The *Live Well Allegheny* Conversation Project: Increasing Social and Civic Engagement in Order to Address Health Disparities in the Mon Valley

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Abstract

The Mon Valley region currently experiences a disproportionate burden of chronic disease when compared to county and national standards. *Live Well Allegheny* (LWA) Mon Valley, a program of the Allegheny County Health Department, works to combat regional disparities by partnering with area municipal councils and others to draft and implement health policies that combat chronic disease behaviors and promote healthy community environments. The effectiveness of the LWA program is hindered by a lack of community buy-in and direct resident engagement. The purpose of this thesis is to produce a program plan for a LWA community-engagement initiative, called the LWA Conversation Project, which will host resident-led discussions and create action plans inspired by resident input. The program plan is drafted using the PRECEDE-PROCEED model and includes community health assessments, implementation and evaluation frameworks, and a facilitator's guide. The intervention incorporates community organizing principles and draws from established community engagement models. The creation of a resident-driven complement to the current *Live Well Allegheny* program is significant to public health in its dual purpose of empowering residents to take an active role in health promotion in their region and of providing LWA and its partners with first-hand information about the needs of the communities they serve. By increasing the social and civic engagement of the region's residents, the program will increase the social capital and overall health of the Mon Valley region through the empowerment of individuals to become active participants in shaping their community.

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Preface

I would like to thank the Allegheny County Health Department and the *Live Well Allegheny* team for their insight and encouragement throughout the thesis writing process. I would also like to thank the team at the Human Services Center Corporation and members of the Mon Valley Providers Council for fostering my love of the Mon Valley region and its residents. I am grateful for my committee members, Jeanette Trauth, Richard Garland, Tracy Soska, and Maria Cruz for their guidance and support in producing this thesis. And finally, I would like to thank my spouse, family, and friends for their patience and love as I pursued this next phase of my career.

1.0 Introduction

Live Well Allegheny (LWA) Mon Valley, a program of the Allegheny County Health Department (ACHD), works to combat disparities in the burden of chronic diseases in the Mon Valley region. LWA partners with area municipal councils, school districts, and service agencies to draft, implement, and assist with health policies that promote healthy community environments. By encouraging the prioritization of health during the formation of policy, LWA has increased the capacity of area partners to meet community health needs and has created a cross-sector network of *Live Well Allegheny* Communities. However, Mon Valley municipalities have struggled with implementation, as high levels of poverty, shrinking tax bases and aging infrastructure provide limited resources to support new health initiatives. The effectiveness of the LWA program as an intervention to address the development of chronic disease is also hindered by a lack of community buy-in as residents report that established health programs inadequately represent them and do not encourage their input.

The purpose of this thesis is to produce a program plan for a LWA community-engagement initiative, called the LWA Conversation Project, which will host resident-led discussions and create action plans inspired by resident input. This initiative will function as a complement to LWA's current policy-oriented approach and will serve as a guide for fostering collaboration between residents and area stakeholders. The program plan was developed using the PRECEDE-PROCEED planning model.

Following the introductory chapter, the thesis is divided into five additional chapters. Chapter two provides background information detailing the results of several assessments which comprise the PRECEDE portion of this planning model. Chapter three describes the methods used

in the creation of the program plan and details the sources used to support its components. Chapter four presents the thesis results which includes information on implementation and evaluation of the planned program. The results section is guided by the PROCEED segment of the planning model. Chapter five provides a discussion of the challenges and implications of implementing the proposed program. The thesis conclusions are contained in Chapter six.

1.1 The Mon Valley: Study Setting

The Mon Valley is a region in southwestern Pennsylvania comprised of 70 municipalities that span four counties: Allegheny, Fayette, Washington, and Westmoreland. Communities in the region share a common economic history, being comprised of a patchwork of mill towns and neighboring residential areas that made the region at one time one of the most concentrated centers of heavy industry in the United States (UCSUR, 2015). For the purposes of this thesis, the Mon Valley is defined as those municipalities within the boundaries of Allegheny County (the catchment areas of the ACHD) that have been recognized by LWA as the service area for the Mon Valley branch of the program. Twenty-five communities meet this definition including the cities of Clairton, Duquesne, and McKeesport; the boroughs of: Braddock, Braddock Hills, Dravosburg, East Pittsburgh, Elizabeth, Glassport, Homestead, Liberty, Lincoln, Munhall, North Braddock, Pitcairn, Port Vue, Rankin, Turtle Creek, Versailles, West Elizabeth, West Homestead, and Whitaker; and the townships of Elizabeth, Forward, and South Versailles.

The region is currently home to 103,358 residents (PA Department of Health, 2017). Municipalities range in size, with 50% having fewer than 2,500 residents and 75% with a population of fewer than 5,000 people. Approximately 75% of residents are white, non-Hispanic,

about 21% are black non-Hispanic, and 4% identify with another ethnic group (U.S. Census Bureau, 2014). The Mon Valley is also home to some of the largest black communities in Allegheny County outside of the city of Pittsburgh, including Rankin and Braddock boroughs and segments of the city of McKeesport (Deitrick, Briem, and Williams, 2005). The region's median household income of $35,724 falls well below county and national averages (Allegheny County $52,548/ US $53,694) (UCSUR, 2015). There is also wide variability in income within the region based on geography, with the highest median household income of $59,681 reported in the more rural Elizabeth Township and the lowest of $20,000 in the inner-ring suburb of Duquesne. Racial disparities in income are also present, with white residents on average reporting roughly $8,000 more than their black neighbors. Unemployment in the region averages higher than surrounding areas, with a current rate of 6.2% (Pittsburgh 5.3%, Allegheny 4.5%, PA 4.3%) (U.S. Census Bureau, 2014). The primary occupations reported are office and administration support, professional and related fields, and sales and related fields (UCSUR, 2015).

1.2 *Live Well Allegheny:* Current Programming

Live Well Allegheny was launched in January 2014, with the aspirational goal of making Allegheny County the "healthiest county" in the nation by addressing behaviors that contribute to the development of preventable chronic disease (Live Well Allegheny, 2016). Housed within the Chronic Disease Prevention Department of the ACHD and spearheaded by Director Dr. Karen Hacker, the initial focus of the program is reducing smoking and obesity rates and increasing physical activity in the county through promotion of healthy habits, proper nutrition, and individual health management.

Using a "health in all policies" approach whereby policymakers prioritize health in the drafting of new policies, LWA strives to target individual health behaviors by engaging private and public institutions in the creation of healthy and supportive environments for residents to live and work. Members recruited to become *Live Well Allegheny* Communities sign a resolution to partner with the initiative to work toward health and well-being goals and draft three action steps designed to improve health outcomes for their residents. LWA supports partners in these efforts through the creation of a multi-sector coalition, including school districts, community-based organizations, and businesses, and by providing increased access to ACHD resources, such as educational materials and promotion of partner events. The LWA program strives to partner with all 130 Allegheny County municipalities and 90 city neighborhoods and, starting in 2015, launched a targeted campaign in the Mon Valley.

The ACHD's 2015 Plan for a Healthier Allegheny outlined goals to reduce disparities in the burden of disease across geographic and racial lines within the County, leading to increased intervention efforts in the Mon Valley. Compared to local and national standards, Mon Valley residents experience higher rates of cancer, diabetes, and heart disease as well as associated risk factors such high rates of smoking and obesity. The social and built environment of the region also present unique, place-based challenges that affect the level of risk and severity of chronic disease. There are currently eighteen Mon Valley municipalities that are a part of *Live Well Allegheny* (Figure 1), and efforts are underway to recruit the remaining seven municipalities to join the initiative. Figure 1 was obtained from the *Live Well Allegheny* website and modifications were added to highlight Mon Valley communities and their engagement with the program.

1.3 Public Health Significance

The creation of a resident-driven complement to the current *Live Well Allegheny* program will serve the dual purpose of empowering residents to take an active role in health promotion in their region and of providing LWA and its partners with first-hand information about the needs of the communities they serve. By meeting these objectives, the program will increase resident interest in and engagement with local health programming, with a long-term goal of decreasing health disparities in the region by improving health outcomes.

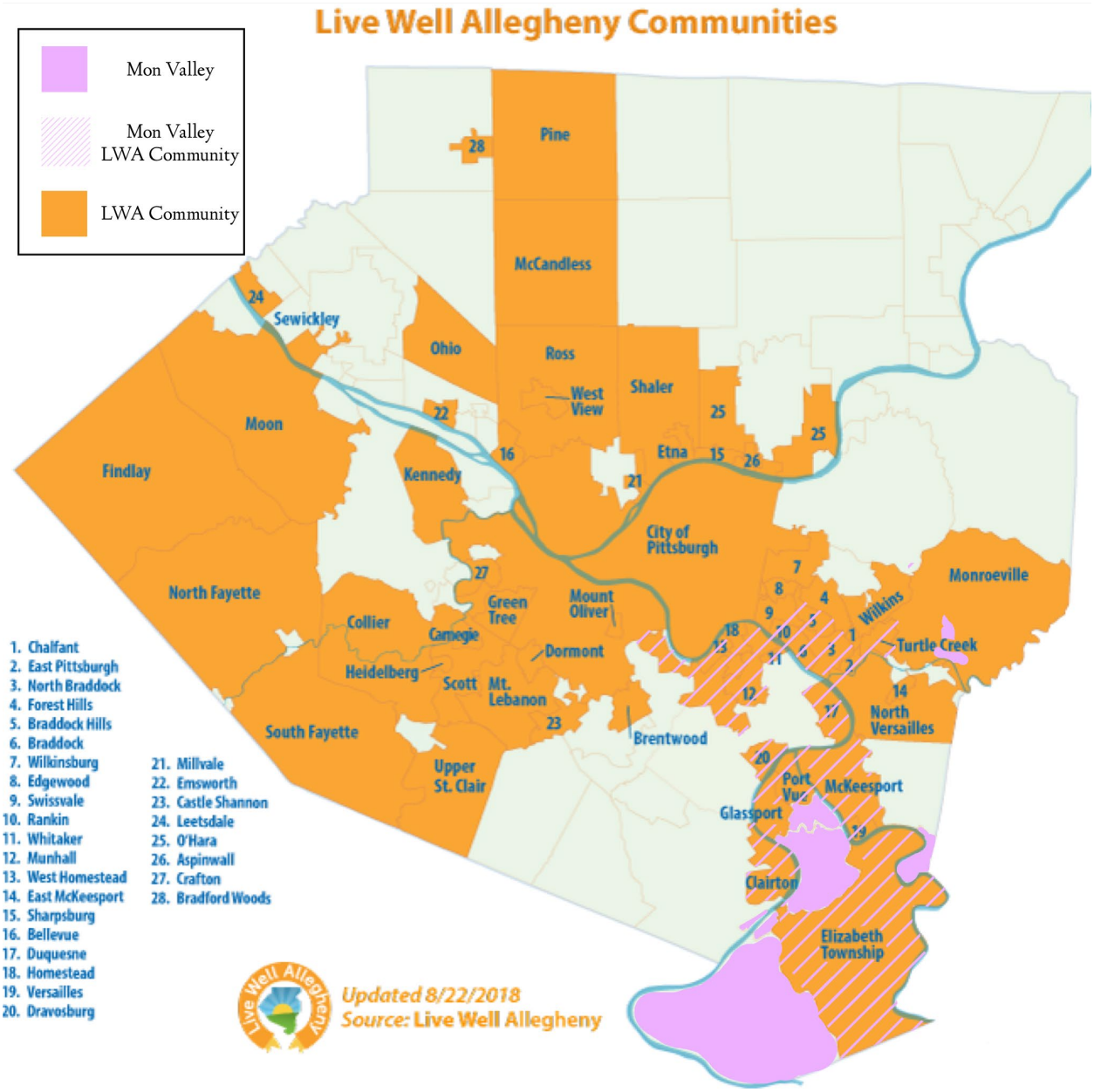


Figure 1 The Mon Valley and LWA Communities

2.0 Background

While the overarching goal of the *Live Well Allegheny* program is to improve the health and wellbeing of all Allegheny County residents, the creation of a targeted *Live Well Allegheny* Mon Valley initiative recognizes a need to address persistent health disparities. The 2015 Plan for a Healthier Allegheny concluded that current inequities in health outcomes within the County exist not only across typically significant factors, such as ethnicity and socioeconomic status, but also appear deeply tied to geographic boundaries. Place-based health disparities often arise as the result of several social determinants of health combining and concentrating in a given region. In order to design interventions that best address region-specific issues, an assessment of possible determinants, their level of impact, and of factors that may amplify their impact is a first step. The following background provides a snapshot of current chronic disease rates and behaviors in the region as well as an overview of historical, environmental, and social factors that may contribute to place-based disparities.

