Master of Public Health

Integrative Learning Experience Report

EVALUATION OF THE H.O.P.E PROJECT

by

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MASTER OF PUBLIC HEALTH

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Abstract

The main goal of The Health Opportunities through People Empowerment (HOPE) project is to advance health equity by organizing and providing residents training and support for community organizing, focused in the Northview neighborhood of Manhattan, Kansas. More specifically, “the focus is to improve health and equity through policy, system, environmental, and personal change”. The project began in 2017, shortly after a community needs assessment revealed health disparities were prominent in the Northview area of Manhattan, Kansas. The project was funded by the Kansas Health Foundation and led by the Flint Hills Wellness Coalition (FHWC). The purpose of the current project was to evaluate community-organizing aspects of the HOPE project by assessing the perception of community residents regarding the strengths of community involvement in this neighborhood health program. This applied practical experience (APE) with the FHWC seeks to improve health by engaging with residents in local communities throughout Manhattan and Riley County. Within the FHWC, I was mentored by Brandon Irwin, PhD. Dr. Irwin was the Community Liaison within the H.O.P.E. project. His background includes Kinesiology and he works at the community level to promote health and wellness to residents throughout Manhattan, with a specific focus on the Northview Neighborhood.

Evaluation of community organizing aspects of the HOPE Project was conducted through the use of Appreciative Inquiry theory (Coghlan et al., 2003) and guided by the following questions: 1) What is working? 2) What needs changed? 3) What is most important for resident-led community organizing? and 4) How well did outcomes align with or represent the HOPE project Theory of Change? The methods included individual interviews with project team members, involved residents, and key influencers. The analysis process utilized a data matrix to identify themes. The findings suggest that the HOPE project is working to increase community organization and engagement. Results show that the project is successfully encouraging social neighborhood connectedness, discussions of shared interests between residents, and project ownership and leadership. Some challenges of the work include increasing the number of people involved, demographic diversity within residents, and financial sustainability.

Subject Keywords: community organizing, equity, health disparities

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Chapter 1 - Literature Review

Health equity is defined as “the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographic areas in health status and health outcomes such as disease, disability, or mortality” (Health Resources and Services Administration, 2018). Health inequity, which is the presence of these disparities in a community, has a crippling effect on the health of our nation. We see that health inequities create differences between people, causing specific groups to have poorer health outcomes than other groups of people. Neighborhoods experiencing decreases in life expectancy (Wilson & Daly, 1997, Sanders-Phillips et al., 2009), certain demographics experiencing higher maternal death rates (Fang, Madhavan, & Alderman, 2000), and low socioeconomic status children growing up with less opportunities and poorer health outcomes than children in middle or upper socioeconomic classes (Epps, 1995) are all examples of health disparities we see in the United States today. Health disparities are defined as differences in a society, economy, environment, or structure that result in poorer health outcomes for different groups of people within the same society (Bauciu et al., 2017).

“Community organizing is both a tactic to address specific problems and issues and a longer-term engagement and empowerment strategy and a longer-term engagement and empowerment strategy. Longer-term objectives of community organizing are to develop the internal capabilities and to increase the decision-making power and influence of underrepresented groups” (Gittell, 2016). Community engagement, an aspect of community organizing, is important to health equity and is defined by the Center for Disease Control and Prevention as “the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members“ (CDC, 1997, p. 9). Research by Pastor, Terriquez, and Lin show the connection specifically between health equity and community engagement. Health equity can be utilized as an outcome or as a framework in health programs. Health equity as an outcome focuses on increasing

awareness and advocating for better health in communities; this is especially needed in areas that experience racial injustices, immigrant harassment, and LGBTQ discrimination (Pastor et al., 2018). Decreased measures of health disparities would be seen if the outcomes to a specific program were successful. For example, if a program was successful, there would be decreased rates of maternal deaths for women of color in the area where the program was implemented.

Using health equity as a framework allows for certain disparities to be addressed, which can change overall health outcomes. In California, community organized campaigns advocated for policy change to address racial discrimination in school discipline. Research showed that, especially for boys of color, school discipline resulted in higher stress and trauma (Rich, 2016). These boys were more likely to have criminal records in young adulthood, leading to unhealthy lifestyles later in life (Terriquez et al., 2013). Community organizers and advocates in California replaced the harsh school discipline policies with a “restorative justice” program (programs that focus on nonpunitive approaches in school discipline) in places such as Fresno, Long Beach, Los Angeles, Oakland, San Diego, and Santa Ana. With this program replacing old policy, the organizers and advocates saw increased education attainment and higher student retention rates, which both directly relate to improved health outcomes later in life (Bloemraad & Terriquez, 2016).

Another successful community level example of using community engagement as a framework to improve health is the Healthy Neighborhood project. This grassroots movement in California focused on addressing the needs of community members. This focus was counter to previous initiatives that implemented program priorities instead of engaging with the community to uncover the felt needs by residents. This project started by training neighborhood health advocates who would work with residents in their community and discussing with them the needs they felt were important in their community. After their needs were uncovered, the community was able to decide upon their most pressing health need(s) and create a Plan of Action to target them. Residents felt a sense of control over their environment and over the program and were then able to establish trust with local health departments, who had historically disregarded the felt needs of the neighborhoods. This was a large step for these communities and allowed

