 rural communities: surveys, after-action reviews, temperature checks, and mid-and-end point focus groups. • Mid-and-end point focus group data from the seven implementation practitioners supporting the 15 communities were thematically analyzed for practitioner experience.
2a. Synthesize knowledge	• Conducted a theme identification literature review of qualitative research techniques (coding, refining, and summarizing themes) and key search terms. • Search terms included 'defining community capacity' and 'community capacity domains.' • Literature was stored in NVivo and thematically coded definitions and domains.
2b. Knowledge tools and products	• Review of existing community capacity tool domain definitions and questions. • Two tools previously tested and identified as useful by CPSI implementation practitioners served as the knowledge foundation: o 1. PHAC Community Capacity Building Tool (Public Health Agency of Canada, 2005)—a tool assessed for its face and content validity (Maclellan-Wright et al., 2007) o 2. AHS Central Zone Community Capacity Assessment (Alberta Health Services Central Zone, 2000)—a tool that had been implemented by AHS for 19 years (at the time of CCAT creation) and perceived by the CPSI implementation practitioners as providing a template of more open-ended, conversation facilitating tool
3. Identify, review and select knowledge	• Literature themes (2a) were compared with existing tools (2b) to review how domains were conceptualized in literature versus captured in assessment tools. • Eleven domains were identified from the comparison and thematic analysis. • Definitions for each domain were drafted. • Assessment questions from existing tools were reviewed and ranked: o 1. high priority—question captures community priorities and needs o 2. medium priority—question captures community priorities and needs, but can be cut to keep the tool at a reasonable length

	○ 3. low priority—question does not capture community priorities and needs • Questions were drafted per domain. • A 5-point Likert Scale was developed to capture the range from one extreme to another, starting with 'haven't started', to 'on the road' (moderate, neutral option), to 'we're there'. A 'not applicable' option was included to enable communities to answer and adapt the tool to their community context.
4. Adapt knowledge to local context	• Implementation support tools to facilitate and capture communication conversation were developed to encourage critical and respectful conversations to build consensus per domain. • Tools included PowerPoint presentations, diagrams, and in-person exercises to visualize the domains. • A 'reflections page' was included in the tool to capture and facilitate conversation and record ideas and key points that led the group to agree on a certain level of capacity for that domain.
5. Review and production of CCAT (2019)	• CCAT was reviewed by all CPSI implementation practitioners who shared detailed feedback. • Feedback was compared to the literature (2a) to re-assess for alignment. • Feedback was incorporated to produce and complete the creation of the CCAT for August 2019.

3.4 Community Capacity Domain Conceptualization

The review stages and processes outlined in Table 1 resulted in the conceptualization of 11 community capacity domains and assessment questions. The domains included Sense of community; Communication; Partnerships, linkages, and networks; Participation; Resources; Skills and knowledge development; Asking why; Learning from experience; Shared vision; Shared community leadership; and Sustainability.

The decisions for the revisions or additions in the conceptualization and questions stemmed first from *how* the domains were experienced by community members as reflected upon by the health promotion facilitators, and second, to support conversation and discussion. For example, domain definitions and measurement questions were revised from "Have you overcome barriers to participation of the target population in the project?" (Public Health Agency of Canada, 2005, p. 1) to "To what extent do we do things in ways that make it easy for community members to get involved?" in the CCAT (p. 9). This revision changed the question from being specific to 'a project' or 'program', to a plain language question about participation accessibility in community action. Further, the incorporation of 'we' in the question facilitated a conversation of all community members participating in the tool and as the target audience. Using a Likert Scale required conversation for participants to come to a consensus and select the score as a 'we'. These changes led to domains and questions that were more open-ended while preventing repetition between domains (as capacity domains are often asking about the same action but from a different perspective, such as participation, communication, and asking why).