2.1 Epidemiological, Behavioral, and Environmental Assessment

The programmatic activities selected by LWA of increasing physical activity and decreasing obesity and smoking rates are timely as the treatment of chronic disease accounts for roughly 86% of healthcare costs in the United States. Approximately 50% of the US adult population is engaged in managing their diabetes, heart disease, or other chronic conditions (Soler et al., 2016). Two-thirds of all deaths in Allegheny County are attributable to chronic disease, with

heart disease and related conditions accounting for 34% of deaths and cancer for 30% (UPMC McKeesport, 2016). A leading contributor to these rates at both the national and local level is a dramatic increase in persons living with obesity. Approximately 1 in 3 adults (34.0%) and 1 in 6 children and adolescents (16.2%) in the US are obese (Healthy People 2020, 2019). Being overweight can contribute to poor health status by increasing one's risk of high cholesterol, high blood pressure, certain cancers, diabetes, and heart conditions. The rate of obesity in the Mon Valley is currently at 34% (Allegheny County Department of Health, 2019), versus 26.6% of the population living in the rest of the County (Open Data Network, 2015). The region also has the highest rate of childhood obesity in the County, ranging from 19% to 30% by school district (Live Well Allegheny, 2016). The effects of this rate are evident in the current rates of diabetes in the area, with 14.3% of adult residents in the Mon Valley currently living with the condition, as compared to the County rate of 11% and the national rate of 8.4% (Live Well Allegheny, 2016).

Among risk factors that contribute to obesity, physical activity levels and proper nutrition are modifiable behaviors that can improve individual wellness. In Allegheny County only 23.7% of adults report that they engage in regular physical activity (Open Data Network, 2015) and 11% of adult residents reported not participating in either moderate or vigorous physical activity in a usual week (Live Well Allegheny, 2016). Approximately 14% of County residents lack adequate access to food (County Health Rankings and Roadmaps, 2019) and eight municipalities within the Mon Valley are considered food deserts by the US Department of Agriculture Economic Research Service. Access to different types of food varies within the county, with 37% of residents reporting a lack of fresh fruits and vegetables within their neighborhood and 57% reporting many opportunities to purchase fast food within their neighborhood (Allegheny County Health Survey, 2009-2010). Access to nutritious food can also affect mental wellbeing. For instance, 36% of adults

in Allegheny County report they have experienced stress or worry about buying nutritious food in the past 12 months (Allegheny County Health Department, 2017).

A lack of pedestrian-friendly design and a dearth of green spaces negatively impact efforts to reduce sedentary behavior in residents. The design of many area municipalities was meant to support business and as such is not always pedestrian friendly, with major roadways intersecting business districts and residential neighborhoods. Updates to design and general infrastructure are hindered by small tax bases for funding and by the restrictions of outdated zoning codes. As a result, walkability of the region's terrain is spotty, with most municipalities ranking anywhere between 3% and 57% on the walkability scale and the region averaging 42.3% (Jones, 2018). The Mon Valley region is home to several parks, however, and work is currently underway to convert spaces previously reserved for industry into green spaces that are friendly to resident physical activity. Recent examples of this include the opening of the Braddock Civic Plaza in 2018 on a plot that once housed UPMC Braddock Hospital and the work of Grounded Strategies, an area nonprofit that converts abandoned lots into public spaces and who has worked in areas such as Pitcairn where population loss has led to an increase in delinquent properties.

Modifiable health behaviors and environmental factors also contribute to disparities in cancer rates in the region. The county has slightly higher cancer rates (501 per 100,000 residents) than the rest of the state (489 per 100,000 residents), tied in part to high rates of lung cancer (Robert Wood Johnson Foundation, 2016). Roughly, 27% of cancer deaths are linked to cancer of the trachea, bronchus, and lung (Chronic Disease Prevention Program, 2018). Smoking cigarettes and the use of tobacco products are large contributors to lung and related cancer rates. The rate of adults who smoke in the Mon Valley is 26% (Allegheny County Department of Health, 2019), while the county rate is 23% (PA at 21%, the US 19%) (Richards, 2018). Environmental conditions

unique to the Mon Valley also contribute to disparities in cancer and asthma rates as compared to other areas of the county. Due to past and present industrial activities, as well as the slow rehabilitation of toxic sites, multiple areas in the Mon Valley have been designated Environmental Justice Areas by the Pennsylvania Department of Environmental Protection (DEP) (Jones, 2016). This designation allows area organizations to apply for additional assistance in combatting pollutants and brownfields. Air pollution measured in fine particulate matter density in the county is among the worst in the state at 14.7/pm2.5 (County Health Rankings and Roadmaps, 2019), with heavy concentrations and originating sources in the Mon Valley. For example, residents of Clairton, where U.S. Steel operates a coke plant, experience a cancer rate tied to air toxins that is about three times higher than the national average (Holsopple, 2018).

One of the region's strengths is that it is home to a large number of invested stakeholders, including medical systems and nonprofit organizations dedicated to the prevention and/or the maintenance of chronic conditions. While high poverty rates and shortages of primary care physicians has led to 6 area municipalities becoming federally designated Medically Underserved Areas (UPMC McKeesport, 2016), the Mon Valley region is a covered service area for 3 area hospitals attached to two healthcare industry giants, UPMC and Allegheny Health Network. The region also has a high concentration of social service agencies and foundations whose sole focus is the betterment of the Mon Valley. Outreach from area agencies is demonstrating a positive effect on residents' health-seeking behaviors, with high levels of engagement within the most distressed communities. Service utilization is lower, however, in municipalities deemed to have "deepening" or "emerging" needs, which indicates an opportunity for introducing more targeted efforts in these communities (Good, Collins, and Dalton, 2014). "Deepening" and "emerging" need are designations within the Community Need Index derived by the Allegheny County Department of

Human Services. Communities with "deepening need" have been classified as within the top 40% of need in the County and that have demonstrated increased need when compared to a previous assessment. "Emerging need" refers to communities that have increased in need between assessments and that have entered the top 50% of need in the County.

2.2 Ecological Assessment: The Importance of Place in Health Disparities

While the root causes of chronic disease are myriad, the disparities in chronic disease rates in the Mon Valley are attributable in part to the deep influence of the region's industrial history on the area's current geographic, economic, and demographic features. The first of the Mon Valley's municipalities were established in the mid-1800s as mill towns and cities that operated independently from but in harmony with steel manufacturing taking place in the urban center of Pittsburgh. The region was developed as rings of residential communities orbiting industrial centers, with supportive area businesses providing residents with amenities without needing to travel to the county's urban core. At its height, the region was a bustling metropolis, rivaling the state capital for third largest metro area in the state.

Like most of Allegheny County, area plants and associated industry were the primary employers for residents, leaving the area vulnerable to economic shifts as a single-source economy. Unlike the rest of the county, however, the Mon Valley would begin to experience decline before the ultimate collapse of the steel industry in the 1970s. After reaching population peaks in the 1930s and 1940s, a series of outside macroeconomic and policy forces eventually lead to dramatic changes in the community structure of the area. Changes in labor rules at the mills and improvements in economic stability granted greater mobility to managers and skilled workers

within the plants. Residents of mill town municipalities began to relocate to newly available suburban track housing and to parts of Pittsburgh in order to get away from the pollution produced by the mills. This out-migration was facilitated by expansions in the local highway infrastructure that allowed for greater access to other parts of the county. The residents who remained were either of limited means or had experienced other barriers to mobility, including African-American residents who faced economic restrictions and barriers produced through the bank practice of housing segregation accomplished through the policy of "redlining" (Berry, 2015).

The loss of skilled manufacturing workers and their economic contributions to the areas directly surrounding the plants eventually affected investment in regional cities as well. When the steel industry finally collapsed in the 1970s, the Mon Valley had already lost a significant portion of its population. Ultimately, the region lost about 38% of its total population, with some municipalities experiencing losses as high as 90% (Deitrick, Briem, and Williams Foster, 2005) as compared to its population pre-collapse in the 1960s. The decline of social capital and a shrinking tax base has transformed the Mon Valley from a once vibrant small metropolitan area to a patchwork of suburban communities that are increasingly reliant on Pittsburgh for economic opportunities and social amenities.

This change from a metropolitan to suburban landscape has brought with it a new set of challenges. Nationally, suburban communities are "home to the largest and fastest growing poor population in the country" (Good, Collins, and Dalton, 2014, p. 5). Mon Valley communities are no exception, with some of the highest concentrations of poverty in the county, including roughly a third of municipalities experiencing distressing levels between 19-46% (Deitrick, Briem, and Williams Foster, 2005) compared to the county rate of 13% (U.S. Census Bureau, 2014). Poverty is an established social determinant for poor health outcomes and is reinforced by other ecological

factors such as education and transportation. Currently, roughly 9.3% of Mon Valley residents possess less than a high school education, compared to 6.5% in the county. On average 20% of residents report their household has no access to a vehicle, with some communities reporting as high as 48% of households. Approximately 10% of Mon Valley residents use public transportation, with higher usage rates of 21% to 39% in inner-ring municipalities. Public transportation use rates are likely impacted by a lack of access, as the number of bus lines that move between economic centers and parts of the region are limited and, in some areas, are nonexistent.

The Mon Valley's designation as a suburban region may help account for why disparities persist in the region while other industrial centers, including Pittsburgh, are beginning to experience a degree of revitalization. The geography of poverty is changing, with suburban areas across the country now home to more persons living in poverty than any other geographic designation. Suburban residents account for 48% of the total national increase in poverty between 2000 and 2015 (Kneebone, 2017). Over 3 million more people live in poverty in suburban areas than in urban areas and 8 million more when compared to rural areas (Kneebone, 2017). This trend is not isolated to any one part of the country and appears to be driven by a set of common causes including growing and diversifying populations in suburbs, regional housing market trends, and the prevalence of low-wage work.

These causes of suburban poverty can be seen within Allegheny County as the "renewal" of Pittsburgh has produced the unexpected consequences of more people, in particular black and low-income residents, starting to relocate to the Mon Valley in search of affordable housing options. The housing stock in the Mon Valley has declined from neglect leading to a higher dependence on rental and subsidized housing for new residents (Jones, 2018). Demographic trends also appear to show the continued out-migration of residents with the economic means to do so.

Residents of the Mon Valley are increasingly households dependent on low wage employment with limited economic mobility. This change in demographics without accompanying boosts in economic investment creates an ever-increasing burden on local systems. Municipal governments are faced with diminishing resources to sustain current health programming and may have limited ability to implement new measures. This strain also proliferates historic health equity issues, as black residents in Allegheny County continue to experience higher rates of chronic conditions compared to white residents and disproportionately experience barriers to wellbeing such as lower rates of access to employer-based health insurance and higher rates of poverty and housing insecurity (Robert Wood Johnson Foundation, 2016).

Efforts to combat suburban poverty, and, in turn, increase suburban wellbeing, are met with the unique challenge of combatting a mixture of urban and rural issues. The changes in demographics and economic standing, discussed above, lead to increases in distressed communities, a barrier to health faced by many urban communities. Public health practitioners in suburban communities also contend with the difficulty, commonly encountered in rural areas, of delivering services to low-density populations spread out over large distances (Kneebone, 2017). The practical barriers of efficient and timely delivery are compounded by funding sources and service agencies that have not adapted their models to accommodate the unique features of suburban environments. Eligibility formulas for programs that promote wellbeing that prioritize funding based on poverty rates may miss suburban areas with substantial low-income populations because of their spread over a greater geographical area than urban communities. At the federal level, communities are given geographic designations defined by their level of urbanity. This process does not allow for a clear designation for suburban areas, however, as suburban communities are often lumped in with the urban metros they surround (Bucholtz & Kolko, 2018).

This lack of definition has far reaching effects, impeding researchers' ability to study suburban regions independent of urban considerations on a macro level and it can concentrate large-scale programmatic efforts within urban centers when poor health rates are actually being driven by exurban communities.

2.3 Educational Assessment: The Environment's Influence on Health Behaviors

A prolonged struggle to regain economic vitality and a seismic loss in social capital due to dramatic shifts in population has dramatically altered the environment in which residents of the Mon Valley live. An ecological assessment provides an understanding of how the environment affects large-scale social determinants of health, but it also helps to identify possible environmental barriers to fostering individual positive health behaviors. Many highly successful health behavior interventions are based on an understanding of the importance of place and use a social ecological perspective as the framework for designing intervention activities. In contrast to earlier lifestyle theories that targeted the individual's ability and responsibility to prevent chronic disease, the social ecological model views health outcomes as emerging from the interplay and reciprocity of the external environment on individual behaviors and vice versa.

The social ecological model views the health environment as comprised of five levels: the intrapersonal, interpersonal, organizational, community, and public policy domains. Successful interventions, such as national anti-smoking campaigns, use activities that cut across and connect the various levels, allowing positive changes in one domain to influence behaviors in other domains (Glanz, Rimer, and Viswanath (Eds.), 2008). Activities normally target the physical environment and/or sociocultural factors, two domains that cross ecological levels and that often

support and reinforce one another. For example, activities that change community design or policy can make the physical environment more supportive for positive individual behavior. Individual motivation and education surrounding positive behaviors, in turn, can affect one's ability to take part in or generate supportive environments.

