COMMUNICATING THE HEALTHY CHOICE TO OUR COMMUNITIES:
A COMMUNICATION TOOLKIT

A Manuscript Style Project Report Submitted in Partial Fulfillment of the Requirements
for the Degree of Master of Public Health in Community Health Education

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COMMUNICATING THE HEALTHY CHOICE TO OUR COMMUNITIES:
A COMMUNICATION TOOLKIT

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We recommend acceptance of this project report in partial fulfillment of the candidate's requirements for the degree of Master of Public Health in Community Health Education.

The candidate has met all of the project completion requirements.

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Communicating the Healthy Choice to Our Communities: A Communication Toolkit is a graduate project in partnership with the La Crosse Medical Health Science Consortium’s Healthiest County 2015: La Crosse project. Over 30 area organizations are partners in the project and are working together to help make the healthy choice the easy choice in La Crosse County. The goal is to positively influence health behaviors to increase La Crosse County’s health ranking to number one (according to the Robert Wood Johnson Foundation’s County Health Rankings) in Wisconsin by 2015. The goal of the communication toolkit is to help the partners create strategic communication plans, align communication efforts across the partners with a tagline (*making the healthy choice together*) and promote innovative thinking about communication and its influence on health behaviors. The communication toolkit was used during the 3rd annual Health Summit when the project partners came together to discuss the Healthiest County 2015 project. Facilitators guided the partners through a step-by-step process to create strategic communication plans for each focus area. By creating greater awareness in the general public with effective communication about healthy choices, we can increase the likelihood of becoming the healthiest county in Wisconsin by 2015.
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LITERATURE REVIEW

Introduction

Choice plays a significant role in one's health. Making small everyday choices with health in mind can lead to positive outcomes in our overall personal health. However, there is one choice that carries significantly more weight in determining the outcome to one's health and can influence those small everyday choices—where one chooses to live. According to Booske, Kindig, Nelson and Remington (2009):

There is increasing recognition across the nation and the world that our health is not only dependent on the way we act and the health care we get but also on where and how we live. A wide set of societal influences such as education, employment, income, and the neighborhoods where we live, all affect our health and well-being. Research suggests that these factors can influence our health as much as genetics and health care. (p.6)

Every community in America has a different make-up of the societal influences listed above. Some cities have many jobs available, but poor access to health care. Others have excellent educational opportunities, but few jobs and a high cost of living. The make-up of a community largely determines the strength of the social capital (e.g., trust between people of a community) that exists within it. And, it is the overlap of physical and social environments that create a community's capacity for health (“Robert Wood Johnson Foundation,” 2009). By taking an assets-based approach, that is to say, by focusing on the strengths and positive aspects of a community, health educators can facilitate community change through the people to positively influence health. Health communication is an important tool that allows health educators to provide information to
people about health behaviors and may influence people’s ability to make decisions about personal health, as well as the health of their community (U.S. Dept. of Health and Human Services, 2000; Kreps & Thornton, 1992). Health educators should consider framing health communication with positive affect appeals to shift public perspective about healthy behaviors. A simple shift in perspective may be the key to helping people feel empowered to make healthy choices not only for themselves, but for the betterment of their community.

Environment

*What Works? Policies and Programs to Improve Wisconsin’s Health* is a report prepared by the University of Wisconsin Population Health Institute demonstrating evidence of effective health policies and practices from a large body of research (Booske, et al., 2009). This report identifies three key drivers of health influencing health outcomes: health behaviors, social and physical environment and health care and public health systems (Booske, et al., 2009). While all three have interlocking roles concerning the outcome of health, the focus of this literature review is on social and environmental health and how communities can promote health within the social and environmental context using effective communication.

According to Hancock and Duhl (1986):

A healthy city is one that is continually creating and improving those physical and social environments and strengthening those community resources which enable people to mutually support each other in performing all the functions of life and achieving their maximum potential. (p. 7)

The concept of a healthy city is rooted in policy change at the local level through the support and participation of an entire community, including local government, to create a conducive environment, both physical and social, for optimal health for all (Hancock,
Advancing health promotion through program delivery and policy change by focusing on physical and social environmental factors on health determinants and behaviors can bring about vast gains in health outcomes (de Leeuw, 2009). According to Hancock (1993), “The focus of health promotion activities… is to develop a broad range of strategies to address the broad social, environmental and economic determinants of health, and ultimately to change the corporate and community culture by incorporating health” (p.8).