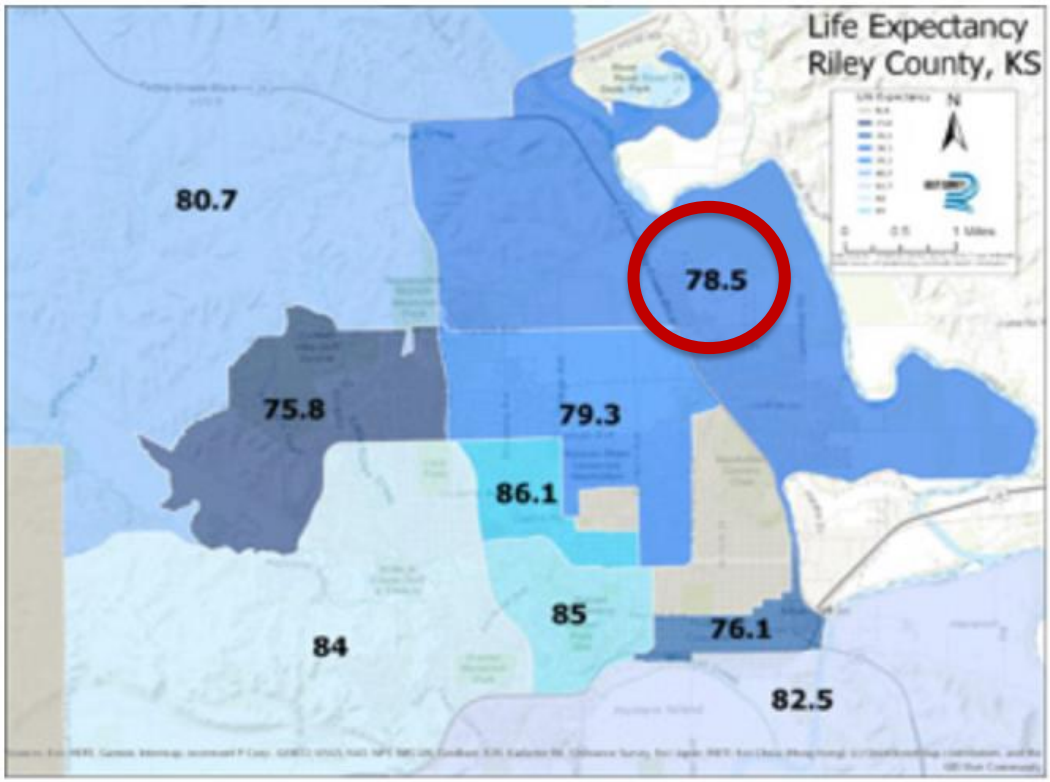
for the health departments to begin engaging and implementing policies that best fit the health of those communities (Contra Costa Health Services, 1999).

The Appreciative Inquiry model is a project evaluation model with growing application for community engagement and health equity. This model focuses on the strengths of a project or program and asks questions to participants about what is going particularly well. The ultimate design is to cast a future vision for the people in the program, to focus their attention on what the project could look like if they saw the strengths occurring more (Coghlan et al., 2003). This design also empowers and encourages the participants, allowing them to focus on their successes and gain a sense of ownership of the project before it is completed (Hammond, 1996). This design is different from many other designs because the focus is place on identifying and targeting the strengths of the project. It also allows for gaps to be seen because people state things such as, “I wish I saw more of this happen”. This allows for the positive to be focused on and the participants to feel engaged with the project, without ignoring the negative. The Save 100 Babies project used the appreciative inquiry model to focus on what worked during the project. The project used a community engagement model to advance justice and health equity for African American birth outcomes (Jackson et al., 2014).

Chapter 2 – Project Description

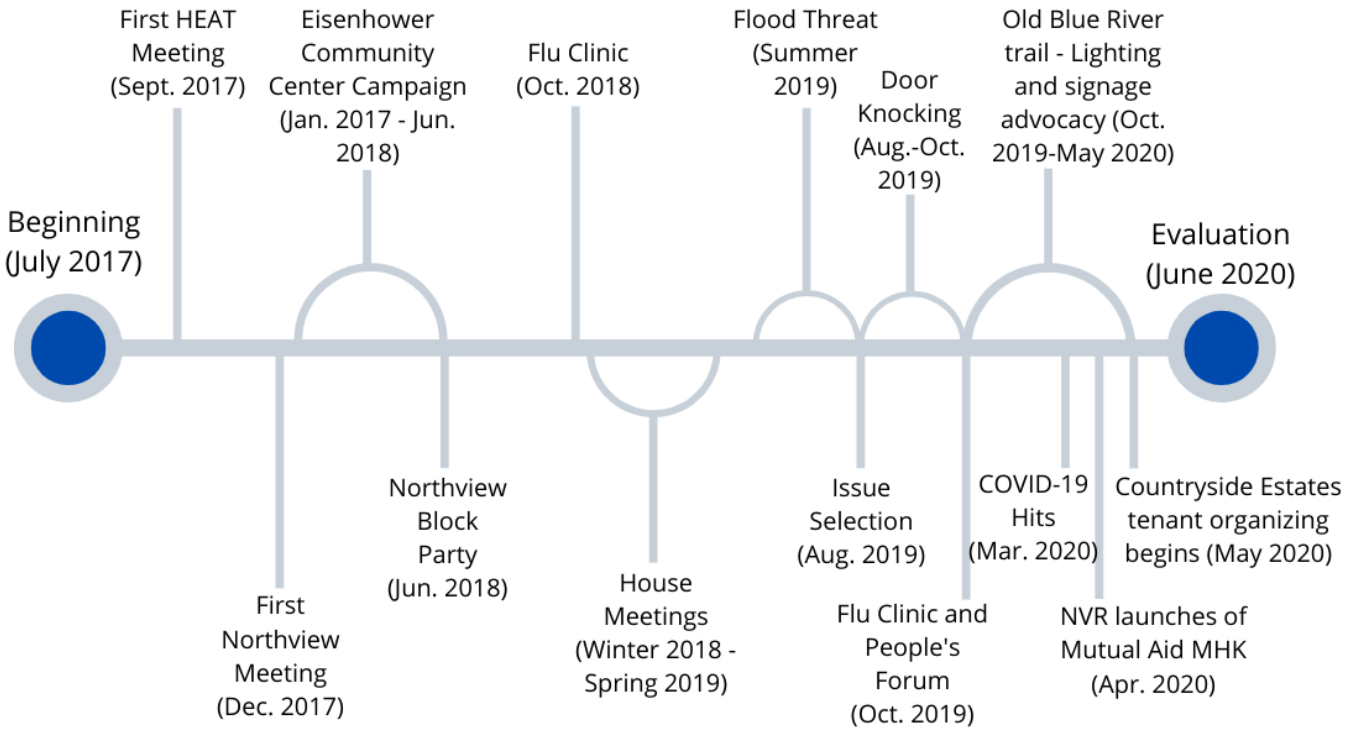
In 2015, a Community Needs Assessment in Riley County revealed a dramatic difference in life expectancy in the Northview neighborhood compared to central and southwest Manhattan (Figure 2.1 below). Those living in the Northview area (circled in red) had an average life expectancy of 78.5 years, while those in central Manhattan had an average life expectancy of 86.1 years. This reveals that those who lived in Northview comparatively lived an average of 5.7 years less than those in central Manhattan. The Community Needs Assessment also showed that the neighborhood experienced decreased transportation options, poorer housing conditions, and limited access to food and healthcare services. With so many unmet needs, the Flint Hills Wellness Coalition (FHWC) sought the opportunity to increase the health and health equity of the Northview neighborhood through the Health Opportunities for People Empowerment (H.O.P.E) Project (grant funded by the Kansas Health Foundation). The aim of the H.O.P.E. project is to increase health equity through community organizing and civic engagement.