The study of how place-based characteristics act as a contributing factor in lifestyle interventions is a growing field of study and one that has predominantly focused on urban settings (Chrisman, M. et al., 2015, Kegler, M.C. et al., 2012). However, there is a growing interest in expanding our understanding of the influence of geography on behavior, especially as it relates to health disparities. For example, in studies of obesity rates and other modifiable chronic conditions, researchers have identified a growing urban-rural divide where behaviors such as physical activity levels and nutritional habits appear to have place-based attributable factors (Trivedi, et al., 2015). Research highlights common physical and systemic barriers that may contribute to this difference, including a lack of designs that encourage walking, such as public green spaces and sidewalks. Additional barriers include: no convenient public or inexpensive exercise facilities, unsafe conditions due to traffic or lack of lighting, a shortage of quality medical practitioners in the region that can assist in the prevention or maintenance of chronic conditions including obesity, and a lack of healthy food choices (Chrisman, M. et al. 2014; Cohen, S.A. et al., 2017; Robertson, M.C., et al., 2018). Assessments of the Mon Valley also demonstrate similar barriers to healthy behaviors as place-based factors found in these studies of rural areas.

The social environment, from individual social networks to larger cultural norms, is thought to be a powerful influence on health behaviors and to play an even larger role in health maintenance than the physical environment (Sriram, U. et al., 2018). Individual perceptions of their own behaviors and of the influence of social factors on health behavior are important research

areas of interest. Social Cognitive Theory (SCT) is a theoretical framework commonly used in the design of lifestyle behavior interventions and measurement of study outcomes. Several SCT concepts are thought to be mediators in initiating and successfully sustaining health behavior change. For instance, individuals' perceptions of self-efficacy and normative beliefs have been shown to impact the long-term maintenance of weight loss and other behavior change benefits (Teixerira et al., 2015; Kegler, M.C. et al., 2012; Sriram, U. et al., 2018). The support of an extended social network and the influence of social circles are also thought to connect to behavior outcomes, providing opportunities for observational learning (another SCT construct) that support the adoption of new behaviors (Kegler, M.C. et al.; 2012, Sriram, U. et al., 2018). The domain in which social interactions takes place is also of interest, with observational studies attempting to measure how social factors are augmented or magnified by home, work, and church environments. Results of these studies have been inconclusive, however, and the current consensus is that each domain likely has a unique but inter-related influence on physical activity levels and other behaviors (Chrisman, M. et al., 2014).

The social constructs identified in the literature are thought to serve as mediators for lifestyle changes in any geographic setting; their significance and power, however, are potentially greater in rural and suburban environments due to a complex configuration of ecological factors. These communities have lower overall population and patchy population density, resulting in fewer opportunities for unplanned social exchanges and encounters with positive behavior role models. In regions like the Mon Valley, a lack of public spaces designated for physical activity and a degree of physical isolation caused by highway infrastructure and empty lots limits natural facilitators for conversation around and encouragement of healthy behaviors. These factors act not only serve as physical impediments to health but also impact the social environment and individual

perceptions about the accessibility of healthy behaviors by placing a greater burden on institutional and home environments to serve as supportive spaces.

Without a direct study of resident perceptions and behaviors, it is difficult to ascertain the degree to which the social environment in the Mon Valley is impacted by the external environment or how social networks influence behavior. National surveys, such as the National Health Attitudes survey, have identified the general influence of family and friends, and to a lesser degree co-workers and neighbors, on individual health choices (Carman, et al., 2016). Successful lifestyle interventions, like the Robert Wood Johnson Foundation's Diabetes Initiative and the NIDDK-sponsored Diabetes Prevention Program, also recognize the interplay of social and physical environments, highlighting the need to translate intervention activities not only to better meet the needs of individuals but to consider the influence of place on participant interactions and outcomes (Glanz, Rimer, and Viswanath (Eds.), 2008; Gary-Webb, Suglia, and Tehranifar, 2013). Experts in addressing rural health issues call for the tailoring of services, underscoring the shared hurtles but different dynamics present in diverse communities (Active Living Research, 2015). Overall, place-based research of lifestyle behaviors in non-urban spaces recommends a socioecological approach that prioritizes both physical and social factors, with interventions that leverage and align connections between "…health messages, social milieus, and built environments [that] support healthy behaviors" (Kegler, M.C. et al., 2012).

2.4 Administrative and Policy Assessment: Support for Interventions

Smaller tax bases and a lack of internal economic opportunity can hinder suburban municipal systems from supporting environmental and social conditions that promote good health

behaviors. The potential impact of new policies and interventions in the region is often tempered by the degree to which area governments remain disconnected (Robert Wood Johnson Foundation, 2018) and resistant to collaboration or mergers (Rosenfeld, 2018). Other stakeholders in the area, including health and human service groups, must navigate a wide service area with limited resources for outreach. *Live Well Allegheny*'s collaborative approach allows the program, and by extension the Allegheny County Health Department, to serve as a convener of disparate groups around a common cause. Members of the government, education, and business sectors are all eligible to become *Live Well Allegheny* Communities, with LWA using a Health in All Policies approach to define membership and guide participant activities.

The Health in All Policies (HiAP) approach recognizes the influence of local government on the health of its citizens and works to harness that influence to create healthier environments for residents. HiAP is defined as a collaborative approach to improving health outcomes that, "integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people" (Center for Disease Control and Prevention, 2015). This is considered to be a promising approach in health promotion as many of the important social and environmental factors that affect health are directly shaped by policies that fall outside the purview of health departments and healthcare settings. As a model, HiAP does not refer to a specific set of policies, but rather to the process of incorporating health as a priority in policymaking (Hall and Jacobson, 2018). This flexibility is important as it allows participants to tailor their resolutions to better fit their specific needs.

LWA has successfully recruited roughly 75% of Mon Valley municipalities to become *Live Well Allegheny* Communities. As a condition of LWA status, local governments have signed resolutions and drafted policies meant to foster healthy environments for their residents; these

policies are in varying stages of implementation. LWA provides a template resolution with example policies to assist municipalities in determining what actions best fit their specific needs. Municipalities can choose to use the template as it is, to adapt its policies using place-specific terms, or to create an original resolution. As indicated in Table 1, the sample policies drafted by LWA for use by partners cover an array of health promotion activities, including fiscal and built environment changes, health education and promotion, adopting new regulations, and fostering community engagement.

Table 1 LWA Mon Valley Community Resolutions

Municipalities Signed	LWA Sample Action Steps
Braddock, Clairton, Dravosburg, Elizabeth Twp., Glassport, Munhall, North Braddock, Port Vue, Versailles	Promote participation in a voluntary wellness campaign for the community's employees
Braddock, Dravosburg, East Pittsburgh, Elizabeth Twp., Glassport, Homestead, North Braddock, Port Vue, Versailles, West Homestead, Whitaker	Share information on wellness campaign events with the broader community to encourage the voluntary participation of residents
Dravosburg, Elizabeth Twp., Glassport, Homestead, North Braddock, Port Vue	Plan, promote and implement a *Live Well Allegheny* event in cooperation with the campaign that encourages active living
Braddock, Dravosburg, Elizabeth Twp., Glassport, Homestead, North Braddock	Develop indoor and outdoor wellness trails accessible to residents of all abilities
Dravosburg, Glassport, Munhall, North Braddock, Port Vue, West Homestead	Develop walking maps; measure the distances mapped and encourage residents to meet goals
Braddock, Dravosburg, Glassport, North Braddock	Offer incentives for employees who walk or bike to work
Braddock, Dravosburg, East Pittsburgh, Glassport, Homestead, North Braddock, Rankin, West Homestead	Encourage multi-modal transportation of residents by providing facilities or policies that encourage walking and bike riding
Dravosburg, Glassport, North Braddock	Ask your vending machine company to add healthy foods, and work with the company to post calories and nutrient contents and amounts for the foods offered
Braddock, Clairton, Dravosburg, Duquesne, Elizabeth Twp., Glassport, Homestead, North Braddock, Port Vue	Promote and support farmers' markets
Braddock, Dravosburg, Elizabeth Twp., Glassport, Homestead, North Braddock, Port Vue, Versailles, Whitaker	Encourage involvement with community volunteer activities
Braddock, Clairton, Dravosburg, Duquesne, East Pittsburgh, Elizabeth Twp., Glassport, Homestead, Munhall, North Braddock, Port Vue, Rankin, Versailles, West Homestead, Whitaker	Promote smoke-free buildings and perimeters
Dravosburg, Elizabeth Twp., Glassport, North Braddock, Port Vue, Rankin, Versailles	Provide health information focused on monthly or seasonal events
Dravosburg, East Pittsburgh, Elizabeth Twp., Glassport, Homestead, North Braddock, Port Vue, Versailles, West Homestead	Utilize web sites and social media to provide information on physical activity, nutrition, stress management, tobacco cessation, and other health and wellness related initiatives
Unique resolutions: Braddock Hills, Clairton, Duquesne, McKeesport, and Turtle Creek.	

Live Well Allegheny combats barriers caused by governmental fragmentation by widening its network to include local school districts and businesses. LWA is also forging relationships with local human service agencies outside of the formal *Live Well Allegheny* Community relationship. LWA has become a member of two prominent collaboratives of providers in the Mon Valley, the Jefferson Community Collaborative and the Mon Valley Providers Network. Each organization boasts memberships of over 70 human service and healthcare agencies who service the region, and both have active working groups focused on improving health outcomes.

While the large collection of partners and resolutions provides a solid foundation for future action and collaboration, participants and LWA staff members alike report apprehension about the lack of direct resident input. This concern is not without merit, as historically there has been inadequate engagement by service organizations of marginalized communities in Allegheny County, especially black residents and distressed municipalities. This has resulted in residents reporting that social and health programs inadequately represent them and that their input is not encouraged (Robert Wood Johnson Foundation, 2018). In keeping with the social ecological model as a guide, residents require motivation, through supports in the social environment and engagement in health education, in order to benefit from changes in their physical environment. LWA and its partners also run the risk of tailoring their programs with incomplete information, resulting in a mismatch between the intervention and community need.

2.5 Theories of Change and Selection of Community Organizing Intervention

Live Well Allegheny's overall design aligns with the social ecological model, supporting collaboration between a variety of stakeholders to "make healthy choices default choices" through

positive changes in the physical and political environment (Hacker, K., 2015). In addition to the HiAP approach, LWA was designed using the ecologically-minded Culture of Health Action Framework as its guide. The Action Framework was drafted in 2014 by the Robert Wood Johnson Foundation (RWJF), in collaboration with the RAND Corporation and diverse stakeholders, and provides guidance in addressing systemic, social, and political barriers to health. The framework is composed of four interlocking pillars: making health a shared value; fostering cross-sector collaboration to improve well-being; creating healthier, more equitable communities; and strengthening integration of health services and systems. The Action Framework outlines how each of the pillars is comprised of social, environmental, and political components and offers examples of how to engage with and measure these components. By these measurements, LWA is making strides in addressing many of the environmental and political hurdles identified as crucial by the framework. The program falls short, however, in addressing social components as it does not engage residents directly, relying instead on government and human service agency partners to act as proxies for the local community.

Direct community engagement is outlined by RWJF as a critical aspect of interventions guided by the Action Framework. The preceding assessments support this approach, demonstrating the need for community engagement to inform the tailoring of lifestyle interventions to meet the unique needs faced by suburban communities. Engaging with the more micro inter- and intrapersonal levels of influence on behavior, in addition to the macro systems level, was also identified as key in creating long-term impacts. While community engagement plays a role in each of the pillars, it is most prominently featured in the pillar of making health a shared value. Activities that address this pillar foster a deeper sense of community and increased civic

engagement among participants. These outcomes are achieved in part by creating a shared mindset and expectations between participants around what influences and supports healthy behaviors.

With the results of the assessments and the guidance of the Action Framework in mind, an intervention designed using the principles of community organizing appears appropriate. Community engagement models generally have been shown to positively impact outcomes across various health conditions and to effectively address health inequities, with no one model demonstrating significantly greater results than others (O'Mara-Eves et al., 2015). Community organizing falls within a spectrum of engagement practices that vary in their level of participant involvement, often directly involving communities in the identification of issues and in the design and implementation of interventions. Community organizing is the most appropriate model of engagement for LWA as it will not only raise awareness of community-specific health issues but will encourage positive community changes through increased resident problem-solving ability and group identification.