Physical Environment

The physical environment of a community largely contributes to or detracts from the health of the individuals living within it. According to the Robert Wood Johnson Foundation (2009), an average American spends almost half their time at home, making the place one lives a central component of one’s health. Unhealthy and unsafe neighborhoods and communities can and do determine the choices and resources available to people living within them and may act as a barrier to better health regardless of individual will (“Robert Wood Johnson Foundation,” 2009). Accordingly, healthy neighborhoods and communities can promote better health by making healthy behaviors easy to adopt and maintain by providing accessible grocery stores with healthy food options at a reasonable price, safe and attractive spaces for recreational activity, social environments where people can gather and interact, high-quality education institutions, employment opportunities and public transportation (“Robert Wood Johnson Foundation,” 2009). Environmental based interventions tend to be more powerful because of the passive nature of change; meaning health promotion efforts enhance the health of all persons exposed to an environment rather than one person at a time without
requiring an active or sustained effort by the individuals being impacted (Stokols, 1996). Identifying and removing barriers that make it difficult for people to act in healthy ways must be a priority in health promotion and intervention (“Robert Wood Johnson Foundation,” 2009).

Understanding the environment is a contributor to community health, a group of residents in a neighborhood in Portland, Oregon began work on reversing urban decay in their community in 2001 through the re-design of a busy intersection to a public gathering place (Semenza, 2003). The first phase of the project included painting a giant sunflower, a neighborhood symbol, across the busy intersection. The second phase added an art wall, a glass mosaic fountain, and a kiosk to facilitate social interactions (Semenza, 2003). Through a cross-sectional survey the researcher found the physical revitalization of this busy intersection actually increased walking and biking, as well as residents feelings of living in a neighborhood that was an excellent place to live. The researcher suggests that urban design can improve public health through increasing community capacity and social network systems as well as increasing physical activity (Semenza, 2003).

An additional study by Takano, Nakamura and Watanabe (2002) found similar results concerning urban residential environments in large cities. The researchers concluded senior citizens living in an urban environment that included walkable green space had better health and the longevity of their lives was positively impacted regardless of their socioeconomic status—a significant determinant of health (Takano, Nakamura & Watanabe, 2002). Not only was green space associated with favorable air quality, but in the environmental context for the senior citizens studied, green space was also a factor in
providing a setting for healthy exercise otherwise unavailable to those who did not live in an environment with walkable green space; potentially influencing the longevity of their lives (Takano, Nakamura & Watanabe, 2002). High-walkable neighborhoods have specific features more conducive to physical activity including, pleasing aesthetics (e.g., attractiveness of streetscape), safety, high connectivity (e.g., continuous routes, sidewalks, crosswalks), and high mixed land use (e.g., housing and business located in close proximity) (Frumkin, Frank & Jackson, 2004). The RWJF Commission to Build a Healthier America has recommended the incorporation of health (e.g., green spaces, sidewalks and bike paths) into the design of community development and redevelopment projects because of the strength of influence environment has on health and disease ("Robert Wood Johnson Foundation," 2009).

**Social Environment**

The social environment is made up of and influenced by education, employment, income, and the physical environment of our neighborhoods (Booske, et. al, 2004). Perhaps most importantly, the social environment is made up of and influenced by the people living within it. Many causes of health problems originate in our social environment (Strack, Lovelace, Jordan and Holmes, 2010). Together, these societal influences set the stage for our communities to become places where people not only work, live and play, but where they can also become healthier or unhealthier by virtue of their social environments.

The relationships and the feelings of connectedness that exist between people can greatly impact health. When there is a high amount of trust and strong feeling of connectedness with others a health enhancing effect can be produced. However, when
those relationships lack trust and support health negating outcomes such as anxiety and depression may result ("Robert Wood Johnson Foundation," 2009). The physical environment can largely influence the social environment of a community. When people have public spaces to gather and socialize the opportunity to enhance health through the creation of social relationships and establishment of social networks is greater ("Robert Wood Johnson Foundation," 2009). The social-ecological model highlights the connectivity of health influences at the individual, interpersonal, organizational, and community levels of social ecology (Strack, et al., 2010). The social-ecological theory links the relationships between human personal (social) and environmental factors and its impact on health and disease (Stokols, 1996). This theory indicates that the effectiveness of health promotion is determined by the cumulative effect of multiple factors such as environmental conditions and one's physical, mental and emotional well being (Stokols, 1996; Stokols, 1992). Health promotion applied with this theoretical model can offer health educators a more comprehensive approach to intervention by leveraging environmental change to enhance physical and social surroundings beneficial to behavior change (Stokols, 1996). By addressing the web of factors contributing to health disparities and behaviors with multiple tools and varied programming, health practitioners and educators are able to address the various social and physical needs of a diverse population. According to Duhl (1996), "We can no longer separate housing and transportation, economics, or politics from health. What we define as health constantly changes because illness and 'dis-ease' are not contained. Health promotion must address the problem as a whole" (p. 259). To begin addressing the problem of ill health as a
whole, a further look into the social environment and the outcomes social interactions can produce is necessary.