Table 2 presents the CCAT domain definitions and the fidelity of the domain based on foundational literature (Alberta Health Services Central Zone, 2000; Gibbon et al., 2002; Labonte, 2003; Labonte & Laverack, 2001a, 2001b; Liberato et al., 2011). All domains

were revised based on feedback from communities and CPSI implementation practitioners, who contextualized the domains based on the rural Alberta context. Table 2 also provides an overview of which domains align more closely with the foundational literature (score of 1), went through moderate revisions but still moderately aligns with the foundational literature (score of 2), or went through significant revisions and was supported with either foundational or newly, innovative literature conceptualizing community capacity (score of 3). In sum, one domain (Sustainability) received a score of 3, and two domains (Leaning from experience; Shared community leadership) received a score of 2. The remaining eight domains received a score of 1.

3.5 Implementation Supports

Facilitation of the CCAT conversation requires the creation of a safe space and neutral ground for the community team to share without judgment. This supports the conversations and sharing of perspectives that create the rich learning of the CCAT. The implementation supports were also meant to encourage critical thinking for transformative learning, as described by Mezirow's theory of transformative learning (Fleming, 2018). Mezirow's theory suggestions that providing a critical lens to one's thoughts or habits can free the individual from constraints or distortions and provide an expansion of meaning (Fleming, 2018). The implementation supports were designed to challenge participants assumptions through critical thinking to inform transformative learning. To support this and to facilitate ease of CCAT use, the following implementation supports were developed:

1. Reflections: The CCAT includes a 'reflections table' at the end of each set of domain questions to capture initial thoughts and discussion sparked by the questions. Increased reflection allowed communities to better contextualize the tool based on communities' understanding of the AHCA process, the community context, the perspective of team members, and the importance of the tool. This supported weaving the CCAT results into prioritization, action, evaluation, and sustainability planning from the outset.
2. Supporting Tools and Resources: To facilitate utilization of the CCAT by local teams, additional training supports, tools, and resources were required to explain the concept of community capacity and its importance. In response, an implementation guide and PowerPoint presentation were created to support the facilitation of the CCAT.
3. Analogies: Recognizing the complexity of community capacity, a garden analogy to support the knowledge translation process was utilized to explain how to "grow community capacity." This analogy explains the "seeds" of community capacity that may be present, and the importance of creating the conditions needed for those "seeds" to bloom. The CCAT was an important conversation starter to uncover the "seeds" that are present, challenge assumptions, and highlight opportunities to foster community capacity growth.

Table 2. *CCAT Domain Conceptualization, 2019*

Domain	**Domain definition 2019**	**Fidelity of domain definition and questions with literature, 2019**	**Justification for 2019 revisions**
Sense of community	A sense of community refers to feelings of belonging and working together (Jackson et al., 2003; Littlejohns et al., 2000; Schulz et al., 2003), and to trust among community members (Jackson et al., 2003; Schulz et al., 2003). When a sense of community exists, the broad community can identify issues and solve problems by owning the planning and implementing of actions (Jackson et al., 2003; Schulz et al., 2003). Sense of community also means that the community values diversity (Jackson et al., 2003), respects other viewpoints (García-Ramírez et al., 2009), shows compassion (Lempa et al., 2008), and reflects a shared identity regarding the community's physical and social environments (Parker et al., 2010).	1	Feedback from communities and the CPSI implementation practitioners identified that the literature and assessments outlined 'sense of community' effectively. Revisions to the domain and questions focused on contextualizing a sense of community in rural communities and using plain language.
Communication	Strong communication provides opportunities for different people to share thoughts, ideas, and information with others honestly and openly—without fear of being judged—with the goal of bridging gaps, resolving conflicts, and creating effective ways of working together (Alberta Health Services Central Zone, 2000).	1	Feedback from communities and CPSI implementation practitioners identified that the literature and assessments outlined 'communication' effectively. Revisions to the domain and questions focused on contextualizing communication to rural communities and using plain language.
Partnerships, linkages, and networks	Partnerships, linkages, and networks refer to the community's ability to form connections, and the level of connections- with diverse groups, organizations, and individuals who share similar interests and goals. By partnering, linking, and networking, the community and its partners develop mutual trust, share information and resources (Maclellan-Wright et al., 2007), enhance their separate and collective capacities and strengthen their relationships (Schulz et al., 2003).	1	Feedback from communities and CPSI implementation practitioners identified that the literature and assessments outlined 'partnerships, linkages, and networks' effectively. Revisions to the domain and questions focused on contextualizing partnerships, linkages, and networks to rural communities, using plain language, and selecting the questions most important to communities to reduce the length of the tool and prevent repetition in questions.

