

Discussion Suppers as a Means for Community Engagement

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ABSTRACT: *Purpose:* This paper describes how Lehigh Valley Hospital and Health Network (LVHVN), a large tertiary care urban hospital, used discussion suppers as a means for community engagement designed to lead to community health improvement. An overview of the implementation of the project is described. *Project:* In 1996, with an awareness of the need to address population-based health improvement, the Dorothy Rider Pool Health Care Trust and LVHVN undertook a multiyear, multidimensional effort to improve health and quality of life in the Lehigh Valley of Pennsylvania. Data were obtained via a series of community and health assessments. Action-Oriented Community Diagnosis and the Behavioral Risk Factor Surveillance System survey, a national instrument, are 2 assessments discussed. The community was engaged through a series of discussion suppers in which community data were shared in a friendly, interactive fashion. The process included community definition of priorities from the data and the subsequent determination of corresponding actions (programs). *Conclusions:* The success of these activities demonstrates the discussion suppers were an effective approach and that data can be shared with rural areas in ways that build partnerships and provide a basis for joint actions. This is increasingly important as communities expect our health care systems to provide care both within the hospital as well as outside its walls.

There is widespread agreement that hospital systems should not only provide acute care but also attempt to reach out into the community with health assessments and prevention programs. Community-oriented primary care has been one framework that has been advocated by family practice programs in the US and around the world.¹⁻⁵ A relevant set of tools and methods has been developed to assess health and design interventions to improve health. Further, there has been recent widespread utilization of the Behavioral Risk Factor Surveillance System survey.⁶⁻⁹

Relatively few examples are available that describe the implementation issues involved when an individual hospital system attempts to improve the health of its community,¹⁰ especially rural communities. This paper provides a case study that describes how 1 hospital network, in partnership with a rural community, designed, implemented, and evaluated a series of community health assessments and interventions.

Lehigh Valley Hospital and Health Network's (LVHVN's) primary service area includes 2 counties in southeastern Pennsylvania that are considered to be urban according to the Census Bureau's definition.

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Selected Findings for Project Area from 1998 Behavioral Risk Factor Surveillance System (n = 277)

The Good News	Opportunities for Improvement
<p>Physical exercise</p> <p>72% Participate in some type of physical activity.</p> <p>20% of men and 14% of women reported some type of physical activity 3 or more times a week.</p> <p>27% reported a doctor advised them to exercise more (50% reported they are exercising more because of advice).</p>	<p>Only 17% participate in physical exercise for ≥ 20 minutes at least 3 times a week.</p> <p>23% of men and 32% of women reported no physical activity.</p>
<p>Obesity</p> <p>34% reported a doctor advised them to eat less fat/cholesterol (66% eating less fat/cholesterol because of advice).</p>	<p>33% of respondents are overweight (48% of those aged 45–64).</p> <p>Only 19% reported eating ≥ 5 fruits and vegetables a day.</p>
<p>Smoking</p> <p>24% of residents surveyed are former smokers.</p>	<p>28% of 18–29-year-old residents smoke.</p> <p>33% of 30–44-year-old residents smoke.</p> <p>28% of men and 21% of women smoke.</p> <p>>50% of smokers smoke $\frac{1}{2}$ to 1 pack a day.</p>

However, the focus area for the work described in this report is a rural population within these counties.

Health Assessment Methods

Action-oriented Community Diagnosis¹¹ emphasizes building community competence rather than merely identifying needs. The technique includes extensive qualitative interviews and secondary data analysis. LVHHN hired and trained 2 residents of the rural community to interview 80 other community members over an 8-month period in an effort to build relationships and gather information. Residents were asked questions focused on community composition, economic development, social environment, community capacity, physical environment, disease and disability, health services, and educational services. Importantly, strengths as well as needs were elicited to identify ways the community had been effective in meeting challenges. Community strengths identified included community ownership, neighborliness, stability, and safety. The shortage of employment opportunities, decline in voluntary support, substance abuse, lack of leisure opportunities, and the adjustment to changing times (eg, diminishing tax base, fewer jobs, and the arrival of new low-income residents) were revealed as community challenges.

Behavioral Risk Factor Surveillance System Survey. The Behavioral Risk Factor Surveillance System (BRFSS) is a cooperative effort of the Centers for Disease

Control and Prevention (CDC) and individual states. LVHHN elected to use the 1998 Pennsylvania BRFSS survey (with the alcohol-consumption module added) to enable state and national comparisons. The BRFSS survey was conducted in the Lehigh Valley (n = 2,096) in 1998. Five communities within the 2 counties of the Lehigh Valley were sampled at higher rates to allow analysis of the results within those areas; our focus area (n = 277) was one of these communities. Respondents were selected using a 2-stage random-digit dialing sample design. First, a disproportionate stratified random sample of telephone numbers based on the geographic strata was selected and screened to exclude nonresidential telephone numbers. Second, an adult within the household was randomly selected to participate. Trained interviewers using a computer-assisted telephone interviewing system conducted the data collection for the survey. Weighted data were used to adjust for underrepresentation of certain population subgroups in the sample.