Figure 2.1 Life Expectancy in Riley County, Kansas



The H.O.P.E project began in 2017 and is scheduled to end in December 2020. A full timeline with major events of the project, including the Eisenhower Community Center Campaign and the People's Forum, can be seen in Figure 2.2 (below). The purposed of the applied practical experience (APE) was to complete an evaluation of community organizing and engagement aspects of the H.O.P.E. project with the FHWC. The project was grant funded by the Kansas Health Foundation (KHF), and a part of the grant was earmarked to evaluate the "success" of the project.

Figure 2.2 H.O.P.E. Project Timeline



The H.O.P.E. project utilized the KHF Theory of Change Model (Figure 2.3 below), so a portion of the evaluation process focused on how the project implemented and aligned with this model. The Theory of Change guided the events and actions of the HEAT team for the different events and programs developed and implemented. Since the theory was the foundation of the project, it was used to categorize the data after the

interviews were completed. This theory has five components: leadership capacity, authentic engagement, advocacy capacity, multisector relationships, and sustainability. All of these parts function together to make a lasting change within a community. Each of the program pieces or outcomes fell into one of these five components.

Figure 2.3 Kansas Health Foundation Theory of Change Model

The evaluation process began in September 2019 and ended in July of 2020. During that time, I assisted with developing interview questions, scheduled all interviews, compiled and compared data to view trends and analyze the project, and wrote the evaluation report. A full list of the major activities I participated in during my time doing the project evaluation can be include facilitating weekly meetings, creating interview questions and collecting and analyzing data from interviews.

The 240 hours were completed through the course of 10 months (end of September through beginning of July), as shown on Table 2.1 below. I was the lead on an evaluation team for this project. The evaluation team was comprised of Brandon Irwin, PhD, Kerry Priest, PhD, Susan Rensing, PhD, and Mr. Frank Bailey, a student of American Ethnic Studies at Kansas State University. Though project evaluation was a team effort, my responsibilities were to aid in designing the interview questions, schedule and conduct interviews (Frank Bailey helped conduct interviews), analyze and process data, and write the final evaluation report. During this time, the evaluation team met every 2 weeks, increasing frequency to every week in February through July. I was in charge of facilitating the meetings with the team by keeping them updated on the interview and evaluation processes. I was also in charge of weekly communication via email to the team and hosting team meetings over zoom. A full list of the major activities participated in during the project evaluation can be seen in table 2.1 (below). The activities included facilitating weekly meetings, creating interview questions, and collecting and analyzing data from interviews.

Table 2.1 Activities

Months	Personal Activities and Tasks performed during timeframe
Sept. - Oct.	Start weekly meetings. Developing interview questions off of Appreciative Inquiry Model.
Nov. – Dec.	Interview process including scheduling and conducting interviews, capturing data from interviews, and transcribing interviews
Jan. – Apr.	Developing data matrix, coding and categorizing data, analyzing results, and finding common themes from all interviews. KSU Community Engagement Symposium was also in April.
May – Jun.	Writing the evaluation report
July	Present all findings to the Flint Hills Wellness Coalition

From September through October 2019, we began developing the interview questions. The beginning of the project evaluation focused on producing interview questions. There were three categories of stakeholders, so three types of interview question guides were developed: one for residents, one for Health Equity Admin Team (HEAT) team members, and one for key influencers. The evaluation team based the interview questions on the Appreciative Inquiry model (Figure 2.4). The Appreciative Inquiry model highlights strengths of a program, rather than the weaknesses. Some alternative models become constrained through a narrow focus on weakness (Cooperrider and Whitney, 2011). The Appreciative Inquiry model has four stages, which all work together to point those interviewed to a common vision and allow for expansion of future work within the project

Figure 2.4 Appreciative Inquiry Model

(Benedictine University, 2017). The four stages are discovery, dream, design, and destiny. Our questions were based off of the first two stages, discovery and dream.

The intention for interview questions in this model was to focus participants on the positive aspects and about their highlights and what went well during their involvement in the project. The questions focus on “what went well” and “what would you like to see in the future”. Example questions that would be in the discovery stage include, “what influenced or motivated you to participate in this work?” and “Describe a high-point experience from your involvement in this work – a time when you were most engaged.” Examples of questions in the dream stage include, “What is your vision for the community?” and “in the future, what would you want to hear about his work?” (the full interview guide is found in Appendix 1). The hope is that the responses lay the foundation for designing a better project (design stage) and implementing those changes in this project, or similar projects in the future (destiny stage).