The practice of community organizing contains a range of models to generate broad social impact and action that includes the use of community conversations. The model of community conversations has a long history and spans geographic and cultural lines in its application. Central objectives of this and other strength-based models include building community identity, increasing critical awareness and reflection, generating political and legislative action, and fostering culturally relevant practices (Glanz, Rimer, and Viswanath (Eds.), 2008). These objectives align with LWA's current practices and identified needs. Community conversations as an intervention is also supported by established health behavior theories. Social Cognitive Theory supports the use of group-driven problem solving as a means of increasing collective efficacy. By fostering a greater sense of social cohesion and shared expectations through uniting behind a common cause,

participants become more confident in their ability to enact health-promoting behaviors on both a collective and individual level. The Sense of Community Theory endorses community conversations as an effective means of generating and sustaining community-level change as it raises the social capital of residents through the integration of resident needs with policy-level goals.

3.0 Methods

Program planning models in the field of public health are generally an elaboration on the iterative process of public health management, in which practitioners formulate objectives, identify and implement interventions, measure the impact of program activities, and revise programs in response to impact evaluation. The PRECEDE-PROCEED model was selected for the drafting of the LWA Conversation Project as it not only aligns with this management model but also prioritizes community and stakeholder input.

3.1 The PRECEDE-PROCEED Model

The PRECEDE component (Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation) of the Model represents the formative phase of planning and is divided into four stages. These are: the identification of the desired outcome(s) of your intervention (often the product of a social assessment or a community-identified issue); epidemiological, behavioral, and environmental assessment of the target population; identification of predisposing, enabling, and reinforcing factors associated with the results found by the assessments; and, identification of an intervention after consideration of policy and administrative factors that may facilitate or hinder implementation. The PROCEED component (Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development) represents the planning phase and includes the stage for design and implementation and evaluation (process, impact, and outcome evaluation). The model is also meant to be iterative

as the results of the PROCEED component guide continued research found in the PRECEDE component that can then support any needed revisions to the program (Community Tool Box, 2018).

Multiple sources were used to gather information needed to design the plan described in this thesis. Information accessed for the PRECEDE stage was drawn from peer-reviewed journals, publicly available data sets, and *Live Well Allegheny* resources. The Background section of this paper contains the assessments detailed in the PRECEDE stage and provides the basis of the program's logic model. The Results section is guided by the PROCEED stage and contains the proposed program activities and evaluation plan. Members of the *Live Well Allegheny* team and experts on and within the Mon Valley region were consulted in the drafting of program activities. I also drew upon field placement experiences as the program assistant for the Mon Valley Providers Council from in the Spring of 2017 to 2018.

3.2 Desired Program Outcome

The objective of the LWA Conversation Project program is to foster shared values around health within Mon Valley communities through increased social and civic engagement. Conversation participants will generate sustainable solutions for supporting positive health behaviors through the drafting of action plans based on their lived experiences and increased awareness of local resources. Examples of possible action plans include establishing a community walking group or petitioning a municipal council to create a Community Advisory Board that assists with health policy implementation. LWA partners will benefit from collaborating with resident conversation groups, using action plans as a means of better understanding region-specific

social, environmental, and systemic issues that contribute to inequities in chronic disease. This information can be used to tailor existing programming to better address resident needs.

The LWA Conversation Project is an example of a community organizing public health intervention. Community organizing, a subset of community engagement practice, increases social capital and overall health in communities through the empowerment of individuals to become active participants in shaping their community. Empowerment in a public health context is derived through the "cultivation and use of transferable knowledge, skills, systems, and resources that affect community- and individual-level changes consistent with public health-related goals and objectives" (Goodman et al., 1998, cited in Yoo et al., 2004). Community organizing interventions teach participants practical skills, such as identifying community issues that impact health and analyzing different strategies for intervention, that can be applied during the intervention as well as transferred to future actions. Intervention activities incorporate the knowledge and experience that participants already possess as members of their community, increasing participants' sense of self-efficacy in replicating intervention activities in different contexts. Practitioners can also assist participants in identifying community assets and resources based on this information and aid in generating healthy solutions tailored to their needs.

The content of the conversations within the Conversation Project are designed to meet the objective empowering residents through increased social and civic engagement and follows the generic structure of community organizing initiatives (Figure 2). The Project is informed by three primary sources: Collaborative Community Empowerment: An Illustration of a Six-Step Process (Yoo et al., 2004), How to Develop Discussion Materials for Public Dialogue (Everyday Democracy, 2017), and Discuss. Decide. Do. (Swerhun & Avruskin, 2012). Through their Six-Step Facilitation Process, Yoo et al. demonstrates how public health concepts can be incorporated

into established community organizing initiatives. The LWA Conversation Project adapts their methods of educating community groups on how community challenges fit within the social ecological framework and on how the levels of the model can act as a guide in formulating intervention strategies. The work of Everyday Democracy is focused on increasing civic engagement through informal conversation where residents can serve as facilitators. The general structure and several activities in the Facilitator's Guide for the Project were adapted using their manual. Finally, Discuss. Decide. Do. is an overview of how community engagement can be used as a decision-making tool for the leaders of community projects. This work assisted in conceptualizing how the activities of the Project fit in with the broader goals of LWA and provided practical considerations when implementing a community-engagement initiative.

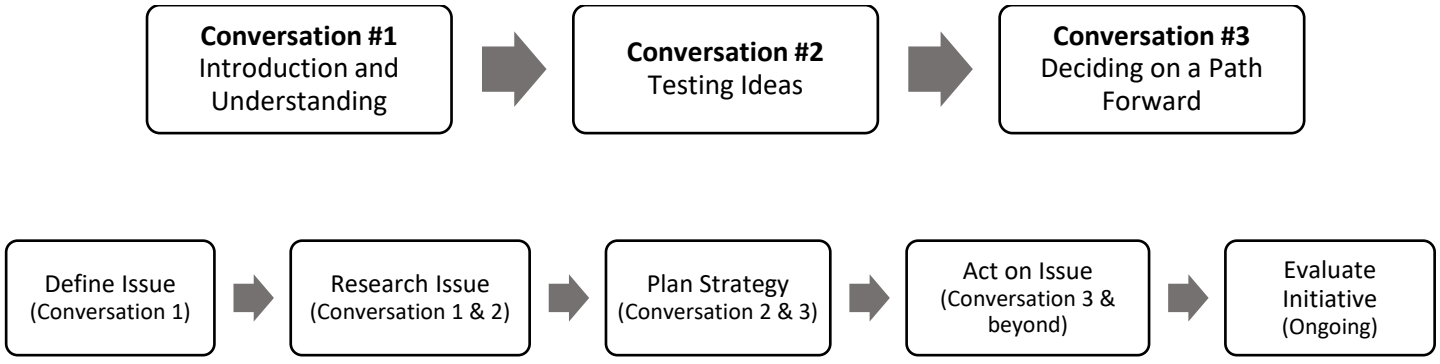


Figure 2 Community Organizing Overlap with the Conversation Model

4.0 Results

The *Live Well Allegheny* Conversation Project addresses a lack of community engagement by building upon established LWA partnerships to complement the current "top-down" policy approach with a "bottom-up" resident-led program. The Project is designed to foster community-level initiatives meant to make healthy choices for individuals' default choices through facilitating collaboration between residents and area stakeholders in the Mon Valley region. This addition to the LWA program plays a vital role in fulfilling the promises laid out in LWA-assisted municipal policies by raising resident awareness of local efforts, instilling a sense of ownership in health-promotion activities, and fostering trust between the community and its institutions. The ultimate goal of the Project is to create shared values of health within Mon Valley communities by increasing rates of social and civic engagement.

This project goal will be achieved through completion of the following objectives outlined as a pilot program. *Live Well Allegheny* will hire a full-time community organizer, from here on referred to as the LWA organizer, who will spearhead the Conversation Project. The LWA organizer will recruit area partners and residents through immersion in assigned municipalities. The organizers will ultimately recruit 4 current or new partner organizations, one in each pilot municipality, to act as conversation sites. Conversations will include approximately 60 resident participants—that is, between 10-15 participants per site. Organizers will then facilitate 12 conversations over the course of six months, with 3 conversations taking place per site. The LWA organizer will provide information on LWA municipal resolutions and area resources at the first conversation. Conversation groups will begin drafting action plans during the second conversation and complete plans in the third conversation, resulting in one action plan per site for a total of 4

action plans. With the assistance of the LWA organizer and relevant LWA partners, conversation groups will implement a community project related to their action plans within one year of the first conversation. The LWA organizer will identify and trained interested residents to facilitate future conversations and/or maintain current partnerships. A complete logic model of program activities is located in Appendix A.

The program plan takes into consideration the current resources available from the Allegheny County Health Department (ACHD). In addition to staff already working within the program, ACHD has added another position to the program to work specifically within the Mon Valley. The following plan is designed as a pilot program that can be implemented once that position is filled. Discussion of sustainability beyond the initial pilot is also discussed, including potential sources of additional funding. A projected program budget can be found in Appendix B.

4.1 Program Staffing and Responsibilities

The key staff involved in implementing the program will be the LWA organizer with support from the LWA staff and program manager, Hannah Hardy. The ideal organizer candidate should demonstrate an understanding of the techniques of meeting facilitation, how to listen for and accurately capture community voices in conversation notes, reporting, and other documents, and how to educate and guide residents in understanding public health concepts including the social ecological model and social determinants of health. Upon initial hire and completion of orientation, the LWA organizer will meet with Maria T. Cruz, MID, the current lead Public Health Administrator for LWA Mon Valley. She will provide an overview of the program and review established partnerships cultivated in the Mon Valley. Together Ms. Cruz and the organizer will

determine which four municipalities would be ideal pilot locations. The LWA organizer will then move from the training phase to the immersion phase, familiarizing themselves with their pilot communities via common organizer activities such as windshield surveys, walking tours of the area, and attending local community meetings and events.

The LWA organizer will be full-time personnel, with initial availability required during regular business hours. After the initial adoption phase (see Figure 3), the LWA organizer will be permitted flexibility in terms of when their work is completed inasmuch as many community organizations and residents will have limited availability to participate during working hours. The LWA organizer will oversee implementation of all project activities within their pilot municipalities. Initial activities will include recruitment and promotion, conversation facilitation, generation of resident action plans, and administration of evaluations. The organizer will have the ongoing responsibility of keeping residents informed and engaged in the conversation process through actions such as providing conversation notes, distributing incentives, and reminding participants of upcoming conversation times. Ultimately, the organizer will assist in the implementation of community projects born of resident action plans, connect residents with relevant local partners, and encourage group ownership of conversations by training interested residents to become conversation facilitators. Upon successful navigation of conversation activities in the pilot municipalities, the organizer will then expand the scope of the project to include additional Mon Valley communities.

The program manager will provide additional assistance with project operations. The manager will provide practical assistance by distributing incentives and resources for conversations as well as leading a weekly staff meeting where organizers can share challenges and suggestions. In later stages, they will assist with procuring support for community projects. They

will also perform administrative duties of collecting, compiling, and reporting themes and results from conversation notes and resident evaluations. The project manager will be responsible for enacting the project's retention strategy, and for providing regular project updates to community partners, LWA stakeholders, and the project manager of the Chronic Disease Prevention Program.