Social Capital

Social capital has more recently gained attention as a consideration in health promotion. While not the first to define social capital, Robert Putnam brought forth a working definition in his book *Bowling Alone* (2002); social capital is defined as “connections among individuals—social networks and the norms of reciprocity and trustworthiness that arise from them” (p.19). Further defined, social capital refers to “available resources (capital) that can accrue to people by virtue of their mutual acquaintance and recognition (social) and that can be used for a variety of productive activities (capital)” (Macinko & Starfield, 2001, p.388). Health and the quality of life of a community can lead to increased social capital and vice versa. However, social capital may have negative effects for those existing outside the social network (Portes, 1998; Putnam, 2000), particularly the exclusion of outsiders (Portes, 1998). Despite the possibility of negative consequences, social capital is generally seen as an asset within a community (Mansyur, Amick, Harrist & Franzini, 2008). Social capital benefits a community because it contributes to the mutual support and trust among community members, including norms of reciprocity, and is generally linked to civic engagement (Putnam, 2000). The social trust Putnam lists as a benefit of social capital may be vertical or horizontal. Vertical social trust is when a community trusts in institutions and political authorities, and horizontal social trust is when a community trusts in one another (e.g., people in a similar social position) (Putnam, 2000; Frumkin, Frank & Jackson, 2004). While both forms of social trust are beneficial and necessary, high horizontal trust
is representative of more productive social capital (Putnam, 2000; Frumkin, Frank & Jackson, 2004).

Studies have allowed researchers to derive that communities with a high level of social capital are healthier than those with lower levels (Kawachi & Berkman, 2000; Kawachi, Kennedy & Glass, 1999; Beaudoin, Thorson & Hong, 2006). In a study on social capital and self-rated health, Kawachi, Kennedy and Glass (1999) reported social capital may affect health through a variety of ways including the possibility of rapid information distribution, the adoption of healthy norms of behavior and the exertion of control over deviant health behavior (Rogers, 1983). Trust plays an important role in health promotion because innovative behaviors (e.g., use of preventive services) spreads more quickly in a community that trusts one another (Rogers, 1983; Kawachi, Kennedy and Glass, 1999). In fact, according to Kawachi, Kennedy and Glass (1999), “levels of collective efficacy are determined by the extent of trust in a neighborhood” (p. 1191). It should not be ignored that an adequate level of vertical trust must also be in place within a community to ensure even development of communities. Uneven development of communities may contribute to the absence or ‘flight’ of social capital which contributes to increased levels of crime and incivility (Mohan, Twigg, Barnard and Jones, 2004).

Community

The physical and social environment overlaps to create a community’s capacity for health (“Robert Wood Johnson Foundation,” 2009), largely determining the strength of the social capital that exists within it. According to the Robert Wood Johnson Foundation (2009), “a community’s health profile and opportunities for improving it emerge from a local configuration of resources and assets, leadership and priorities” (p.
To change community health, leaders must recognize and identify the resources and assets available to the population and collectively promote opportunities to utilize those strengths (Stokols, 1996; Green & Anderson, 1994). To understand how a community can effectively promote change concerning health, it is important to first understand concepts of community change. The core concepts of community change: change from the people, empowerment of the people, and strengths of the people, together can facilitate a transformation that can allow people to ‘make sense of their situation in a new way’ (Checkoway, 1997, p. 12). When applied to public health, the core concepts of community change may allow people to look at their health and the health of their community with a new perspective, allow people to (re)consider the role they play in the health of their community and feel empowered to make desired changes.

First, and perhaps most importantly, community change must come from the people (Checkoway, 1997; Heritage & Dooris, 2009). When people join together in collective action they can multiply their efforts to create a greater outcome than what would have been possible acting individually (Checkoway, 1997); a concept referred to as synergy. Community change from the people is representative of the horizontal trust necessary for social capital (Putnam, 2000; Frumkin, Frank & Jackson, 2004). Change should start with the people not only because the potential outcome may be greater, but because “people are the best judge of their own situation and the process should originate in the experience of the people themselves” (Checkoway, 1997, p. 17; Tweeten & Brinkman, 1976). In many cases, community change begins with professionals because of special knowledge they may hold; but when professionals treat people as active participants in the process rather than passive recipients of services, the potential for
synergistic community action is greater (Checkoway, 1997). By doing this, professionals and leaders have an opportunity to build vertical trust with the community (Putnam, 2000; Frumkin, Frank & Jackson, 2004) and in doing so increase the community’s capacity for social capital and even development. Furthermore, when people see their ideas and input reflected in changes being accomplished, their ownership in the outcome is enhanced (“Prairie Region Health Promotion Research Centre,” 1998) and successful change is more likely to occur.