The interview process started in early November 2019 and were finished by mid-December 2019. Each interview was scheduled through an e-mail listserv. There were two interviewers involved in this process. From a compiled fifty-three people, thirty-one interviews were scheduled and completed in person, which is a 58% response rate. The compiled list of participants was provided to the interviewers from the Community Liaison. The list was compiled from everyone who had been a part of the HEAT team, the resident team, and key influencers in the community. The interviews lasted an average of forty minutes. The same questions were used for every individual within each specific group (i.e., HEAT team, resident, or key influencers). Different groups, however, were subject to an alternate set of questions. Every interview was recorded and saved on a secure drive (permission was captured through an informed consent, [see Appendix 4]). Written notes were also captured during the interview and transcribed on to the data matrix for the evaluation team to see. The interviews were transcribed using Otter, an online application specific for interview transcription. The interviews were completed before winter break.

The months of January through April were spent categorizing, coding, and analyzing data. The notes from every interview were compiled on an excel spreadsheet, with interview questions as reference forming column A and the interviewer info in row

1. Each of the 3 groups had its own data matrix because different sets of questions were asked to each group (residents, HEAT team members, and key influencers). Answers to each question from each participant were recorded in the appropriate place to make comparison of answers quicker and more efficient.

The first step in the evaluation process consisted of reading through all of the interviews and the notes captured on the data matrix. The notes on the data matrix were summarized from the answers provided by the participants during the interviews. Next, common themes for each of the questions were highlighted, and every question was coded. As a result, a column was added to the end of each question that highlighted common words, phrases, or thoughts spoken by the participants. Both interviewers did this separately and then compared notes and discussed how these themes were interpreted. Then the entire evaluation team went over the data matrix and looked more in depth at the common themes pulled. After that, the common themes from each question were categorized into four main evaluation questions: 1) “what is working/what is going well?”, 2) “what is not working/what are common barriers?”, 3) “what are the most important things to resident led community organizing?”, and 4) “how well did the outcomes align with the KHI Theory of Change Model?”.

During April, a multimedia presentation with a PowerPoint for the Kansas State University Community Engagement Symposium was developed. The original design was a poster presentation, but due to the COVID-19 pandemic, the platform was switched from in-person to online. The multimedia presentation summarized the findings from the interviews and was the step between the data analysis and the evaluation report. The live presentation was no longer an option, so no community feedback was received from this pre-recorded presentation. This was challenging and a bit disappointing due to the loss of valuable feedback that could have come from presenting before the community audience.

In May and June (year), the final evaluation report was drafted and written. A background of the evaluation was provided, as well as the methods for data collection and analysis. In the evaluation report, major themes were summarized. Direct, anonymous quotes were pulled from the interviews and provided for each theme. An example of one major theme in the “what is working?” domain was a mutual desire

within the HEAT team and the residents for sustainability. Participants in the interview process talked about how much they enjoyed the work and how they wanted the group to continue past the life of the grant. One HEAT member commented, “I want to see a diverse and cohesive group, continuing to work on neighborhood issues. Also, more community participants, and the continuation of the initiative and it not stopping when the primary goal is accomplished.”

In July 2020, the formal evaluation was presented to the FHWC via zoom with a PowerPoint slide that showed the main findings and themes pulled from the interviews. The final document was submitted in July as well.

Table 2.2 Learning Objectives

	Learning Objectives
1	Learn about the Kansas Health Foundations Theory of Change and the Appreciative Inquiry model
2	Learn how to extract data from one on one interviews
3	Learn how to conduct effective interviews through feedback and examples
4	Learn how to communicate efficiently and clearly to members of an interdisciplinary team
5	Learn how to communicate research findings effectively to the general public

There were five major learning objectives for this APE project, as shown in table 2.2 (above). The first objective focused on the KHI Theory of Change and the Appreciative Inquiry Model. One of the main questions the evaluation sought to answer was “how well did the project outcomes align with the theory of change model”. To answer this, activities of the project were split into the five categories. For instance, during the interviews, participants talked about how the project started with living room huddles. The residents held meetings in their living rooms with a HEAT team member to help the meeting flow. This fell under the category of authentic engagement because HEAT team members went out to the neighborhood to get the project going. The members were in direct contact with the residents and brought people together through organic relationships and partnerships.

The second and third objectives looked at interviews specifically; the 2nd focused on extracting data from interviews and focus groups, while the 3rd focused on conducting effective interviews. Due to time constraints and various circumstances, focus groups did not end up being a part of the evaluation project. However, extracting data from interviews and looking at qualitative data were still informative about the challenges and strengths of qualitative methods. Extracting data from interviews was a long and tedious process; this actually took up the most amount of time in the APE project. A data matrix was formed after all interviews were completed and the main thoughts, ideas, and quotes were captured on the matrix. The data matrix was designed with all the questions in column one and all the participants in row one. The interviewers (Frank and I) would fill out the answers for each question answered after the interview was completed. This ensured that all answers were organized and easy to compare during the analysis process. For the first step of the analysis process, I went through the data matrix on my own to compare the answers and highlight common topics, phrases and themes. Each question had its own common theme or idea. After that, looked through all the common answers and discovered the common themes from the whole interview process. The second step of the analysis process, the team came together and reviewed the themes. We began to go over all answers again to ensure that all of the data were captured and that other commonalities could be uncovered. This step was completed multiple times by everyone on the team, to ensure that the data had been exhausted and everything that the participants said in the interviews was captured. From here, all of the themes pulled from the individual questions were compiled to capture the major themes of the project itself. These themes answered the questions, 1) “what is working/what is going well?”, 2) “what is not working/what are common barriers?”, 3) “what are the most important things to resident led community organizing?”, and 4) “how well did the outcomes align with the Theory of Change Model?”.