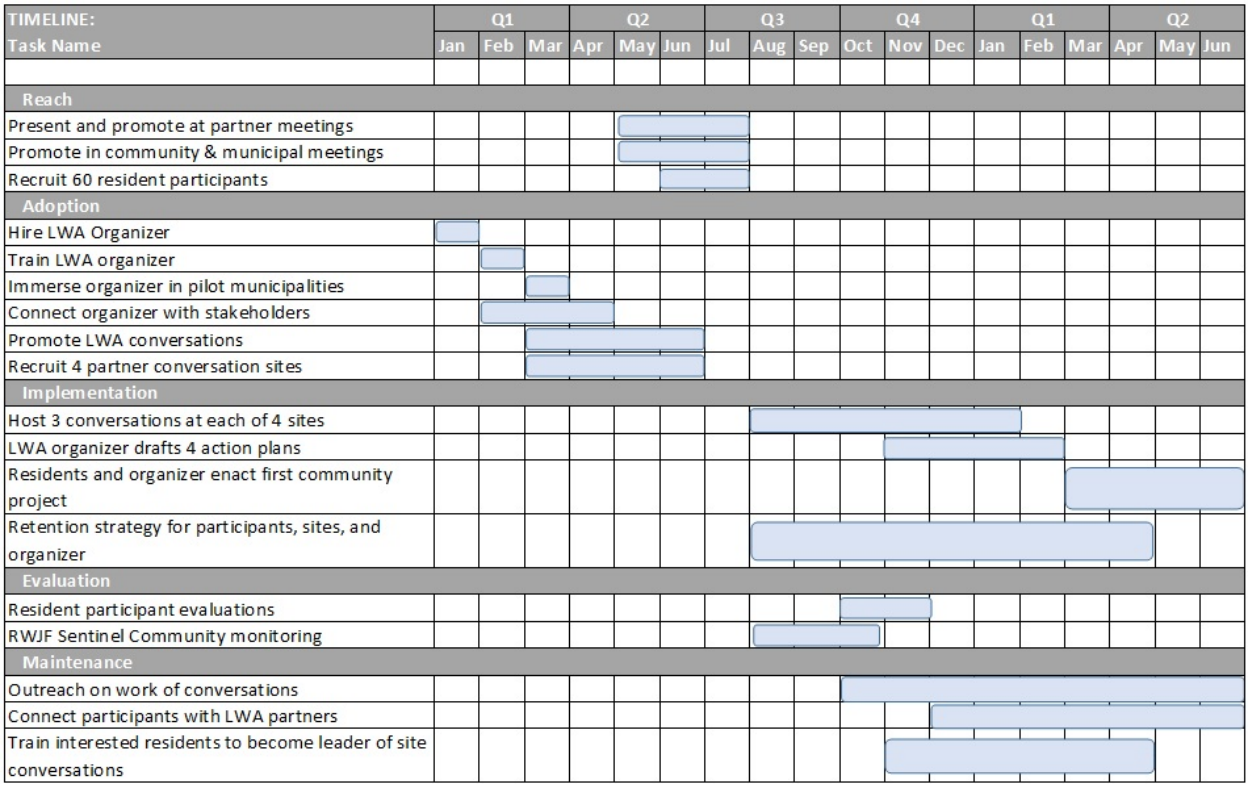


Figure 3 Conversation Project Program Timeline

4.2 Resident and Stakeholder Engagement

Recruitment and engagement of Mon Valley residents is a core responsibility of the LWA organizer. The organizer will initially focus on four municipalities where they will be the lead recruiter of resident participants and of conversation sites. Upon completing their initial training, the organizer will become familiar with their assigned communities through a combination of

traditional community organizing practices and contact with established LWA partners. A lack of awareness of, or a deep distrust, of the work of the Allegheny County Health Department (ACHD) and affiliated programs could act as a potential barrier to recruitment and community engagement. The LWA Conversation Project will work to overcome resident skepticism by striving to make meetings accessible and emphasizing in promotional material that conversations will be resident-driven, solutions oriented, and receive support from a large and influential network of partners. LWA staff will work to identify and leverage new and established partnerships with local organizations that residents trust in order to increase Mon Valley residents' interest in LWA initiatives.

In the three years of operating its targeted Mon Valley program, LWA has partnered with 15 municipal councils, 6 school districts, and numerous service agencies to realize its mission of combating chronic disease behaviors and promote healthy community environments through the drafting and implementation of health-promoting policies. The LWA organizer will build on these established relationships by meeting with municipal council and agency partners to discuss current progress toward policy goals and to promote the LWA Conversation Project. LWA is also a member of two regional provider coalitions, the Jefferson Community Collaborative and the Mon Valley Providers Council (MVPC). The organizer will attend the quarterly Jefferson Community Collaborative meeting and the monthly meetings of the MVPC Working Group on Health to promote the project and recruit residents and host sites. The organizer will also target and formally approach trusted partners individually to act as conversation sites.

In addition to pursuing referrals generated by partner agencies, the LWA organizer will carry out grassroots activities to recruit residents to participate in conversations. The organizer will go to various community meeting spaces, such as churches, schools, and businesses, and ask them

to provide promotional materials to residents. The organizer will also attend municipal council meetings and other open community gatherings to learn more about the area and to demonstrate LWA's commitment to the region. Information on the conversation initiative will be posted in public spaces and municipal buildings. Residents will be encouraged to RSVP for upcoming conversations, but materials will emphasize that conversations will be open to all residents of the municipality and residents will be able to attend without formal notice. Interested residents will be able to contact the organizer via phone or email. The organizer will be responsible for recruiting between 10-15 residents in each assigned municipality and for maintaining contact with residents about upcoming conversations and other LWA activities.

4.3 Resident Conversations

Resident conversations are the primary activity of the LWA Conversation Project. A Facilitator's Guide is located in Appendix C. The following is an overview of each conversation session.

4.3.1 Preparation and General Meeting Structure

In preparation for facilitating conversations, the LWA organizer, with assistance from the lead Public Health Administrator for LWA Mon Valley, Maria T. Cruz, MID, will create a database of established LWA partners with connections to the four pilot municipalities. Each entry should include a personal contact at the organization and information on who their target audience is, their services, and any outreach methods the organization employs. The organizer will also draft

a list of potential priority areas that residents could identify in the conversations. This list should include the LWA priorities of physical activity, food access, and anti-smoking initiatives but will also include possibilities informed by the organizer's immersion experience in the region, such as vacant lots or safety concerns. The organizer will then compare the priority list with the database of partners, looking for connections between the two. If a priority area is not addressed within the partner database, the organizer should begin researching potential new partners to meet those needs. Thorough preparation on the part of the organizer will allow them to pursue future collaborations between residents and partners and will also allow the organizer to suggest relevant partnerships in real time during a resident conversation. Finally, the LWA organizer will draft conversation agendas and fact sheets tailored to each pilot community as well as collect general written materials on potential priority areas.

Conversation dates and times will be coordinated with site partners and will preferably take place in the evening to promote greater accessibility for working residents. Ideal conversation sites would be trusted institutions that are easy to locate and provide enough space for residents to mingle as well as take part in formal conversation, such as schools or welcoming service agencies. Each conversation will last no more than two hours and a meal will be provided. The LWA organizer will facilitate the conversations and an LWA staff member will assist, handing out materials and taking notes for the group. All resident participants will receive conversation agendas and an area fact sheet. Written materials for social service agencies and ACHD programming related to health priorities will be present, but not actively promoted, at all conversations. The organizer will refer any resident that self-identifies as needing services to relevant local partner agencies. These referrals and other outside interactions with partner groups

will be tracked with an evaluation in the third conversation, detailed in the Program Evaluation section.

4.3.2 The Conversations

In the first conversation, residents will engage in a semi-structured discussion of the facilitators of and barriers to healthy behaviors that they encounter in their community. Residents will also be introduced to the work of LWA, the social ecological framework, and to their municipality's policies designed to support healthy living through a fact sheet generated by the LWA organizer and in a brief presentation at the meeting. The purpose of the educational segments of the conversation is to familiarize residents with social ecological concepts so that they are then comfortable applying the model in the second and third conversations. Residents will learn how the physical and social environment are factors in their individual health and discuss ways they can alter their environment in order to lead healthier lives. Participants will be encouraged to discuss the contents of their conversation with their social networks and will complete an initial evaluation at the end of the conversation.

This discussion of barriers and facilitators will continue into the second conversation, where residents will identify a top priority that will guide their action plan. The group will identify factors that contribute to the priority issue. The organizer will assist residents in applying their knowledge of the social ecological model, aligning factors with their ecological level in order to better understand who in the community can help and the types of actions they can take. Residents will finalize their action plans in the third conversation, devising next steps and determining an initial resident-driven community project. The organizer will also assist residents in identifying potential partners to assist in implementing the action plan and the group will determine when and

how to integrate outside partners. LWA will then provide promotional and practical support to each community project, either directly working to implement a project or by acting as a mediator between the conversation group and a relevant partner. Examples of possible community projects include the formation of a neighborhood walking club, approaching municipal council to act as a resident advisory board for LWA policies, or hosting a community event to raise awareness of healthy activities and services taking place in the community. The organizer will provide all participants with hard copies of meeting notes and the finished action plan.

Throughout the course of resident conversations, the LWA organizer will serve as a link to available local resources in addition to helping residents identify gaps. With permission from resident participants, the organizer will arrange meetings with organizations and governmental bodies relevant to the implementation of community projects. Upon completion of the action plan, the organizer will work with residents to define the future of the group and to assess what role the organizer can continue to play in supporting residents in future endeavors. The organizer will offer to provide training to interested residents in meeting facilitation skills in order to further conversation objectives, either working with residents individually or hosting a training that would allow residents from different municipalities to meet and learn together.

4.4 Program Sustainability

Throughout the project, the LWA organizer will take steps to gradually minimize their role, finding and acting upon opportunities to give ownership of conversations and projects to the residents. As a part of drafting their action plans, residents will determine whether to continue meeting after the completion of the implementation of their first community project. For groups

that want to continue meeting, the organizer will offer conversation facilitation training to interested residents. The organizer will also approach partner sites about continuing to act as hosts or work with residents to find a new conversation location. The organizer may also approach municipal councils about offering continued support to residents by recognizing conversation groups as community advisory boards. For all conversation groups, the LWA organizer will provide ongoing support in completing their community projects.

At the completion of this pilot program, the conversation project will seek to expand support for the program to host additional conversations and support the continuing efforts of the pilot conversation groups. As a program designed in response to goals set in the Plan for a Healthier Allegheny (PHA), *Live Well Allegheny* also has a network of PHA stakeholders from within and outside the Mon Valley region that have pledged financial and strategic support. These entities include all major healthcare systems servicing Allegheny County and social service agencies with missions to address the multiple facets of the social environments that impact chronic disease development and progression. New and established stakeholders and partners could be approached to assist with the expansion of the Conversation Project as doing so would not only further the goals outlined in the PHA by combating chronic disease but would also raise partnering organizations' profiles in the region. By being on the ground floor of a community-based effort, either by acting as host sites or providing materials and other practical support, partners can further resident awareness of their services and generate goodwill from within the community. All affiliated entities should be included in LWA promotional materials and would form a direct channel to request resources and assistance from the LWA.

Live Well Allegheny's targeted Mon Valley program has previously received financial support from the Jefferson Regional Foundation in recognition of its alignment with the

foundation's priorities of supporting vulnerable populations. As action plans evolve, the priority areas of the conversation groups can be assessed for alignment with the priorities of previously untapped funding sources. For example, plans designed to address smoking and/or area walkability may qualify for funding through the American Heart Association. The project can also pursue funding from the Robert Wood Johnson Foundation as program activities are designed to align with their Culture of Health framework and evaluations will capture their effectiveness at bolstering a sense of shared community and values.

4.5 Program Evaluation

All objectives in the *Live Well Allegheny* (LWA) Resident Conversation Project initiative are designed to address chronic disease disparities in the Mon Valley by increasing residents' collective efficacy in performing health-promoting behaviors through social and civic engagement. The following measures will be evaluated and monitored to ensure consistency across all conversation groups and to address implementation issues as they arise.

4.5.1 Process, Impact, and Outcome Evaluations

Process measures will be used to demonstrate attainment of the following short-term and intermediate outcomes. A total of 60 residents will gain awareness of current area wellness activities and gain skills for designing wellness activity priorities, such as promoting individual modeling and encouragement or collaborating with fellow residents and area partners. This objective will be met following the first conversation and will be built upon in subsequent

conversations. At the end of the second conversation, 75% of residents will demonstrate an increased awareness of how local community impacts individual health. By the end of the third conversation, 80% of residents will report a greater sense of connection to community. We also expect knowledge gained in conversations to spread beyond the immediate conversation group, with 75% of residents reporting more conversations about positive health behaviors with members of their social networks. By connecting residents to area partners and by training interested residents to become facilitators, the LWA Conversation Project will encourage and support conversation groups to sustain the program beyond the initial pilot run.

Program objectives in community organizing projects reflect a combination of process activities, awareness and knowledge acquisition, tangible products, and relationships built across power structures. As a result, it can be difficult to strictly categorize data collection methods and tools as many process measures also serve as outcome measures. For clarity, objectives and their measurements for the Conversation Project have been categorized using community organizing objective definitions derived from the Center for Evaluation Innovation and the Urban Institute and can be reviewed using a matrix found in Appendix C.

The LWA organizer will be responsible for most data collection responsibilities. The organizer will recruit area agencies to act as conversation sites and record confirmation of participation through organization-specific written agreements, such as email exchanges or completion of an organization's room reservation forms. The organizer will also record whether an established or newly recruited partner provided the conversation site. If the site is with a new partner, representatives of the organization will be referred to Public Health Administrator Maria T. Cruz, MID, to complete the formal process of becoming a *Live Well Allegheny* Community partner. Site recruitment will be recorded in an internal tracking document accessible to the

organizer and the program manager and site agreements will be stored in electronic form in a shared folder. Partners will be expected to act as sites for the duration of the project and the organizer will be responsible for reporting any change in site status to the program manager. Data on partners will also be collected in relation to community project implementation. The organizers will use an internal tracking document to record partner participation in community projects, including number of partners, status as an established or new partner, and type of contribution, such as monetary, educational resources, or volunteers.