Second, empowerment is a core concept for community change because when a community becomes empowered, people believe they have the ability to change their situation (Checkoway, 1997). The levels of trust, both horizontal and vertical, present in social capital are important in producing collective efficacy of the people (Kawachi, Kennedy and Glass, 1999) which is a significant component of empowerment. Empowerment can be a two-way process. Individuals can experience personal transformation and empowerment through community change and communities can benefit from individuals who are empowered to create community change (Checkoway, 1997). Perhaps one of the most important components of empowerment is belief that change is possible. Individuals who believe community problems have solutions and take decisive action to work toward creating a positive outcome, tend to have disproportionate power to their belief (Werner & Bower, 1983; Checkoway, 1997). On the other end of the spectrum there are those individuals who do not believe change is possible and generally feel alienated from the community (Werner & Bower, 1983; Checkoway, 1997). Yet, empowered individuals along with the community can show
non-believers that it is possible to make a difference by role-modeling their behaviors and communicating successes.

Third, it is important to focus on the strengths of a community rather than constantly focusing on its needs (Checkoway, 1997). According to Werner and Bower (1983), "the need is not to gather information... but to gather everyone together and look at what they already know" (p. 6). An emphasis on needs not only takes empowerment out of the hands of the people and makes a community dependent on professionals to solve problems, but it may contribute to the loss of confidence in their ability to effectively handle problems they otherwise would be able to handle (Garber & Seligman, 1980; Checkoway, 1997). The way leaders use skills, strategies and communication will impact the capacity for community change (Checkoway, 1997). Leaders can encourage the community change process by initiating an evolution of the people’s perspective of the power and potential they already possess.

These core concepts should guide community change and public health.

According to Checkoway (1997):

Community change has a history of voluntary action that arises from the “hearts and minds of the people,” including indigenous individuals who emerge spontaneously and facilitate the process through their commitment of social values rather than through the promise of remuneration. (p. 20)

The above statement is important for health educators to remember when attempting to influence health because the power needed to create change is already present in the people; successful health educators will draw that out of the people. The most effective change makers have a solid understanding and knowledge of the community and none better than the people who make up that community.
Communication

According to Kreps and Thornton (1992), “Human communication is the singularly most important tool health professionals have to provide health care to their clients” (p.2). Yet, communication is often ignored. Health communication may be ignored in part because health information is complex and most often health educators are put in the position to ask people to give things up, change habits and refrain from partaking in activities they enjoy doing (Monahan, 1995). By changing the frame health educators use to communicate about health from a negative one to a positive one, health educators may find more success in changing attitudes and behaviors. In fact, researchers have reported that messages promoting positive self-esteem are more likely to lead to increased intention to adopt healthy behaviors than those that promote negative messages using a warning or threatening tone (Hafstad, Stray-Pedersen & Langmark, 1997; Robberson & Rogers, 1988). Health practitioners and educators must also understand that health communication may not produce immediate behavioral change that so many health practitioners eagerly look to for proof of success. Statistically significant, evidence-based behavioral change may not be the best measure of success. According to Springston and Lariscy (2010), “it may be more beneficial to view the benefits of increased community awareness, participation, and empowerment as important first steps to health status and systems changes” (p. 555). Positive health communications may contribute to behavior change through increased awareness, intention, participation and empowerment.

Positive affect refers to a wide range of feelings and emotions that can emerge in a person as a response to a message or, can be an emotional component in the message
itself that attracts a person to what is being said (Monahan, 1995). Communication is the way in which we understand our environment and reality (Kreps & Thronton, 1992). Ultimately, communication is the tool we use to understand ourselves and others. People tend to respond to messages that promote good feelings about the self because people have a strong need to think of themselves in a positive way (Isen, 1987). By framing health messages positively (e.g., ‘you have made a healthy choice by choosing to live right here’) health educators can help people feel better about themselves which may lead to an increased goodwill toward others (Monahan, 1995; Isen, 1987).

The feelings that people have in response to messages are important because they lead to cognitive processing which is how a person thinks about the message. It is believed we first feel and then think (Zajonc, 1980). An important part of any message is not only what is being said but how it’s being said. All messages have content and relationship. Content is the information provided in the message (the ‘what’) and relationship “refers to the feelings communicators express for each other through their communication” (the ‘how’) (Kreps & Thornton, 1992, p.23). Interpersonal communication is a highly effective form of communication when how a message is being communicated is as important, if not more important, than what is being communicated.