Conducting effective interviews took practice and patience. The first interview was conducted on the preceptor for the APE project. He was able to provide personal feedback about the interview, such as what could be done better and what were some strengths of the interview process. This feedback allowed for my personal growth in the

interview process. The most important take-aways from the interview process were to keep the participants on topic while allowing them to answer the questions the way they wanted, and to not rush participants but to respect their time. If the interview time slot was set for 30 minutes, checking with them when it got close to that time was one way to respect the participants time.

The fourth and fifth objectives focused on communication, with objective four specific to communicating with an interdisciplinary team, and objective five communicating to the general public. Communication is important for the success of any project, and I had to learn to adapt around busy scheduled and learn that everyone has different perspectives and backgrounds, so taking everyone's' thoughts and considerations is important. Most of the time, our team had good communication and worked well together. But there were times when evaluation team members were unable to make it to a meeting but had opinions about the items discussed during the meeting. When meeting minutes were not fully captured, the team members who were not present would become confused or even frustrated because the evaluation was not going exactly where people thought it would or there was a change in direction that was not anticipated. This happened when developing the PowerPoint slides for the KSU symposium presentation. We were able to come together and have a meeting to sort out the differences and all get on the same page, which allowed for the presentation to develop to everyone's standards. Also, asking questions and clarifications is immensely helpful when working with an interdisciplinary team. Everyone is willing to go into depth or detail about what they are wanting or needing, so asking questions really aligned vision to the project as a whole. Asking questions to members of the team who study and excel in qualitative data allowed for me to gain knowledge about this type of research method.

Chapter 3 - Results

The results for this project are broken down into four themes 1) what is working, 2) what is not working, 3) what is most important for resident led community organizing, and 4) how well did the outcomes align with the H.O.P.E project's Theory of Change. These four questions combined are able to answer the overarching question: did this project work?

The results for the "what is working" category show that the project has multiple things going well including: increasing neighborhood connectedness, collaborating people over common interest and concerns, a sense of leadership from residents over the project, a long term desire for sustainability, and successful relationships with key influencers. Neighborhood connectedness, or social connectedness, has been linked to many health outcomes including depression (Fiori et al., 2006), cognitive health (Ertel et al., 2008), and life expectancy of a population (Giles et al. 2012). Many of the residents also participated in the project due to safety concerns within the neighborhood, such as lack of streetlights and sidewalks.

A sense of leadership was commonly spoken about during the interviews. Residents felt as though they had personal investment and ownership of the project. Out of this ownership came the desire for the project to continue past the life of the grant. Residents in the neighborhood felt as though the project was allowing for them to see change in their neighborhood. They wanted to play a role in that change and continue working to make improvements in other areas of their neighborhood.

The results for the "what is not working" category show: the population demographics for the neighborhood are not fully represented, there is a big need for growth and expansion of the resident group, there was confusion and unclear vision in the beginning of the project, and there is a need for financial sustainability. The most common "complaint" from residents was that there was not a lot of diversity in those involved. Everyone was pretty well established in the community. There was a diversity in age, but there was a lack of diversity in race and ethnicity. Specifically, the Hispanic population in the Northview Neighborhood was not represented within the group. With that, there was a desire to bring more people in, especially different demographic or

underrepresented groups. There was also a spoken desire for expansion of the group overall.

During the beginning stages of the project, there was an unclear and overwhelming vision. The HEAT members had different ideas and until the residents were involved in the project, there was an unclear vision on what exactly was going to happen within the project. This led to frustration and some residents feeling overwhelmed during the beginning phase of the project.

Financial stability is a major concern for all groups interviewed. The HEAT members have ideas for fundraising and the possibility for grant renewal, but there is concern that once grant funding ceases, the community organizing results will not last. This is also a concern for the residents. However, there is more optimism from the residents that the group will continue beyond the life of the grant.

The results for the “what is most important for resident led community organizing” category show that community organizing is a long process and resident involvement is the key to long term success for the project. This means that those involved with the project in the beginning must commit in the long run to the project. Also, getting residents involved quickly after the project begins is an efficient way to launch the project. Residents were engaged through door-to-door canvasing, but there was a gap between the start of the project and when the residents actually became involved.

The results for the “how well did the outcomes align with the HOPE project’s Theory of Change” category show that the five components of the theory were met in various ways throughout the project. The five components include: leadership capacity, authentic engagement, advocacy capacity, multisector relationships, and sustainability.

Chapter 4 - Discussion

The HOPE project began because of the unmet needs seen in the Northview Neighborhood. The purpose of the project evaluation is to gain knowledge about program involvement and activities, improve existing program operations, and provide evidence to support program replication. We found that, when utilizing the Theory of Change model, this project was successful within the community when looking through the lens of community organizing and engagement. The project successfully increased the number of residents from the Northview neighborhood who started engaging with community organizing and civic engagement. Through the efforts of this project, a long-term organization has been established (called Northview Rising). This showed success in community organizing because getting residents involved in the beginning allowed for people to connect and begin to shape their neighborhood and make changes to better the overall health of the community.

Strengths of this evaluation include: a qualitative-based evaluation approach, replicability, cost effectiveness, and standards followed to ensure high quality data. This evaluation utilized different evidence-based theories and models, such as the appreciative inquiry model, Theory of Change, and other elements from previous successful community engagement efforts. The evaluation style was easily replicable; all interview questions are available and could easily be asked to the same group of people involved in the project. The process of interviewing people one on one can be easily replicated as well. It was also cost effective due to having little cost to follow through with the evaluation; all technology utilized during this process was free. The only cost would be the intern(s). High quality of inquiry standards was met through attention to the rigor (utilizing a theorized approach, aligning our models, questions, and results), sincerity (through honesty and peer debriefing processes), ethical (through consent forms for interview subjects), and credibility (through member reflections) (Tracey, 2010). These standards are in place to ensure that qualitative data is of high quality.