Domain	**Domain definition 2019**	**Fidelity of domain definition and questions with literature, 2019**	**Justification for 2019 revisions**
Participation	Participation means that the community actively and intentionally engages its members, organizations, and other stakeholders throughout the initiative (WHO, 1998)—from planning through implementation to evaluation. Active and intentional engagement, means there are community (or local) opportunities for people to share their thoughts, ideas, experiences, concerns, and solutions openly and safely—without the fear of discrimination or judgment (Public Health Agency of Canada, 2005), Participation also happens when people collectively take action to implement initiatives in the community.	1	Feedback from communities and implementation practitioners identified that the literature and assessments outlined 'participation' effectively. Revisions to the domain and questions focused on contextualizing participation in rural communities and using plain language.
Resources	Resources include people (such as volunteers), buildings and facilities, money, and time (Alberta Health Services Central Zone, 2000). Resources can be mobilized and leveraged to ensure the success and sustainability of community initiatives and actions. For example, organizations can provide meeting space, businesses can become sponsors, people can offer time and/or skills to help implement actions, conduct or compile community assessments or evaluations, write grant proposals, manage finances, and so on.	1	As asset mapping is essential to progressing through the AHCA to identify resources and community strengths and opportunities for growth, the resource domain was revised to encompass both identifying resources and mobilizing resources.
Skills and knowledge development	This domain is very similar to resources; however, skills and knowledge further includes "unique knowledge, skills, gifts and talents possessed by community members" (Littlejohns et al., 2000). Two important kinds of knowledge and skills in a healthy community are process and content. • Process knowledge and skills are those that help people work together effectively (Alberta Health Services Central Zone, 2000).	1	The literature and assessment tools identified in various ways that developing skills and knowledge is essential to progressing opportunities for growth for resources needed. The literature merged with the feedback from communities and implementation practitioners to contextualize the opportunities for how communities develop skills and knowledge.

Domain	Domain definition 2019	Fidelity of domain definition and questions with literature, 2019	Justification for 2019 revisions
	• Content knowledge and skills refer to specific activities, such as how to find information on the Internet, and how to apply for a grant (Alberta Health Services Central Zone, 2000). The 'skills and knowledge development' domain also includes providing equal opportunities to gain new skills and knowledge.		
Asking why	Asking why is the ability of a community to identify the root causes of concerns raised by citizens, groups, or organizations (Public Health Agency of Canada, 2005). Asking why is this happening enables community members to dig deeper into the individual, social, organizational, and/or system factors that seem to be the true origin of a problem (Public Health Agency of Canada, 2005). Asking why throughout the planning, implementation, and evaluation process sheds light on the (issues or factors) that matter most, income, literacy, racism, or housing, for instance. These factors are called the social determinants of health. Once root causes are identified, the community can plan comprehensive, innovative, and equitable solutions. Asking why is a necessary step for achieving lasting social change.	1	Feedback from communities and implementation practitioners identified that the literature and assessments outlined 'asking why' effectively. Revisions to the domain and questions focused on contextualizing asking why in rural communities and using plain language.
Learning from experience	The collective actions or initiatives of a community are perceived by its members as the community's experiences. Learning from experience means that the community regularly, systematically, and intentionally checks how closely the team's actions and the results of those actions align with the group's shared vision, principles, and goals (Alberta Health Services Central Zone, 2000). Learning from experience is the result of reflecting on and seeking community feedback to	2	Learning from experience is essential to the AHCA process, which includes implementing assessment tools, designing evaluation plans, and executing evaluation methods by communities, at the community level. This domain was expanded from 'seeking general feedback' to being purposeful in community actions to learn from experience, communicate these learnings, and translate these learnings into actions.