Interpersonal communication should be utilized by health educators for a number of reasons. First, interpersonal communication has the most persuasive impact regarding the ability for a message to be appropriately received and acted upon (Smith, 2002). Second, according to Kreps and Thornton (1992), “One of the most important outcomes of interpersonal communication is the development of human relationships” (p.15)
because “every time you tell someone something you are not merely expressing information but you are also defining the relationship you are in the process of establishing with your communication partner” (p.23). People will more likely be impacted by the positive affect of a message if it is being communicated by someone they know. Establishing relationships through communication also contributes to a sense of community—a component of social capital. And third, the more people talk and think about an issue, the more likely change will occur; and if it does occur, those individuals will be more inclined to discuss it further. Also, involving people in discussion will increase their likelihood of tending to future messages (Flay & Burton, 1990). This third point about the importance of interpersonal communication should also be considered in light of how a particular community communicates with its members. Health educators should have a thorough understanding of the target audience they are attempting to reach, and that includes understanding how that audience communicates with one another and what they communicate about. The following is an example health educators might consider when looking to create health communication messages in a community setting.

Health educators should consider looking to existing communication structures for effective communication techniques. In a report on health communication campaigns, Singhal (2010) uses an example of how positive deviance, the understanding of something that is working when most practices are not, can prevent hospital-acquired infections. Adherence to hand hygiene practices is alarmingly low in U.S. hospitals. However, a few have shown dramatic decreases in methicillin-resistant *Staphylococcus aureaus* (MRSA) and researchers are wondering why (Singhal, 2010). Singhal (2010) has found the successful hospitals that are showing decreases in MRSA are not looking
outward to solve the problem, but rather inward to their employees who practice those behaviors, albeit deviant in a positive way. These successful hospitals are looking to prevent the spread of MRSA by attempting to replicate the 'correct' behavior. Replicating positively deviant practices already in place to create successful behavior change is not limited to hospitals looking to prevent the spread of disease, but it in fact can and should be applied as a health communication practice (Singhal, 2010).

According to Singhal (2010):

Innovative ideas are often lurking within the system, where the change agents’ primary role is to facilitate a process whereby the community can self-discover these ideas, and where dialogue and “social proof” result in an organic spread of the innovation, in contrast to passive adopters buying into a change agency’s prescription. (p. 605)

In the case of health educators, the innovation (healthy behavior) spreads through the relationships that exist between community members and the messages they share with one another (interpersonal communication). Participating in healthy behaviors ultimately becomes a community phenomenon rather than the result of the change agency’s (health educators) prescription of asking the community to behave in a different way. As this example highlights, effective interpersonal communication can influence behaviors positively through persuasion, relationship building, and frequency of discussion, which together contribute to the production of social capital (Viswanath, Randolph-Steele, & Finnegan, 2006). This approach in diffusing health messages is effective because it requires few resources and it comes from the community “further incorporating [an] asset-based approach to improve the quality of life of individuals and communities” (Singhal, 2010, p. 606), as well as enhances the social environment of a community. In addition, interpersonal communication is a primary form of interaction between people
belonging to a particular social network. Another component of social capital is the
interpersonal trust (horizontal) established between members of a social network
(Viswanath, Randolph-Steele & Finnegan Jr., 2006). According to Viswanath,
individuals to be aware of particular topics present in the environment and, thus, result in
recall of more health messages” (p. 1460). By increasing opportunities for interpersonal
communication about health, health educators also increase a community’s capacity for
social capital, which only further contributes to the health of a community; as was
discussed previously in this review of literature. Furthermore, health educators should
focus on identifying opinion leaders within the community and involve them to enhance
the interpersonal communication and social capital building process because of their
potential to have a greater influence on others as a result of their leadership position (Flay
& Burton, 1990). Because of its persuasive potential and meaningfulness in relationship
building, interpersonal communication should be factored into the forefront of any plan
to improve public health. The synergistic combination of both persuasion and
relationship building could potentially create significant positive outcomes (e.g.,
increased social capital) and enhance community health through the spread of health
messages.

Health communication information transmitted through interpersonal
communication must be reinforced. News media is a critical component in getting health
messages to the public. In particular, the news media is influential in the field of public
health because of its ability to reach large audiences, including policy makers, and
influence what people think about (Greenwell, 2002). When media attention about
preventive health decreases, risk and mortality increases (Viswanath & Finnegan, 2002). By becoming media advocates and establishing relationships with media gatekeepers, health educators can promote health focused social change through strategic use of the media (Wallack, 1990; Greenwell, 2002).