Weaknesses of this evaluation include the time commitment, the potential for bias in interview answers, and the lack of a diverse sample. There was a large time

commitment and it took time to schedule interviews. The interviewer also needed to be highly flexible and work with the schedules of everyone being interviewed. Due to the interviews being held in person and being recorded, some interviewees may have felt pressured to answer questions in a certain way or be briefer than desired. Also, subject feedback may have been lost in the interview recruiting process if the person held a negative view of the project or did not feel like their involvement in the program was important or valuable. There were people who I reached out to for interviews who did not respond, even after emailing them multiple times. This would shift the bias, because those who felt like the project was important or those who were more involved may have had more input than those who did not feel the project was successful.

It is important to note the difference in the Appreciate Inquiry model design in contrast to other designs. The Appreciative Inquiry first looks at the strengths, or what is going particularly well in an organization. The focus is then to cast vision on the future of the project and allow members to envision what the project or program could look like if those strengths occurred more often (Coghlan et al., 2003). With the viewpoint being on successes of the project, it also empowers and motivates those interviewed. The model focuses on personal stories and successes, giving an opportunity for participants to portray their actual experiences and allowing them to feel committed, confident, and affirmed that the work they are doing is successful (Hammond, 1996).

Though the Appreciative Inquiry model may seem to dismiss the problems or potential negatives, it does address them, but not directly. Those interviewed are asked to provide what they wish they saw more of in the program, or things that they feel may be missing. This highlights the gaps of the program, and allows for those things to be added in, without focusing on what is negative or problematic (Coghlan et al., 2003). Though this is a strength of the Appreciative Inquiry model, it is to note that this may lead participants who have not had a positive experience in the program to give false testimony or give feedback in a more positive light than they actually experienced.

It is important to consider community and resident engagement. Resident must be willing and able to take on the challenges in their own neighborhood in order for the project to have a long-term impact and to see health changes on larger level. Projects risk not making lasting impacts when they don’t align with the goals and needs in a

specific community. As health professionals, we must partner with community members, and empower them to seek health equity and provide them with opportunities to change. When we partner together, we will see lasting change for a healthier, more equitable nation.

Community organizing and engagement could be useful for future research to increase health equity at the community level. If community organizations view health as a priority, there can be promotions and programs put in place from that community that increase need for new policies and for policy change to better fit the needs of the community (Minkler, 205). If community members address health concerns and advocate for change within their communities, they are able to build healthier movements and have a healthier overall community (Pastor et al., 2018). Community organizing and engagement also needs long term sustainability. If policies are not put in place or priorities in health shift, the work done may not last. Long term changes, such as policies, structural, and environmental changes, can keep those health changes in place. Also, keeping community organizations engaged, funded, and focused on solving community health issues is another good way to sustain long term results. Promoting health and advocating policy change can lead to overall better health for the community as a whole, not just the neighborhood where the work is being done because communities are not made of individuals without relations, but social networks that link all people in a community together.

Chapter 5 - Competencies

Student Attainment of MPH Foundational Competencies

The core competencies I focused on for my APE are listed in Table 5.1 (below). I was able to utilize all five competencies through various ways during my time with the FHWC.

Table 5.1 Summary of MPH Foundational Competencies

Number and Competency		Description
4	Interpret results of data analysis for public health research, policy or practice	From results provided through the interview process, be able to interpret data and provide “next steps” results.
11	Select methods to evaluate public health programs.	Methods for the evaluation process included 1-1 interviews, based off of the appreciative inquiry model and the KHI theory of change model.
16	Apply principles of leadership, governance, and management, which include creating a vision, empowering others, fostering collaboration, and guiding decision making.	Roles for the internship include leadership through directing meetings, relaying information, doing the data analysis and sharing findings with the larger group, and providing a platform for all voices of the team to be heard.
18	Select communication strategies for different audiences and sectors.	Different sectors/audiences need different communication strategies.
21	Perform effectively on interprofessional teams.	Team consisted of people from ethnic studies, genders women and sexuality studies, leadership studies, and the health department.

Competency 4 focused on interpreting results from analyzed data in order to implement policy or practice changes, or to broaden the research currently being done in the field of Public Health. I was able to utilize this competency through the oral presentation to the FHWC as well as in the evaluation report. Through the data analysis process, I focused on how to translate the overall picture from the interviews into meaningful information for the FHWC. Though the data analysis was reviewed by the evaluation team, I was able to run through the data independently to find major themes. The data we found showed that the HOPE project aligned with the Theory of Change

model. These results were shared with the FHWC in order to provide a foundation for this type of project in the future.

Competency 11 focuses on selecting methods for evaluating public health programs. I was able to utilize this competency through designing interviews and writing the final evaluation report. The Appreciative Inquiry model was used to design interview questions and the Kansas Health Foundation's Theory of Change model was used to evaluate the project as a whole. The interview process gave us all of the feedback we used for the data analysis. Themes were pulled from the data to answer the first three questions and categorized into the five different components of the Theory of Change.

Competency 16 focuses on applying principles in leadership, governance, and management to cast vision, guide decision making, empower others, and foster collaboration. Through the utilization of this competency, I was able to grow in my leadership style and capacity in a team dynamic. Part of my position for the FHWC was leading weekly meetings, guiding the direction of the evaluation process (though the help of my preceptor), communicating information to everyone on the team, scheduling the interviews and following through with the process, and sharing data analysis findings with the large group. Each of these things needed leadership and I was able to grow in my ability to communicate and lead a team. Through the interview process, I was able to empower individuals to use their voice and speak their minds and hearts about the project they had been a part of.

Competency 18 focuses on appropriate communication strategies for different audiences and sectors. I utilized this competency through communication with the residents during the interview process, as well as through the multimedia presentation. Sending emails to residents and key influencers looked different. When communicating with residents, I needed to be flexible and work with their schedules. On the other hand, when communicating with key influencers, in needed to be more punctual, because many of them held many roles and were often very busy people. This competency allowed me to grow in my communication skills and made me really think about the audience I was dialoging with. This presentation was also directed at a more general audience, so use of vernacular had to change when speaking to people who were not familiar with the project, and also giving more background on the project was important.