Domain	**Domain definition 2019**	**Fidelity of domain definition and questions with literature, 2019**	**Justification for 2019 revisions**
	understand what is working well and what can be improved upon with respect to community initiatives (The Aspen Institute Rural Economic Policy Program, 1996). These learnings will, in turn, inform future decisions and actions. A community that learns from experience shows accountability to its members.		
Shared vision	A shared vision is "a picture of the community at some time in the future, painted in enough detail that people can imagine it and, at the same time, realistic enough that people believe it is possible to reach" (Alberta Health Services Central Zone, 2000). It is shared only when created through dialogue and consensus with a diverse group of people, who have various experiences in the community (Liberato et al., 2011).	1	Feedback from communities and implementation practitioners identified that the literature and assessments outlined 'shared vision' effectively. Revisions to the domain and questions focused on contextualizing shared vision to rural communities and using plain language.
Shared community leadership	Community leaders are individuals, or organizations who are passionate about promoting the health of their community through positive change and collective action. Leadership does not require running for office or holding an official position or title. Community-minded formal leaders demonstrate community leadership when they ensure citizens' priorities are heard by local decision-makers. Leadership simply takes the form of assuming some level of civic responsibility, a willingness to engage others to make a difference, eagerness to learn from others, and/or recognizing others' strengths and capacities.	2	Feedback from the implementation practitioners identified that there are several assumptions that community leadership is finding one person to lead the community team and work, and that is all that is needed. The feedback challenged this assumption and identified that community leadership includes supporting and fostering current and future community champions and prioritizes engagement and collaboration - hence the phrase 'shared' in the domain title and two subsections of questions of 'leaders recognize and mentor', and 'leaders foster engagement and collaboration'. In addition, the third subsection focuses on formal leaders (local council, mayor/town council, school board) as they are important for both supporting the community teams and community development generally.

Domain	**Domain definition 2019**	**Fidelity of domain definition and questions with literature, 2019**	**Justification for 2019 revisions**
Sustainability	Sustainability means maintaining lasting benefits in a community through ongoing community action (Alexander et al., 2004; Baum et al., 2006; Center for Public Health Systems Science, 2012; Goldenberg et al., 2009). Thinking about sustainability begins at the outset and continues throughout your community project. Enhancing the domains of community capacity contributes to maintaining community actions such as evaluating initiatives and their outcomes to decide whether they should continue; or having ongoing commitment and strong partnerships to ensure that those initiatives are proven beneficial and other efforts continue (Alexander et al., 2004; Baum et al., 2006; Center for Public Health Systems Science, 2012; Goldenberg et al., 2009). Keeping initiatives going requires coalitions, organizations, and communities to focus on their assets and resources to improve and maintain the health of their community.	3	Previous assessment tools did not include a specific domain about sustainability and were limited in asking any questions about sustainability. As sustainability is critical to long-term success of community coalitions and initiatives, and is essential to the AHCA process, the team decided to conceptualize sustainability as a new domain in an assessment tool. To achieve this, literature related to sustaining community coalitions and initiatives was reviewed and the domain went through several rounds of revisions (see Table 1). The domain focused on challenging assumptions about how to sustain such coalitions and initiatives which included not relying solely on funding, continuing partnerships to move work forward, reviewing if the initiative should be sustained (i.e., was successful and had an impact on the community), and resiliency of the initiative and coalition.

Note: Fidelity with foundational literature ranking:

1. Significantly aligns with the literature with minimal adaptations from practitioner experience.
2. Moderately aligns with the literature with significant adaptations from practitioner experience.
3. Significant revisions based on practitioner experience, merged with existing literature.

3.6 Implementation Testing

Settings: The revised CCAT is being tested with 17 of the communities taking part in the second phase of the AHCA implementation from 2019-2023.