Data will be collected from residents throughout the duration of the project. At each conversation the organizer will distribute and collect a sign-in sheet and, after receiving verbal consent from participants, will audio record the discussion for later reference. Anonymous surveys will be administered to residents at each conversation and residents will receive $10 gift card upon completion of each survey. At the beginning of the first conversation, residents will receive a survey with three distinct parts: general demographic information, questions designed to ascertain the residents' personal experience with chronic disease, and an evaluation of resident understanding of the social ecological concept of how local community impacts individual health. Residents who join after the first conversation will also be asked to complete the demographic and experience portion of the first survey. The survey administered at the second conversation will continue to evaluate resident understanding of the interplay of community and individual health and will also contain questions about the resident's sense of connection to their community and level of health-promoting activities. At the conclusion of the third conversation, residents will complete a survey with follow-up questions on sense of social cohesion and level of health-promotion. Residents will also be asked to report their use of any LWA resources or agency

referrals that took place over the course of the project. All surveys will be returned to and analyzed by the program manager.

Finally, the organizer will record and track conversation activities and results. Progress on the drafting of action plans will be recorded in an internal tracking document and final drafts of plans will be stored electronically. Progress on community project implementation will also be tracked. The organizer will promote facilitator training to residents beginning in the second conversation and will track number of residents interested and number of residents trained in an internal document. Beginning in the third conversation through the end of community project implementation, the organizer will record whether resident facilitators convene their own conversation groups, either as a continuation of the LWA project with area partners or as a separate meeting.

The program manager's primary roles are to assist the LWA organizer in performing their activities, to monitor the project's progress, and to assess and report evaluation data. The program manager also serves as a central point person for LWA partners and as such will collect and track partner engagement data, including requests for information by phone or email, agreements to promote the Conversation Project and subsequent type and level of promotion, and the number of new partners recruited.

4.5.2 Evaluation Rationale

Resident participation numbers and trends are evaluated to ensure the project is reaching its target audience and maintaining resident engagement. This information is also essential in confirming the external validity of generalizing the opinions of a group of residents to the experience of the wider municipality they live in. This objective will be measured using sign-in

sheets and completed demographic and personal experience questions from the first survey. The organizer will attempt to minimize potential reporting bias by ensuring all residents are able to sign in and by informing residents that any contact information given is for internal purposes only. As survey answers may be identifiable in a conversation's small group setting, the organizer will inform participants that all completed surveys will be stored in a sealed envelope until reviewed by the program manager. Organizational power, or an increase in engagement between residents and area decision-makers, will be monitored in a similar fashion with the LWA team using internal tracking documents to capture the number of partner organizations and their level of support for each conversation and community project.

Increases in residents' power, which is represented by changes in knowledge and area resource access, will be monitored through survey responses and conversation content captured in audio recordings. The organizer will use recordings to compile meeting notes after each conversation in order to monitor understanding and application of concepts learned over the course of the conversations. The program manager will also review recordings of all conversations to monitor progress and to compile a comprehensive report of larger themes that are shared across municipalities. Survey questions about the community and individual health will be drawn from the Robert Wood Johnson Foundation's (RWJF) National Survey of Health Attitudes (NSHA) questionnaire and are detailed in the matrix. Health promotion activities will be captured in questions adapted from the RWJF Public Discussion of Health Promotion and Well-Being, with measurements designed to capture all forms of communication, not strictly online promotion. A newly created survey question will capture resident interaction with LWA partners.

The NSHA was selected as an evaluation tool as its measurements are used by the Culture of Health Action Framework in ascertaining progress in achieving the pillars of the model. The

Conversation Project was designed to address the pillar of creating a "shared value of health" through community engagement. To that end, the NSHA questions selected for the project's surveys are those used in measuring the same Action Framework pillar. The tool should be directly translatable to the project's target population as the questions were designed for the general public and have been reviewed for internal and external validity. Potential drawbacks to the evaluation design are that the pre- and post-tests fall close together and that there is the potential for a lack of continuity in results if residents stop participating or new residents attend. The current design was chosen in order to minimize the time needed to complete each survey to lessen time as a barrier to completion and to allow action planning and discussion to be the primary activities during conversations.

The culmination of this new knowledge will be the completion of action plans structured using social ecological concepts. The action plan will also serve as a tool to measure the achievement of fostering shared health values, the primary objective of the Conversation Project. Tracking of resident facilitation training and conversation ownership will serve as indicators of sustainability of the organizing win as a growth in community capacity.

While the potential for unintended results is minimal with process measures driving many of the objectives, issues of primary concern are the potential for residents to provide false information to each other on health, for discussion to veer away from the conversation focus, and for drafted action plans to not be feasible based on available resources. The LWA team will attempt to safeguard against and capture any unintended results through the regular monitoring of conversation recordings and by strategizing at staff meetings.

4.5.3 Reporting Out

The LWA organizer will be responsible for drafting meeting notes and action plans and distributing them to resident participants. All other major forms of reporting will be the responsibility of the program manager. Regular updates on conversation outcomes, including aggregates of participation numbers, partner involvement, and conversation themes, will be shared through the LWA e-newsletter and LWA website. Community project promotion and outcomes, including highlights of LWA partners, will also be shared through LWA online channels. Area newspapers will be approached to cover the work of the conversations and community projects. Finalized action plans will be distributed to LWA partners and municipal governments and archived on the LWA website.

Evaluation outcomes, including survey results, will be provided in full detail in reports to the ACHD Community Health Promotion & Disease Prevention Bureau. Results will also be synthesized and distributed in the LWA annual report. Residents will receive certificates distributed at their community project that recognize their contributions to their community and their achievement of new skills.

5.0 Discussion

As the program plan outlines, the LWA Conversation Project requires limited physical resources to operate but relies heavily on established and new partnerships to implement. The success of the program will be directly affected by the LWA staff and organizer's ability to foster trust within the community, to manage relationships with partners and residents, and to follow through on plans generated by the Project.

5.1 Establishing and Maintaining Trust Throughout Program Implementation

In order to receive valuable engagement and input throughout the course of the Conversation Project trust must be fostered between LWA and Mon Valley residents. Many communities have a fraught history with health agencies and academic institutions seeking resident engagement with their programming without offering clear benefits for participants in return. For the Allegheny County Health Department, many Mon Valley residents hold the view that their work either does not prioritize suburban communities or is ineffectual in providing community benefit (Cruz, 2019). This perception has been exacerbated by recent events in the region in the community of Clairton. A fire damaged the Clairton Coke Plant's coke gas processing operations, leading to numerous releases of sulfur dioxide emissions into the air that measured above federal standards. The ACHD monitored the emissions but did not release an air quality alert to the public until two weeks after the initial event. Area residents have protested what they view as a slow response to a potential health crisis and the disregard for their well-being.

During the recruitment phase, LWA may experience hesitancy from residents in engaging with ACHD programming as a result of these events and should be prepared to answer resident questions. Resident concerns should be acknowledged as valid and efforts made to redirect residents to how they can impact the work of the ACHD through their relationship with LWA. The immersion of the LWA organizer into the community will also aid in relieving resident apprehension as the organizer will be well acquainted with community conditions and will be known to community leaders. The organizer should be mindful of the accessibility of the conversation location, ideally hosting groups within trusted and traditionally neutral institutions such as schools and community centers. LWA should also be mindful of who promotes their activities and acts as a program partner, taking care to incorporate organizations that are known to the community, even if lesser-known organizations may be a better objective fit.

As a function of facilitating the conversations, the LWA organizer must actively work to create a welcoming environment and provide space for all participants to contribute. The conversation rules outlined in the Facilitator's Guide are meant to emphasize that participants should feel comfortable sharing their experiences with the group. The organizer should be mindful of not inserting their own opinions into conversations or LWA materials, allowing instead for residents to speak for themselves. If the organizer is unclear as to what the resident is describing in the course of discussion the organizer should ask for clarity in the moment and not make assumptions as to intent. LWA should acknowledge the contributions of residents by expressing gratitude at community conversations and through recognition in LWA materials and newsletters. Reports, conversation summaries, and other materials generated in response to the Conversation Project should be mindful of accessibility to residents. The language used should be free of jargon, be readable by the general public, and reflect the unique voices that contributed to the Project.

Copies of materials should be made available to participants and the general public, either by hosting them online or through a method suggested by participants.

Another large component to maintaining community trust is the steps taken by the LWA program to support plans generated by the Project. LWA staff should determine in advance what types of activities fall within the scope of their program resources and responsibilities. The resulting program guidelines should be revisited and reassessed as the Conversation Project is implemented. As action plans are generated, the LWA organizer should be mindful of any commitments they make to the group. If they are unsure as to what level the LWA can be involved in a particular activity, they should express their uncertainty to the group and make a plan to give an update to group members once LWA's response has been clarified for them. LWA should strive to stay in regular contact with participants and give updates on the Project's progress. For example, if the organizer agreed to contact a community partner to aid in implementing the action plan, the organizer should inform participants once the partner has been reached, detail the outcome of their discussion, and provide an outline of next steps for participants and for the partner.

In order to maintain positive relationships with program partners, LWA should be clear from the outset that partner involvement with the project will be guided by resident input and cannot be molded to fit an individual organization's programs or priorities. The results of the Project's resident-driven conversations may often set different priorities from what has previously been identified by local organizations as community needs. LWA and its partners may have to exercise flexibility in how they define the program's goals and place resident input into a broader social ecological context. For example, residents may view violence in their community as a key hindrance to performing healthy behaviors, such as taking long walks. LWA staff will need to

communicate to partners and potential funders how violence is a social determinant of health and as such is one of several ways of addressing the program goal of increasing physical activity levels.

5.2 Implications of the LWA Conversation Project

The creation of the LWA Conversation Project program plan was done in recognition of the importance that place has on health outcomes and of the power individuals possess to influence their local environment. The assessments performed in completing the PRECEDE segment of the planning model confirmed disparities in health outcomes for Mon Valley residents that can be linked to factors present in the physical and social environment. Unique place-based factors included the region's history as an industrial hub and its transformation from a dense metro area into a thinly-populated suburb. The assessments also place the conditions of the Mon Valley in a broader context, however, as poverty and other social determinants are on the rise in suburban communities across the United States.

Limitations in our current appreciation of the breadth and depth of place's impact on health were also uncovered throughout the PRECEDE stage. While place is increasingly recognized as a factor in community health, current understanding of its influence is heavily shaped by studies of urban environments. Public health practitioners in suburban and rural settings are tasked with adapting programs for their populations without the benefit of understanding how best to tailor their work in order to increase program effectiveness. Place-appropriate programming may encounter hurdles in implementation as the target population is spread across a large geographic area or due to a lack of community interest linked to a mismatch in the services offered.

LWA's use of the Health in All Policies approach recognizes some of the unique challenges suburban populations and governments face in fostering healthy environments. The inclusion of a community-engagement initiative within the LWA would demonstrate a recognition of the need for community buy-in and input for creating effective local programming. Its use as an independent intervention in addition to a complement to current programming would also make it unique when compared to conventional health behavior interventions. In many interventions, community engagement activities act as a stepping stone within the larger intervention wherein resident input is incorporated into a larger initiative. While the Conversation Project will provide needed information to inform local agency initiatives, its primary objective is to increase the collective efficacy and sense of shared community identity of participants. These residents will, in turn, play an important role in helping their communities to be healthier. Community conversations bring about these changes by requiring residents to build consensus and to generate collective understanding of common values—key steps in making health a shared value. By raising awareness of LWA's work with municipal governments and others on health policy civic engagement will also be increased.

In the long-term, the Conversation Project is a means of increasing resident investment in their communities and in creating healthier lives for them and their neighbors. Participation in the program will empower residents by recognizing that they are the experts on their own environments and that they can make positive changes to places where they live. The Project is also a means of increasing awareness among local organizations as to the importance of connecting with their target populations and of incorporating their needs into their programming.

6.0 Conclusion

The following is a brief summary of limitations in health data for the Mon Valley as well as final thoughts on the public health significance of the LWA Conversation Project.

6.1 Limitations

The ACHD is working to increase monitoring systems for tracking chronic disease. Publicly available data sets relating to County health are often drawn from a number of sources, including federal and state surveys, and do not always allow for the segmenting of results into geographic regions smaller than the county level or may not accurately reflect current conditions. As a result, some of the health data accessed for this thesis is derived from health surveys of Allegheny County residents where Mon Valley residents may not represent a statistically significant sample of respondents. Other data is based on statistical modeling where the health rates of a demographically similar Census Tract are applied to each community within Allegheny County. In the future, more detailed information on municipal- and neighborhood-level health is needed to accurately assess the needs of communities experiencing health disparities as well as the impact of chronic disease prevention programming.