Media advocacy is a concept that health educators can use to encourage broad social change in a community through using the news media to shape an issue to persuade policy makers, increase public knowledge and sense of community (Greenwell, 2002). Media advocacy takes a social approach to changing health behaviors rather than approaching health as solely an individual responsibility (Wallack, 1990). Through setting the agenda, shaping the debate and advancing policy (Greenwell, 2002), media advocates may gain some control over the messages delivered through the news media; therefore influencing policy and public knowledge about health (Viswanath & Finnegan, 2002). According to Wallack (1990), “The goal is to empower the public to participate more fully in defining the social and political environment in which decisions affecting health are made” (p. 159). Media advocates can enhance newsworthy issues a number of ways. Some examples include: presenting local reaction to national news, writing op-ed articles and letters-to-the-editor, cultivating relationships with news reporters, and reframing ‘old’ health problems previously covered in the news with new angles. By doing so, news media becomes a shared experience and can create a sense of community because it reflects the culture and norms of the group (Beaudoin, Thorson & Hong, 2006). According to Beaudoin, Thorson and Hong (2006), “In terms of information, news provides people with opportunities to interact socially and participate civically, as well as with facts and opinions that can lead to deliberation, discussion, and subsequent
civic participation" (p. 177); therefore, increased civic participation as a result of news media may have a positive impact on social capital. In part, public health can be improved through the news media because of the sense of identity it provides by the presentation and communication of collective health concerns in a community (Beaudoin, Thorson & Hong, 2006).

The media provides a crucial link among the contributing elements of a community's social system (e.g., individuals, social environment and identity, public policy) (Viswanath & Finnegan, 2002) and should be recognized as such by health educators. Health educators must be proactive and strategic in their efforts in communicating with the media and through the media. The news media can be an effective way to improve public health (Greenwell, 2002) by influencing public policy, increasing public knowledge and creating a sense of community, but it is up to health educators to ensure that health messages have a continuous presence in that communication medium in order for improvement to occur.

Conclusion

As health educators look to promote health in communities now and in the future, it will be important to take a community centered, asset-based approach to changing health status. Research suggests that health is not only dependent on genetics and health care, but where and how we live (Booske, et al., 2009). The physical and social environments of a community have great influence on the health of the people who make up the community and can no longer be treated separately; health promotion should address the physical and social components of community health as a whole (Duhl, 1996). To successfully address health needs and facilitate the changes necessary to create
better community health, health educators should encourage opportunities to build social
capital amongst community members and utilize the core concepts of community change
to generate desired health outcomes. By focusing on the strengths and assets of a
community, and enhancing health communication through interpersonal communication
and media advocacy, health educators can shift the community perspective about health
and the public’s role within community health. When leaders enthusiastically use these
concepts and practices they can generate an awakening transformation within a
community that they might take on health not as a necessity to reach a certain goal, but as
a way of creating a richer and more meaningful living experience to be shared with
others. Good health ultimately becomes the outcome of good living.
METHODS

The La Crosse Medical Health Science Consortium (LMHSC) and the Population Health Committee began a project called the Healthiest County 2015: La Crosse project in 2009 to address health needs of La Crosse County using the County Health Rankings distributed by the Wisconsin Population Health Institute. The purpose of the project is to bring area organizations already working on health initiatives and projects to the same table to identify potential areas of duplication and through those efforts become the healthiest county in Wisconsin by 2015. Together, the LMHSC, Population Health Committee and interested area organizations became partners in the Healthiest County 2015: La Crosse project. The project identifies four health focus areas: mental health, chronic disease, infectious disease and injury and violence prevention. All partners are broken down into the respective four health focus areas to form working groups. These four groups have all identified goals and tactics to accomplish that are specific to the individual health focus areas. The goals and tactics of all four groups make up the executive summary plan to achieve the one goal of becoming the healthiest county in Wisconsin by 2015. When I became a graduate preceptor at the LMHSC in August 2010, the project was already underway and some goals of the four groups had already been met or in the process of being met. After attending several Population Health Committee meetings, I noticed a need for a strategic communication plan for the Healthiest County 2015: La Crosse project that would specifically reach the general public of La Crosse County. With the approval of the LMHSC staff, Population Health Committee and
LMHSC Board of Directors, I began to pursue opportunities to construct a communications plan for the project.

To get a better understanding for effective communication techniques and practices in the La Crosse area, I met with twelve community leaders to get their feedback on communication, health and needs of the community. My initial thoughts for a communication plan for the project consisted of creating a comprehensive media campaign using advertising (e.g., billboards, bus advertisements, street banners) and a branded logo available to the project partners to utilize in their own organizational communication strategies. Upon receiving feedback from area leaders, it was deduced that there would not be enough funding to launch such a campaign, nor was there interest from some of the partners to utilize a branded logo with already existing brands. This information brought me back to the drawing board to reconsider the possibilities for creating a communication plan that didn’t cost a significant amount of money, didn’t compete with existing brands and could be completed in a relatively short timeframe. These realities forced me to look at what assets and resources already existed within the project and the community.