Phase 1 (2016-2019) communities were selected after extensive conversations with local health and community leaders and logistical review (proximity to implementation practitioners, community readiness, existing community building projects, etc). Recruitment for phase 2, (2019-2023) began with an open call for participation with 61 interested communities. Twenty communities were selected after an interview with community leaders and a similar logistical review. In both phases, participants in the AHCA self-selected to work with the implementation practitioners in developing a multi-sectoral team that ideally had representation from the community at large, community organizations and facilitates, workplaces, schools and health care facilities. If representatives of the different sectors did not independently choose to participate, implementation practitioners intentionally sought representatives of the various sectors. The resultant multi-sectoral teams from Phase 2 completed the CCAT and created and implemented actions that arose.

Data was collected to assess usability and acceptability to check that the CCAT conceptualized and fit the communities' experiences within their communities. While usability is generally to check the quality of the user experience, acceptability assesses "the perception among implementation stakeholders that a given treatment, service, practice, or innovation is agreeable, palatable, or satisfactory" (Proctor et al., 2011, p. 67). Table 3 outlines the data collection to review the usability and acceptability from the perspective of the 17 Phase 2 communities from the first implementation of the CCAT (2019-2021), as reported by implementation practitioners. Implementation practitioner reports were reviewed, and thematically coded.

Table 3. *Data Collection to Assess the Usability and Acceptability of the CCAT From 2019-2021*

Data source	**Description**
Survey to enter and store CCAT scores (2019-2021)	CCAT scores were entered into a survey to store, complete analysis, and provide a data summary (in the form of a report) back to the communities. This survey included a section for feedback to record any issues or suggestions on the tool. Feedback questions were specific to wording in the domain definitions, questions, repetition, lack of clarity, and other observations to the tool itself.
Knowledge and evaluation translation (KTE) tracking survey (2019-2021)	Following the implementation of the CCAT, the CPSI implementation practitioners recorded in the KTE survey the implementation context (who participated, timelines, any decisions made by the practitioner or community team, etc.) and optional feedback related to the KTE of the CCAT. The feedback included partnerships while completing the CCAT and observations while implementing the tool. Feedback was specific to the implementation of the tool, supporting implementation documentation, and any high-level feedback observations of what worked and what did not.

Table 3 continued

Open-ended survey questions (2019-2020)	On a quarterly basis for the first year of the second phase of the AHCA implementation (2019-2020), the CPSI implementation practitioners responded to open-ended survey questions. These surveys asked about the CCAT's usability, reflecting on which tools were most beneficial to supporting the communities moving through the AHCA process, which tools were most challenging for communities to use, and the ripple effects from using the CCAT. Feedback was required for any tool used by the CPSI implementation practitioners with the communities, optional to mention the CCAT specifically. Data collection was interrupted due to the COVID-19 pandemic and ended in January 2020.

4.0 Results: CCAT Implementation Test

4.1 Usability and Acceptability of the CCAT

The feedback collected from the methods in Table 3 identified strengths, benefits and areas for improvement. Generally, the communities deemed the CCAT "usable" and was "well-received."

The feedback identified the following strengths and benefits to communities:

- Generating conversations, often for the first time, about different aspects of community capacity.
- Using an assessment tool to understand community capacity.
- Planning community initiatives by considering resources, leadership, participation, etc.
- Supporting conversation and encouraging the development of a vision and mission for the community/team.
- Creating community connections through community engagement or identifying gaps in capacity.
- Encouraging 'ah-ha' moments in conversation by expanding the conversation to uncover concerns about health inequities and sustain community initiatives.

User feedback identified potential areas for improvement in the CCAT tool:

- Provide definitions for concepts such as 'diversity', 'inclusion', and 'inequity' to support conversations with clear definitions to avoid misunderstanding of concepts.
- Reduce duplication of questions within and between domains.
- Revisions to questions in the domains or sentences within the domain introduction that were unclear.
- For some communities, the CCAT was too long and took a long time to complete.

4.2 Community Capacity Conversations

During CCAT implementation, every domain could spark deeper conversations, depending on the community. In-depth conversations usually occurred around leadership, participation, and sustainability.