6.2 Final Thoughts

LWA has increased the capacity of area councils to meet community health needs by assisting in drafting policy initiatives and by forming a cross-sector network of partners through recruitment to become *Live Well Allegheny* Communities. By incorporating a community-engagement initiative the LWA can increase its effectiveness through community buy-in and active participation in the program. The Conversation Project program plan serves as a guide for fostering a collaboration between residents and area stakeholders that creates shared values around health and supports positive health behaviors. The program plan provides LWA with a guide for how to access and amplify community voices in order to better understand region-specific social, environmental, and systemic issues that contribute to inequities in chronic disease as well as how to tailor programming to be attractive to Mon Valley residents. By increasing the collective efficacy, civic engagement, and sense of community of the region's residents, LWA has the potential to create long-lasting and sustainable change in lives of all Mon Valley residents.

Appendix A LWA Conversation Project Logic Model

Problem Statement: Residents of the Mon Valley experience stark disparities in rates of preventable chronic disease.

INPUTS	OUTPUTS		OUTCOMES		
	Activities	*Participants*	*Short*	*Medium*	*Long*
Staff: • 1 LWA organizer • 1 program manager • 1 support staff Financial: • Jefferson Regional Foundation • Allegheny County Health Department LWA community partners, including: • Municipal councils/schools • Mon Valley Providers Council (MVPC) • Jefferson Collaborative Materials: • LWA resolutions • Food • Incentives • ACHD resources (educational and practical) • Writing materials	-LWA organizers attended MVPC and Jefferson Collaborative meetings to promote outreach. -LWA organizers recruit 4 partner agencies spread across the Mon Valley to act as conversation sites. -LWA organizers facilitate 12 conversations with residents on barriers to/facilitators of healthy habits. -LWA organizer provides information on LWA municipal resolutions and area resources to 60 residents. -LWA organizer drafts 4 resident-created action plans generated from conversations. -LWA organizer connects residents with area partners to enact plans and produce wellness projects.	60 adult Mon Valley residents. 4 sites provided by LWA community partners to host resident conversations.	-60 residents gained awareness of current area wellness activities and the means of providing input into future priorities via resident conversations. -Resident conversations create a complete action plan by the third conversation. -75% of residents demonstrated increased awareness of how local community impacts individual health, measured through resident evaluations administered during second conversation.	-10 residents utilize LWA and partner organization services. -Each Mon Valley municipality hosts one community project within the year following the first conversation. -Conversations will be hosted in additional municipalities after the pilot is completed -80% of residents report a greater sense of connection to community. -75% of residents report more conversations about positive health behaviors with members of their social network.	-Increased rates of civic and social engagement in the Mon Valley. -Residents take ownership of conversations and continue meetings without the assistance of LWA organizers.

Assumptions/Theoretical Constructs

1. Collaboration between residents and area stakeholders that creates shared values around health fosters community-level initiatives meant to make healthy choices for individuals default choices through ease of access. (Culture of Health)
2. Empowering residents through group-driven problem solving will increase residents' sense of social cohesion and shared expectations for community action, resulting in increased collective efficacy in promoting and performing group-supported health initiatives and behaviors. (Social Cognitive Theory)
3. Integrating municipal-level goals and partnerships into community conversations that happen at regular intervals in supportive environments will allow residents to generate the social capital needed to support LWA resolution goals. (Sense of Community Theory)

External Factors

1. High levels of poverty, shrinking tax bases and aging infrastructure provide limited resources for municipal councils to implement policies designed to encourage positive health behaviors.
2. Residents in Allegheny County's black and distressed communities report that area health programs inadequately represent them and do not encourage their input; this mismatch may contribute to the underutilization of available resources in the Mon Valley.
3. LWA has partnered with 18 municipal councils, 6 school districts, and numerous service agencies in the Mon Valley to draft, implement, and assist with health policies and programs that combat chronic disease behaviors and promote healthy community environments.

Figure 4 LWA Conversation Project Logic Model

Appendix B LWA Conversation Program Budget

Table 2 Program Budget

LINE ITEM	Name	Annual Salary	Level of Effort (FTE)	Funder Request
Personnel				
Program Manager, Chronic Disease Prevention Program Responsible for hiring LWA Conversation Organizer. Oversees orientation and training. Meets with Organizer for regular updates on project goals. Reports progress and any reported issues to ACHD Community Health Promotion & Disease Prevention Bureau.	H. Hardy	64,298.27	0.300	$ 19,289.48
Public Health Administrator 1, LWA Mon Valley Provides overview of the work of LWA to the Conversation Project team. Meets with LWA organizers individually to review partnerships in assigned municipalities. Assists LWA organizers in initial contact with LWA partner agencies and municipal councils.	M. Cruz	47,999.95	0.100	$ 4,800.00
Support Staff, Live Well Allegheny Assists LWA Organizer with setup and breakdown at sites of conversations. Assists during conversations by distributing materials and taking comprehensive notes. Consults with LWA Organizer on the creation of conversation minutes and reports generated with the assistance of Support Staff's notes.	To Be Determined	44,999.97	0.100	$ 4,500.00
LWA Organizer Responsible for promotion and recruitment for conversations in assigned municipalities. Facilitates conversations, administers evaluations, and maintains contact with participating residents. Assists residents in drafting action plans and implementing community projects. Refers residents to local social services. Maintains and grows LWA's partnerships within the Mon Valley region through regular contact with current and potential partners within assigned municipalities.	To Be Hired	41,886.72	1.000	$ 41,886.72
Personnel Wage Subtotal				**$ 70,476.19**
Fringe Benefits Calculated at 38% of applicable salary for employee health insurance, FICA, Workers Compensation, Life Insurance, Long-term Disability, and Unemployment Insurance.				**$ 26,780.95**
TOTAL PERSONNEL				**$ 97,257.15**
Travel				
Local Travel 3 x week x 44 weeks x 16 miles on average x 54.5 cents				$1,151.04

TOTAL TRAVEL				**$ 1,151.04**
Equipment				
Not Applicable				$ -
TOTAL EQUIPMENT				**$ -**
Supplies				
Laptop				$ 600.00
Printing: Promotional materials and evaluation surveys 500 x 20 cents				$ 100.00
General Conversation Supplies: Includes sign-in sheets, pens, Post-it Self-Stick Wall Pads $35 average x 4 sites				$ 140.00
Community Project Implementation Budget: Residents for each site will determine the community project. Budget supports promotion, food, and related supplies. Budget will be supplemented by assistance from relevant partners. 4 sites x $1000 LWA contribution				$ 4,000.00
Sony ICD-ux560 Recording Device: Used to capture conversation audio for future use in drafting notes and action plans.				$ 80.00
SUPPLIES				**$ 4,920.00**
Contractual				
Not Applicable				$ -
TOTAL CONTRACTED				**$ -**
Other				
Printing: Materials on local resources and ACHD programming 1000 x 20 cents				$ 200.00
Meals for Conversations: Includes LWA Organizer and staff support. $11 x 17 people x 4 sites x 3 conversations				$ 2,244.00
Incentives: Residents will receive $10 gift cards upon completion of project surveys and evaluations $10 gift card x 3 surveys/evaluations x 15 maximum participating residents x 4 sites				$ 1,800.00
Total Other				**$ 4,244.00**
Total Direct Charges				**$ 107,572.19**
Indirect Cost				**$ -**
TOTAL COSTS				**$ 107,572.19**

Appendix C Facilitator's Guide

Conversation Project Overarching Question:

How can our community help us to be healthy and Live Well?

(The question can be used in advertising and in recruiting participants to the Conversation Project)

Conversation 1

Conversation 1 Focus: To create a shared understanding of health challenges facing the community.

Preparation for Conversation 1: You will have prepared a list of likely priority areas residents may identify and a contact sheet of potential community partners who can aid in implementing resident action plans.

Supplies: Sign-in sheet, evaluations, newsprint/poster-size paper, agenda for the conversation, fact sheets, and a meal for the group.

Introductions

Welcome and thank participants for coming. Briefly introduce yourself. For participants, you can either go around the room or have people speak voluntarily. Ensure that all participants take part, even with brief answers to the introduction questions.

Questions: Who are you and what part of the area do you live in?

Why did you come today?

What are your hopes for the Conversation Project?

General intro of the structure of the Project and of each conversation

Inform group that each meeting will be working to answer the overarching conversation question, "How can our community help us to be healthy and Live Well?" The facilitator is there to act as a guide, but the participants are the experts on the topic. All ideas and plans created through the conversation will reflect their experiences and expertise.

Rules for engagement

Present a simple list of rules on a large piece of paper visible to the group and review the points outlined on it. Ask the group if there are any rules that are missing that they would like to add. Sample rules include:

- One person talks at a time
- Each person gets a chance to talk
- Listen to one another
- It's ok to disagree
- Treat each other with respect
- 'What's said here stays here, what's learned here leaves here'
  (personal stories and interactions will remain within the group. Things that we learn about health or our community we will share with of friends, family, and neighbors)

Warm up exercise: A Visioning exercise

Question: What does a healthy community look like?

Purpose of exercise: A quick way to get the group to start working together and to find commonalities. The exercise will work as a foundation for the rest of the conversations and the results can be kept in view for all three sessions as a reference for the group.

The group will describe what they think a community needs to be healthy. Encourage the group to think big, focusing on ideas and principles as well as practical items. You can have the group imagine a monument and that these words will be etched there as a beacon for the whole community. Write down ideas on a large piece of paper that all participants can see.

- Ask each group member to give four or five words that capture what a healthy community means to them. If individuals come up with phrases, help them to pare down their suggestion. For example, the phrase, "an easy place to get fruits and vegetables" can become "fresh food."
- Provide examples to get the group started such as "safe", "equality", and "welcoming."
- Ideas can be tangible or cultural. All ideas are welcome.
- If an idea is repeated, confirm with the participant that the two ideas are the same and place a check mark next to the word, rather than repeat it.
- At the end, work with the group to narrow ideas to the top 4-5 words. Check marks next to words can help with narrowing the list.
- Create a separate sheet with the final list of words on paper that is visible to the whole group.

Distribute and go over Fact Sheet that includes:

Purpose of exercise:

- An overview of the Live Well Allegheny program
- A list of the municipalities' health policies (when applicable) or a list of sample policies
- Stats on Mon Valley health
- A brief description of how the environment shapes individual health (social ecological model/ 'your zip code is more important than your genetic code')

Questions: When you look at the information, what stands out? Why?

Does anything surprise you?

How does the vision seen in these policies and stats match up or not with our vision?

Brainstorming session: Strengths and Challenges

Purpose of exercise: To develop a list of possible priority areas that will be used in Conversation 2.

Instruct the group to think about our vision for a healthy community and the facts we reviewed. Display two sheets of paper, one for strengths and one for challenges.

Questions: What are community strengths we could support?

What are community challenges we need to address?

Closing comments and reminder for next conversation

Thank participants for taking part in the conversation and for sharing their personal expertise. Encourage participants to talk to their friends and family about today's discussion and to ask them about what they think a healthy community looks like.

Conversation 2

Conversation 2 Focus: To create consensus around a priority health issue and to create shared understanding of the influence of community on individual health through the identification of issues present on each level of the social ecological model.

Preparation for Conversation 2: Prepare meeting notes from Conversation 1. Draft a summary of what was accomplished at Conversation 1 in plain language and print copies to present to participants at the beginning of Conversation 2. Create the outline of the social ecological model (example attached) in advance.

Supplies: Conversation rules sheet, brainstorming sheets from Conversation 1, sign-in sheet, evaluations, newsprint/poster-size paper, agenda for the conversation, and a meal for the group.

Introductions: Review of what was discussed at previous meeting and overview of second conversation structure/review of agenda.

Question: Since our last meeting, has anything happened that relates to our conversations that you would like to share?

What did your family and friends say makes a healthy community?

Exercise: Review strengths and challenges

Purpose of exercise: To create consensus around a top priority to work on.

Look at list together and ask the following. If additional suggestions are given add them to the list.

Questions: Is there anything missing from our list?

What do you like as a priority area and why?

Select a top priority as a group. Take a vote or ask each group member to choose the top three and select the priority with the best ranking.

If the group is unsure of how to best select a priority area, you can encourage participants to consider one or more of the following factors:

- Number of people it impacts
- How urgent the issue is
- If it will help a group that is vulnerable
- If the issue is tied to other issues in the area, i.e. working on this issue impacts other challenges in the community

Brainstorming session: Using the social ecological model to better understand the priority issue

Purpose of exercise: To identify smaller issues that contribute to the priority issue and to discuss attainable goals for addressing these issues. Approaches for achieving these goals will be discussed in-depth in Conversation 3.

Remind the group of the discussion in Conversation 1 about the impact on the environment on individual health. Explain that by breaking down our priority issue into its social ecological part we can find a variety of ways to address the issue. What we discuss today will be useful when we create our final action plan in Conversation 3.

Questions: What are some of the challenges the community faces in addressing our priority area?

Who can address this challenge? Can residents fix the issue or do we need help?