I concluded that the assets that were available to be utilized for the creation of a communication plan were the individual partners of the Healthiest County 2015 project and local media sources that cover local information. By the recommendation of the LMHSC Communication Committee, a tagline was identified as an effective, non-competitive, way to communicate to the general public. Along with utilizing available assets to create a communication plan for the project, I was under the constraint of a limited timeframe concerning graduation deadlines. After discussing this issue with the
LMHSC staff, an idea was presented to use the LMHSC’s annual health summit as a vehicle for the communication plan distribution to the project partners. After approval from the Population Health Committee, March 4, 2011 was the date agreed upon to unveil a new communication plan to the project partners. A Health Summit planning committee was also set up at this time. With this information, I decided that a toolkit that incorporated local information and evidence-based research on effective communication would be the most effective way to create a strategic communication plan—a training of the trainer type approach. This approach to create a strategic communication plan was unique in that the communication plan wouldn’t be created by a few people, but rather each of the partners present at the breakout sessions of the Health Summit would be able to contribute to and shape a communication plan specific to the focus area they were involved in. With this approach there is not one strategic communication plan for the entire Healthiest County 2015: La Crosse plan, but four unique communication plans that fit each focus area accordingly and were created by the partners who ultimately need to put the plans in action.

After nailing down the approach I would take, I began to consider what I would need to complete my project. The UW-La Crosse graduate studies office offers graduate students the opportunity to apply for a Research Service Education Leadership (RSEL) grant, up to $2,000, to facilitate research projects. With the help of my graduate advisor, Dr. Gary Gilmore, I put together an RSEL grant proposal outlining the need, plan, and budget scope of my communication toolkit project. I also knew at this time that I would want the toolkit to be professionally designed by a graphic designer. I wanted the toolkit to be professionally designed because I wanted the toolkit to become an information
resource that would be utilized multiple times and not just a "nice" packet of information that would be thrown away or put away and never looked at again. I knew professional graphic design would significantly increase the user friendliness and aesthetic appeal of the toolkit, therefore increasing the likelihood it would be used multiple times. I approached Florence Aliesch, good friend and university publications director, to design the toolkit. I presented my timeline for completion and a proposed compensation amount; she agreed to design the toolkit.

After submitting the RSEL grant proposal and securing a graphic designer I began to consider what the toolkit would consist of, what style it would take on, and what it would include. For quite some time I struggled with what the toolkit would be; having a general concept in mind but no model to follow was frustrating. During this time I focused primarily on compiling existing literature to help build my vision for the project. I then discovered a general model for creating strategic communication plans in a public relations text book loaned to me by a advisory committee member. By following this model I was then able to begin putting together the toolkit.

I gave myself seven weeks to compile information for the toolkit. One week prior to the deadline for submission to my graphic designer, I sent out the toolkit to my graduate advisory committee and two classmates to review for revisions, edits and feedback. This same week the Population Health Committee brainstormed and selected the tagline they wanted to see incorporated in the communication plan and utilized throughout the remainder of the Healthiest County 2015: La Crosse project. The tagline chosen was "making the healthy choice." I was initially disappointed with this selection because I felt it did not adequately convey that health is a process and, more importantly,
a process that the project partners were working on together to benefit everyone living in La Crosse County. In addition, I wanted the tagline to have an inclusive, identifying factor for the general public so that they could “see” themselves as a part of the process of making La Crosse County healthier, regardless of where they might be on the spectrum of health behavior change. I set up a meeting to discuss my thoughts and concerns for the tagline with the LMHSC staff, Catherine Kolkmeier and Joanne Sandvick, (also members of my graduate advisory committee) and LMHSC undergraduate preceptor, Kayla Brenner. After some discussion about the tagline and getting an understanding for why it was selected, as well as discussing what the goal was for the communication toolkit, I proposed adding the word ‘together’ to the existing tagline. The LMHSC staff agreed adding the word ‘together’ was o.k. with them and Joanne volunteered to contact the Population Health Committee through email to confirm their agreement or disagreement. After discussing my concern with the tagline, the LMHSC staff then expressed their concern over the style and amount of information in the communication toolkit. Primarily they thought it was very academic sounding and looking and not quite at the level of user friendliness that would be needed for the toolkit to be effective. Initially the feedback was overwhelming and I felt it wouldn’t be possible to do what they were suggesting with the remaining time before the graphic designer deadline. However, Catherine, Joanne and Kayla offered their help to revise the toolkit together. Their willingness to work with me to revise the toolkit made the process one that became ‘doable’ rather than overwhelming. With help from the LMHSC staff, we spent all afternoon Friday before the graphic designer deadline working on editing, re-
wording and re-formatting the toolkit. I submitted the communication toolkit to the
graphic designer on time Saturday afternoon.

The graphic designer worked on the communication toolkit for three weeks. There were multiple revisions and edits of the toolkit during that time. The toolkit was sent to the printer the third week of February and we received it at the LMHSC office on February 21st—two weeks prior to the Health Summit. While the toolkit was being designed and printed, I spent my time working on details to ensure the toolkit would be used effectively at the Health Summit.