Leadership: Communities engaged in new conversations around how leadership is a concept that can be shared. This helped foster dialogue around building community leaders and more engaged community teams.

4.2.1. Participation: Community members identified that participation is more than just 'volunteering' and includes meaningful engagement that provides opportunities to share skills, strengths, and ideas openly without judgement. Broadening the community understanding of participation led to incorporating broader community engagement before, during, and after initiatives to increase the 'participation' and lived experiences of the community.

4.2.2. Sustainability: Sustainability is critical to the long-term success of the initiatives and the future of the team. The addition of sustainability as a domain in CCAT allowed the implementation practitioners to introduce sustainable planning from the beginning. It sparked critical conversations about ownership of initiatives and the differences between innovation and operationalization of activities, and the support mechanisms required. Comparing AHCA Phase 1 and Phase 2, the CPSI implementation practitioners found that communities were able to conceptualize sustainability as more than just 'continuing the initiative,' but rather, ensuring that mechanisms were in place to sustain and improve initiatives. Conversations in this domain encouraged community teams to consider sustaining initiatives with partners, including relinquishing control of the activity to ensure its continuation.

4.2.3. Social Determinants of Health: Sustainability conversations also started important conversations about social determinants of health, diversity, and inclusion, which caused even experienced community teams to pause and reflect on previously held assumptions. These conversations created an avenue for sustainable community action and opportunity for change in an upstream approach by 'asking why.'

The CCAT also solidified an understanding of the AHCA, the importance of partnerships, linkages and networks, and mobilizing collaborative decision making. These concepts are integral to the overall approach, facilitating conversations amongst teams that foster a shared vision and strategy for the future. Further, the creation of the well-received sustainability domain was conceptualized and identified as a need by the implementation practitioners, demonstrating the invaluable experience of implementation specialists as co-creators and knowledge brokers in implementation science.

The CCAT also supported a space for critical reflection through community capacity conversations. By providing a safe space the participants were open to alternative points of view, considered how others think and feel, and reflected on their and community informed assumptions—aligning with an example of critical reflection that informs transformative learning as described by Mezirow (Fleming, 2018).

5.0 Limitations

The CCAT was not tested as a standalone tool to be used for any context as the revisions were specific to rural communities that participated in the AHCA Phase 1 or 2. Additionally, the CCAT was not implemented with Indigenous communities or piloted with cultural community groups or urban neighborhoods. Further, the CCAT was implemented with the dedicated support of experienced implementation practitioners. At the time of writing this paper, not all the participating communities in the second phase of the AHCA have completed the post-assessment CCAT as part of the AHCA. End of project evaluation may include critical, additional feedback, which will be applied to the CCAT at that time (approximately 2025).

6.0 Conclusion

The CCAT demonstrates how a community capacity assessment tool can provide a forum for discussion and reflection about the unique and dynamic community context of rural communities in Alberta. The CCAT was perceived as more 'useful' than the PHAC tool because of revisions to reflect the broader community context. Critical to the success of the CCAT was the focus on community conversations rather than solely evaluating grant-funded initiatives. All communities identified that the tool supported conversations about concepts that even experienced community teams have not considered before and enabled a greater focus on sustainability and the determinants of health. Community teams identified that, although the concepts of the CCAT tool may be challenging, support from the implementation practitioners allowed them to better understand community capacity. The simple nature of the CCAT facilitated the integration of tangible actions to build community capacity within associated healthy community action plans.

As society adapts to a post-pandemic way of life, people are looking to their community for a renewed sense of belonging, participation, shared leadership, and vision for the future. The CCAT can support communities and community practitioners during community development processes by having conversations that identify strengths and opportunities for growth and reflect on actions to build healthier, more resilient communities. The CCAT is available to be used outside of the AHCA by any community member looking to understand the domains of community capacity and collect valuable information to inform sustainable action. As our evaluation did, the CCAT can be used to measure and monitor capacity changes, over time, and a resource to inform grant funding.

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