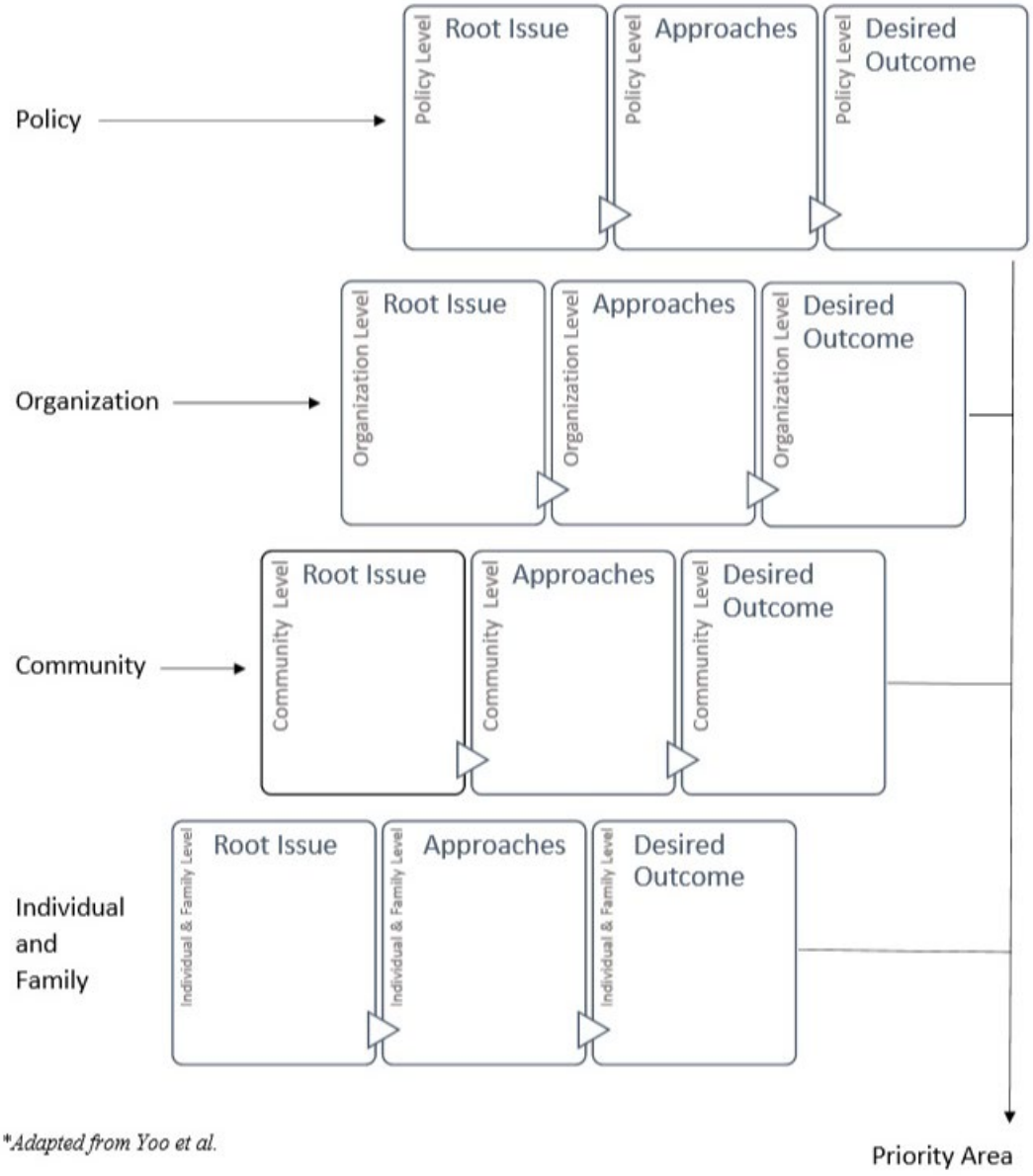
What would achieving progress on our priority area look like? What are smaller "victories" that would help us reach our goal?

Using an outline of the social ecological model (example attached), place participant answers in the corresponding boxes. Work with the group to finish each line, placing challenges under 'Root Cause' and attainable goals/'victories' under 'Desired Outcome.'

Closing comments and reminder for next conversation

Thank participants for taking part in the conversation and for sharing their personal expertise. Encourage participants to talk to their friends and family about today's discussion and to ask them about how they would approach the priority issue.

Example Social Ecological Model



*Adapted from Yoo et al.

Conversation 3

Conversation 3 Focus: To generate an action plan using the Social Ecological model as a guide and to foster community buy-in for projects implemented using the plan. To identify people and/or organization(s) to partner with for the plan.

Preparation for Conversation 3: Draft a list of potential community partners that work on issues identified by the social ecological exercise.

Supplies: Summaries of what was accomplished at Conversation 2, conversation rules sheet, brainstorming sheets from Conversation 1, sign-in sheet, evaluations, newsprint/poster-size paper, agenda for the conversation, and a meal for the group.

Introductions: Review of what was discussed at previous meeting and overview of third conversation structure/review of agenda.

Question: Since our last meeting, has anything happened that relates to our conversations that you would like to share?

Exercise session: Approaches to address the priority issue

Purpose of exercise: To explore different ways of approaching one priority. To think about the priority from different angles in order to capture the perspectives of different members of the community, both present in and outside of the conversation group. To give group members a sense of empowerment (collective efficacy) to address issues that affect them personally. To draft an action plan.

Instruct the group that now we will explore some ways we might solve the priority issue. In small groups or partners have participants think of 4 to 5 approaches to improving the priority situation. 'Approaches' are the materials or activities needed to address the priority issue. Participants are to write each suggestion on a separate post-it note. Suggested approaches can be for any level of the social ecological model. Allot 10-20 min. depending on group size. You can check in with each group as they work and offer suggestions if anyone gets stuck.

After the allotted time, each small group presents their approaches to the larger group, with post-it notes collected and displayed for the group to see. Suggestions will be placed in the 'Approaches' box of the social ecological model. If an approach is similar to a previously given suggestion, group them together by sticking the post-its on top of one another.

The activity is then followed with a discussion:

Questions: Have any of these approaches been tried? If so, what happened?

Which approaches do you like best? Why?

What approaches won't work? Why? (If the group identifies approaches that won't work, ask if they can be removed from the board)

Brainstorming: Turning our approaches into a plan/Identifying partners and assets

Purpose of exercise: To identify assets within the community and potential outside partners that can support the action plan. To increase participant understanding of their community and how to work with others. To increase collective efficacy by drafting an attainable action plan.

Congratulate the group on creating a draft of an action plan! We will now work together to move our model from a collection of ideas to a more concrete plan by identifying who or what can help us achieve our goals.

Introduce the activity by saying that all communities have assets or strengths that can help address problems. Some of these assets might be physical, like money or buildings, but most often are the people that live or work there. Take four pieces of paper and write "People" "Places" "Groups" and "Other" on top of each. As participants answer the following questions write their answer on the corresponding sheet.

Questions: Looking at our list of 'approaches,' who do we know that has skills they might offer to help?

What groups do you belong to? Can they help?

Are there organizations that are already working on the priority issue? Are there organizations that are not working on the priority issue but could?

As you compile the list of assets you can also connect responses to a related 'Approach.' These connections can also be made at the conclusion of the brainstorming activity.

After brainstorming of assets is complete, help the group to plan next steps by asking the following:

Questions: Now that we can see where we have assets that match approaches, which approaches do you think the community should do first?

Which approach may be the easiest to accomplish?

Which approaches would impact the most people?

What role do you want to play, as an individual and as a group, in working on the action plan?

Based on participant responses, make preliminary plans for performing the first steps of the plan. For example, if the group would like to present their plan and policy-level approaches to their municipal council, discuss whether the group would like to meet again to prepare or reconvene at the next council meeting. Be sure that group members have time at the end of the conversation to connect with one another and encourage them to share contact information with each other.

Closing remarks

Thank participants for taking part in the conversation and for sharing their personal expertise. Encourage participants to talk to their friends and family about today's discussion. Remind them that you will send a final version of their action plan to them electronically (or in the mail by request) and that the plan will be shared by Live Well Allegheny with its partners through its website and newsletter.

Appendix D Evaluation Matrix

Outcome	Evaluation Question	Indicator or Performance Measure	Method	Tool or Data Source	Frequency	Responsibility
Organizational Power: Develop relationship with decision-makers	4 LWA partner organizations act as conversation sites	-4 partners sign agreement to be sites -Partners, either established or new, serves as sites for all 3 conversations	Process Measure	-Written agreement between partners and LWA -Organizational records	-Prior to first conversation -After each conversation	LWA Organizer
Organizational Power: Develop relationship with decision-makers	LWA organizer promotes and recruits for conversations with area partners	-Attendance at Jefferson Collab and MVPC meetings -Immersion in assigned municipality	Process Measure	-Staff meetings -Follow-up with partners -Organizational records	Throughout 2nd and 3rd month of project	LWA Organizer & Program Manager
Organizational Power: Changes in stature within community	LWA organizer facilitates 12 conversations with residents on barrier to/facilitator of healthy habits	Number of conversations	Process Measure	-Sign-in sheets -Conversation recordings	Every conversation	LWA Organizer
Organizational Power: Develop relationship with decision-makers	Area partners assist residents to enact plans and produce wellness projects	-Number of partners provide resource or physical assistance -Number of tangible materials provided (if applicable)	Outcome Measure	-Organizational records	Between third conversation and community project implementation	LWA Organizer & Program Manager
Participation and Membership: Changes in attendance, who attends	60 residents attend community conversations	-Number of residents at each conversation -Retention of residents/new residents at subsequent meetings	Process Measure	Sign-in sheets	Every conversation	LWA Organizer
Participation and Membership: Changes in demographics	Adult Mon Valley residents impacted by preventable chronic disease	-Demographic information -Residents at conversations report direct or indirect experience with	Process Measure	-Standard demographic questionnaire -Newly developed by team: ---Do you or a friend/family member currently live with	-First conversation -For new attendees, during first conversation attended	LWA Organizer

and number involved		chronic disease management		one or more of the following conditions: Diabetes, Cardiovascular disease, High Blood Pressure, Obesity ---Do you or a friend/family member currently smoke cigarettes? ---If yes, roughly how many cigarettes are smoked a week?		
Resident Leadership and Power: Change in attitudes, skills, and knowledge	60 residents gained awareness of current area wellness activities and the means of providing input into future priorities via resident conversations	-LWA Organizer provides information on LWA municipal resolutions and area resources	Outcome Measure	Conversation recordings	Every conversation	LWA Organizer
Resident Leadership and Power: Change in attitudes, skills, and knowledge	75% of residents demonstrated increased awareness of how local community impacts individual health, measured through resident evaluations administered during second conversation	Changes in 'Shared Mindsets and Expectations' measurements	Outcome Measure	RWJF National Survey of Health Attitudes: Health Interdependence Questionnaire	-Baseline -Second conversation	LWA Organizer
Organizing Win/ Leadership and Power: Change in attitudes, skills, and knowledge	LWA organizers draft 4 resident-created action plans generated from conversations	-Number of plans drafted -Number of plans completed	Process Measure	Organizational tracking records	-Second conversation (draft) -Third conversation (finalize)	LWA Organizer
Meaningful Impact Following Wins: Sustained shifts in norms	80% of residents report a greater sense of connection to community	Changes in 'Sense of Community' measurements	Outcome Measure	RWJF National Survey of Health Attitudes Questionnaires: -Social Support - U.S. and Community Resource Investment	-Second conversation -Third conversation	LWA Organizer

Meaningful Impact Following Wins: Changes in practices	75% of residents report more conversations about positive health behaviors with members of social network	Changes in self-reported health-promotion behavior	Outcome Measure	Questions adapted from RWJF Public Discussion of Health Promotion and Well-Being measurements	-Second conversation -Third conversation	LWA Organizer
Meaningful Impact Following Wins: Implementation of policies	Each Mon Valley municipality hosts one community project within the year following the first conversation	-Number of completed community projects -Number of community members in attendance	Process Measure	Organizational tracking records	At community project events	LWA Organizer
Meaningful Impact Following Wins: Changes in practices	10 residents utilize LWA and partner organization services	Self-reported use of services	Outcome Measure	Newly developed by team: -Since joining the Conversation Project have you visited one of the following LWA partners? (check boxes with list of partners)	Third conversation	LWA Organizer & Program Manager
Organizational Capacity: Changes in skills	LWA organizer trains interested residents to become conversation facilitators	-Number of residents expressing interest/completing training	Process Measure	-Sign-in sheet -Organizational tracking records	Between second conversation and community project	LWA Organizer
Organizational Capacity: Changes in staffing, infrastructure	Residents take ownership of conversations and continue meetings without the assistance of LWA organizer	-Number of conversation groups that convene after pilot conversations	Outcome Measure	-Organizational tracking records	After community project	LWA Organizer

Figure 5 Evaluation Matrix

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