Competency 21 focuses on performing effectively on interpersonal teams. The evaluation team consisted of the FHWC Community Liaison, a professor of Leadership Studies, a professor of Gender, Women, and Sexuality Studies and a non-traditional student in ethnic studies. Collaboration of the team was really utilized and tested when we began analyzing and interpreting the data and writing the evaluation report. I appreciated having the knowledge and guidance from professors who do research in qualitative analysis, but it was often times frustrating and difficult to understand due to the nature of this data. We spent many hours going through the data multiple times, only to discuss and go through it again. However, this process allows for the data to be more reliable in the long run. I also had to learn the styles and expectations of different people due to the various backgrounds everyone was coming from.

Table 5.2 MPH Foundational Competencies and Course Taught In

22 Public Health Foundational Competencies Course Mapping	MPH 701	MPH 720	MPH 754	MPH 802	MPH 818
Evidence-based Approaches to Public Health					
1. Apply epidemiological methods to the breadth of settings and situations in public health practice	x		x		
2. Select quantitative and qualitative data collection methods appropriate for a given public health context	x	x	x		
3. Analyze quantitative and qualitative data using biostatistics, informatics, computer-based programming and software, as appropriate	x	x	x		
4. Interpret results of data analysis for public health research, policy or practice	x		x		
Public Health and Health Care Systems					
5. Compare the organization, structure and function of health care, public health and regulatory systems across national and international settings		x			
6. Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational, community and societal levels					x
Planning and Management to Promote Health					
7. Assess population needs, assets and capacities that affect communities' health		x		x	
8. Apply awareness of cultural values and practices to the design or implementation of public health policies or programs					x
9. Design a population-based policy, program, project or intervention			x		
10. Explain basic principles and tools of budget and resource management		x	x		
11. Select methods to evaluate public health programs	x	x	x		

Policy in Public Health					
12. Discuss multiple dimensions of the policy-making process, including the roles of ethics and evidence		x	x	x	
13. Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes		x		x	
14. Advocate for political, social or economic policies and programs that will improve health in diverse populations		x			x
15. Evaluate policies for their impact on public health and health equity		x		x	
Leadership					
16. Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making		x			x
17. Apply negotiation and mediation skills to address organizational or community challenges		x			
Communication					
18. Select communication strategies for different audiences and sectors	DMP 815, FNDH 880 or KIN 796				
19. Communicate audience-appropriate public health content, both in writing and through oral presentation	DMP 815, FNDH 880 or KIN 796				
20. Describe the importance of cultural competence in communicating public health content		x			x
Interprofessional Practice					
21. Perform effectively on interprofessional teams		x			x
Systems Thinking					
22. Apply systems thinking tools to a public health issue			x	x	

Student Attainment of MPH Emphasis Area Competencies

The Physical Activity emphasis area competencies are listed in Table 5.3 (below). Though my APE was not in the physical activity area, I was able to work utilize some of the competencies in this emphasis.

Table 5.3 Summary of MPH Emphasis Area Competencies

MPH Emphasis Area:		
Number and Competency		**Description**
1	Population Health	Investigate the impact of physical activity on population health and disease outcomes
2	Social, behavioral, and environmental influences	Investigate social, behavioral, and environmental factors that contribute to participation in physical activity

3	Theory application	Examine and select social and behavioral theories and frameworks for physical activity programs in community settings.
4	Developing and evaluating physical activities interventions	Develop and evaluate physical activity interventions in diverse community settings
5	Support evidence-based practice	Create evidence-based strategies to promote physical activity and communicated them to community stakeholders.

Competency one focused on population level health, which was the focus of the HOPE project. Health equity is a population level issue and is not as seen or recognized in the at the individual level. Though the HOPE project did not directly focus on physical activity, it did focus on physical activity-related issues that residents brought up, which included a poor built environment for physical activity, which leads into competency two. Competency two focuses on social, behavioral, and environmental factors for physical activity. Residents noted that a lack of sidewalks and streetlights (safety concerns) drove them to joining the group. These concerns are part of the environment, though they prevent or limit the amount of physical activity done by residents in the neighborhood. This ties back to lower income children and poorer health outcomes as they grow older (Sanders-Phillip et al., 2009).

Competency three focused on theory application, which is what this project evaluation did. The Appreciative Inquiry theory served as the outline for the interview questions, and the project evaluation was based on the Kansas Health Department's Theory of Change. Again, these theories did not specifically line up with or relate to physical activity, but I believe it is important and necessary to become familiar with other theories and learn how to use them in a practical setting. This theory may also be applied to physical activity projects or programs if the 5 different categories were tied to physical activity promotion for sustained change. This might be especially useful at the community level.

Competency five focused on creating evidence-based practice to promote physical activity and communicate them to stakeholders. Again, health equity was the main focus of the HOPE project, and there was an evidence-based approach to the project. There was also an evidence-based approach for the data analysis; these were

seen by meeting standards set by qualitative researchers to ensure high quality data (Tracey, 2010). So even though this project did not focus on physical activity, I was able to utilize these competencies in a general regard to health.

The public health field is made up of a variety of people from various backgrounds. The work done on this project has prepared me to work on a multidisciplinary team after graduation. The mindset and thought processes of different people allow for unique perspectives and, in that, unique ways to solve major health problems. Also, working directly with members in a community has prepared me for working with individuals who may not view my health priorities as their own priorities. Seeing that residents have their own ideas for what to improve in their communities has given me insight on how to collaborate with people in the future, whether it is at the community level or larger. Unless people desire the change, it will not be sustained. Partnering with communities, valuing what they value, and changing what they desire to change are critical when striving to make communities and the nation a healthier, more equitable place.

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Appendix 1 - Resident Interview Questions

Name:

Date:

Location:

Role in Project:

"Thank you for agreeing to participate in this interview. Today, I/we would like to ask you some questions about your experience with the Health Equity Project. You might be familiar with this project through your involvement in Northview Rising or the Greater Northview Action Team and the work happening in those spaces.