The Table describes some BRFSS results. There were both good news and opportunities for improvement in the areas of physical fitness, obesity, and smoking.

From Assessments to Actions: Community Discussion Suppers to Engage the Community. Neighbor-to-neighbor community discussion suppers provided a forum for important health-related topic discussion and educational information distribution. Supper topics have included assessment results

(qualitative and quantitative), youth issues, community center development, connections across generations, cardiovascular health, physical activity, youth tobacco use prevention and cessation, community exchange (a program designed to build relationships and make connections between individuals through sharing of skills, services, and stories), home safety, stress, asset building, volunteerism, social capital, and leadership development.

Design of a group activity incorporates thoughtful determination of progressive program development. For example, the cardiovascular health supper evaluations revealed strong interest in heart-healthy nutrition and food preparation. A subsequent healthy-cooking demonstration was well received. In another example, a BRFSS data presentation was modeled after the television quiz show "Who wants to be a Millionaire?" Thus, health information about the community was presented in an entertaining and locally relevant manner.

The community identified 2 actionable topic areas: cardiovascular health and the establishment of a community center as an aid in reducing isolation and providing a recreational venue.

Cardiovascular Health. A fitness trail was the first tangible result of the hospital/community partnership's effort to improve cardiovascular health. Numerous individuals enjoy the trail and 2 school district coaches use it for team conditioning and training. Following installation of the fitness trail, a walking club was established from community residents' interest. Over 200 people, ranging in age from 6 to 87 years, have participated in the walking club, launched in October 2000. By popular request, monthly group walks have grown (up to 7 per month) and are scheduled at a variety of locations in and around the community. Volunteer club members now lead the group walks once led by project staff. An assessment revealed 78% of responding club members (25% response rate) had increased the amount they exercised as a result of joining the club, and 96% walked at least twice a week for at least 20 minutes a session. The objective of a self-sustaining program is further advanced as members take more responsibility in choosing walk dates and locations. Information about upcoming walks and other community events are communicated to members in a monthly flyer that also focuses on a health-related topic of interest.

Another effort, this one to improve the fitness level of youth, was recently undertaken in which LVHHN sponsored the equipment and curriculum purchase and the area school district was responsible for installation costs and program implementation.

Community Center. In response to the community's concerns about isolation and the need for more recreational facilities, a community group partnership began work to build a community center approximately 5 years ago. LVHHN staff provided initial grant-writing support and other technical assistance (program funds supported initial capital campaign design expertise). The community has acquired over \$700,000 from state and county sources, as well as other grants.

Discussion and Lessons Learned

We have learned numerous lessons through the process. One of our challenges has been reaching all areas of the community. Limited accessible venues in the rural environment have made scheduling events difficult and, although we work to schedule events throughout the area, it is often a considerable distance for some people to travel. Planning catered suppers with a healthy fare and local food vendors can also be a challenge, but we have been committed to supporting local businesses in all our efforts. Lastly, change is difficult for individuals and communities alike, but we have found working toward positive health improvement is better accomplished together.

We recognize several limitations of our work. Our efforts have not been rapid but rather persistent and sustained. Key to successful community health improvement efforts is building trust between the community and those facilitating change. Often, communities feel they have been assessed and forgotten or have the perception that a health care institution has hidden motives for being involved with them. Our work has benefited from long-term commitment from our hospital's senior leadership, both executive management and the board of trustees, and the substantial financial support from our hospital's supporting trust foundation.

Lessons from the past several years of work include evidence of a genuine belief that community participation is more than theory. Through mutual trust and respect, a strong partnership has been forged with community stakeholders. Residents enjoy newfound confidence in their ability to make their community a better place to live, and we see growing evidence of this as they assume more leadership roles in activities.

The intent in an effort such as this is to facilitate increased community capacity and systemic change and to lessen the need for the support and presence of outsiders over time. Despite our commitment, there are often competing needs and priorities for the hospital, and the focus area is only 1 small part of the hospital's service area. However, we recognize that continued progress necessitates a substantial level of involvement

for the foreseeable future. With the positive relationships developed, we have come to realize that our presence and involvement are appreciated beyond the financial support provided.

The suppers helped introduce LVHNN's community health improvement efforts to the community and served to frame its role in the community as a resource and partner for health information and programming. The suppers also served as a community forum in which members' input was factored into program design, thus encouraging ownership, buy-in, and volunteers in the program. In conclusion, we believe that data can be gathered and shared with communities in ways that engage them and provide a basis for joint actions. This will become increasingly important as communities expect that our health care system provide care both inside the hospital system as well as outside those walls. True partnerships are necessary for community empowerment, and community empowerment is critical for sustainable change.

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