The purpose of this interview is to capture your experience and get your feedback on how you believe things are going. We want to respect your time. Feel free to answer as in depth as you would like; the more detail you provide, the more this helps us work together to make positive change in the community. During the interview, we will be taking notes to ensure we capture what you say accurately, so be assured that we are paying attention to what you are saying. We will provide an informed consent for you to sign. This is stating that we will not duplicate or give away any information that will identify you in this interview. Do you have any questions before we get started?"

1. Describe your involvement in the health equity/Northview work.
    a. How did you get involved?
    b. How would you describe the purpose of this work?
    c. What has been your role in this work?
    d. What influenced or motivated you to participate in this work?
    e. What is it that you most value about yourself, your work, and this project?
    f. Describe a high-point experience from your involvement in this work —a time when you were most engaged?
    g. At what point did you take ownership of something in this work?
    h. How did you connect with other partners in this project? Who did you interact with the most?
    i. In your opinion, how is this work going?

j. What are the core factors that make the project work, without which the work would be extremely difficult or challenging?
k. How have your feelings/attitude about yourself/your community changed with your involvement in this work?

2. What is your vision for the community? Goal for this work?
    a. In the future, what would you want to hear about this work (in 6 months, 1 year, 5 years, etc.)?
    b. What would be different in your community if this 'worked'?

3. Describe the changes you would make to this work.
    a. What would enhance the impact and success of your work?
    b. If you could do this over again, what would you do differently?

Is there anything else you want to add that we didn't ask about that you would like to share that would help us understand this work and how we can help support it?

Thank you for your time and feedback on this work. We would like to extend you an invitation to keep this conversation going with others in the community. Would you be interested in participating in a focus group? If so, we will email you with times and dates to see what would work best with your schedule.

Appendix 2 - HEAT Interview Questions

Name:

Date:

Location:

Role in Project:

"Thank you for agreeing to participate in this interview. Today, I/we would like to ask you some questions about your experience with the Health Equity Project. The purpose of this interview is to capture your experience and get your feedback on how you believe things went. We value your involvement in this project and want to respect your time. Feel free to answer all questions briefly, but the more detail you provide, the more this helps us work together to make positive change in the community. During the interview, we will be taking notes to ensure we capture what you say accurately, so be assured that we are paying attention to what you are saying. Do you have any questions before we get started?

1. Describe your involvement in this work.
    a. When did you get involved?
    b. How would you describe the overall goal of this work?
    c. What has been your role?
    d. What influences or motivates you to participate in this work?
    e. What is the gift you bring to this work that you are most proud of?
    f. Describe a high-point experience in your experience with this project —a time when you were most engaged?
    g. Who did you interact with the most?
        i. How have you connected with other partners in this project?
    h. How well is this work going?
    i. What are the core factors that make the project work, without which the work would be extremely difficult or challenging?

2. What is your vision of the community?
    a. In the future, what would you want to hear about this work (in 6 months, 1 year, 5 years, etc.)?

3. Describe the changes you would make to this work.

a. What would enhance the impact and success of your organization?
b. If you could do this over again, what would you do differently?

Appendix 3 - Key Stakeholder Interview Questions

Name:

Date:

Location:

Organization/Role:

"Thank you for agreeing to participate in this interview. The purpose of this interview is to get your perspectives on the work happening in the Northview neighborhood that is aiming to advance health equity in our community. A key part of this work has involved interacting with elected officials. We would like to hear about your perceptions and experiences with the residents and this work. We will be using your responses to inform future iterations of our work in the Flint Hills Wellness Coalition and in Northview to make it more effective and responsive to the needs of the community.

We want to respect your time. Feel free to answer as in depth as you would like; the more detail you provide, the more this helps us work together to make positive change in the community. During the interview, we will be taking notes to ensure we capture what you say accurately, so be assured that we are paying attention to what you are saying. We will provide an informed consent for you to sign. This is stating that we will not duplicate or give away any information that will identify you in this interview. Do you have any questions before we get started?"

1. Are you aware of the Flint Hills Wellness Coalition?

2. What do you know about this org and what has been your experience with them?
    a. People you know, have interacted with
    b. Reputation in the community
    c. Projects they are working on

3. Are you aware of the Greater Northview Action Team or Northview Rising?

4. What do you know about this org and what has been your experience with them?

    a. People you know, have interacted with
    b. Reputation in the community
    c. Projects they are working on

5. What are you seeing in that neighborhood work that you are excited about?
    a. People, actions, projects, etc.

6. As an elected official/key stakeholder, what role do you play in this work?

7. What role do you play in advancing health equity in our community?

8. As an elected official/key stakeholder, what could this group do to be more effective?
    a. In working with you, specifically
    b. In general

9. Is there anything else that we haven't asked about that you think we should know about your perspective on this work?

Thank you for your time. If you have any other comments or questions, feel free to reach out to us.

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Frank Bailey - frank80@ksu.edu

Appendix 4 - Informed Consent Form

INFORMED CONSENT (AUDIOTAPE)

Consent Form for Audio taping and Transcribing Interviews

Community Evaluation of HEAT

Researcher:

This study involves the audio taping of your interview with the researcher. Neither your name nor any other identifying information will be associated with the audiotape or the transcript. Only the research team will be able to listen to the tapes.

The tapes will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information (such as your voice) will be used in presentations or in written products resulting from the study.

Immediately following the interview, you will be given the opportunity to have the tape erased if you wish to withdraw your consent to taping or participation in this study.

By signing this form you are consenting to:

- ❑ having your interview taped;
- ❑ to having the tape transcribed;
- ❑ use of the written transcript in presentations and written products.

By checking the box in front of each item, you are consenting to participate in that procedure. This consent for taping is effective until June 1, 2020. On or before that date, the tapes will be destroyed.

Participant's Signature _____ Date_____