I worked with Kayla Brenner on creating an interactive presentation using the prezi program (www.prezi.com) to feature the accomplishments of the partners over the past year. The presentation utilized photos, newspaper articles, youtube video clips and music to highlight what has already been accomplished in the plan. This interactive presentation was created to be shown at the opening of the Health Summit.

I developed an evaluation form for the toolkit that would be distributed to all attendees during the breakout sessions at the Health Summit (See Appendix A). The evaluation prompted the attendees to identify their level of agreement using a Likert scale (strongly disagree to strongly agree) with each of the 15 statements. The statements covered various aspects of effectiveness of the communication toolkit, session facilitator effectiveness, attendee’s intended use of the toolkit in the future, and communication in general. The evaluation also included an open-ended question that allowed for additional comments.

I lead a facilitator training at the end of February to educate the breakout session facilitators and two back-up facilitators on how to accurately use the communication
toolkit and explain it to others. I also modified last year’s breakout session facilitator guide to accurately depict this year’s purpose of the breakout session—to create a strategic communication plan for each of the four health focus areas (See Appendix B). The guide and communication toolkit were handed out to the facilitators at the training and any questions were answered.

I continued to attend Health Summit planning meetings as a member of the planning committee. These meetings were held several times prior to the Summit; they provided opportunities to discuss the details of the Health Summit, assign duties and address needs.

I prepared and planned a presentation on the Healthiest County 2015: La Crosse project for a Rotary meeting on March 3rd. In addition, I prepared a presentation to be given to all Health Summit attendees about communication for the Health Summit on March 4th. This presentation provided a background about communication, emphasized its importance in the Healthiest County 2015: La Crosse plan and encouraged attendees to take personal responsibility for communication to achieve the goal of becoming the healthiest county in Wisconsin. I also prepared to present on the process of creating the toolkit to Susan Schuyler’s CST 460 PR Campaign Communication class on Monday, March 7th following the Summit.

The Health Summit brought over 100 health professionals (115 registered, some didn’t attend and some were walk-ins) from La Crosse County together to discuss communication and the Healthiest County 2015: La Crosse plan. There were upbeat music and breakfast items for attendees as they came in during registration from 8:00-8:30 a.m. At 8:30 a.m. sharp the Health Summit opened with the interactive presentation
on past accomplishments. Dr. Jeff Thompson then welcomed all to the Summit and Cindy Kartman, chair of the Population Health Committee, went over the background of the plan and upcoming goals. I was then introduced and gave my presentation on communication and emphasized its importance for achieving the Healthiest County 2015 goal. During my presentation I discussed how the toolkit was a tool the partners would be able to utilize to communicate about the plan more effectively; as I mentioned this, copies of the communication toolkit were handed out to the attendees. A 20 minute break followed before the four breakout sessions began. Each of the breakout sessions (chronic disease, infectious disease, injury and violence and mental health) was lead by a facilitator who guided the partners through the communication toolkit step by step. The 120 minute sessions allowed the various partners to construct strategic communication plans, as well as provided an opportunity for partners to discuss communication priorities and practices and combine efforts to create more effective communication messages together. The evaluation form was handed out at the end of the breakout sessions. Following the breakout sessions an all group wrap-up session was conducted. Spokespeople from each breakout session reported on two communication tactics and two measurements that their group had agreed to do in the upcoming year. Everyone was thanked for attending and the Health Summit wrapped up on time shortly after noon. Following the Health Summit, an electronic copy of the communication toolkit was placed on the LMHSC’s website and can now be found at www.lacrosseconsortium.org.

Evaluation

The assessment I used to evaluate the communication toolkit was a process evaluation that addressed practicality and usefulness of the toolkit, quality of the toolkit
and its application in the breakout sessions, impact the toolkit and breakout sessions had on intended actions of participants and potential for program improvement. (See Appendix A) Evaluation (survey) of the communication toolkit was distributed to the 2011 Health Summit attendees as they finished up their break-out sessions.

Logic Model for Communication Toolkit

1. Goal: To effectively align communication efforts with a common theme and communicate more frequently to reach the public about what partners are accomplishing to make our community healthier.

2. Program: The communication toolkit was distributed to the 2011 Health Summit attendees. This was the 3rd annual Health Summit and approximately 100 health professionals attended.

3. Assumptions: People will attend the Health Summit. People will know prior to entering the Health Summit conference room that the theme of the Summit is “Communication.” People will be supportive of communication being the focus of the Summit. There will be a facilitator to assist in guiding group participants through the steps of the toolkit. People will actively participate and provide their input/opinions during the formation of strategic communication plans for the four sub groups.

4. External factors: Time of year the Health Summit is conducted (March). The day of the week the Summit is conducted (Friday). Highlighted speaker chosen to inform the attendees of why communication has been chosen as the theme. Rooms (e.g., design, noise level) the breakout sessions are held in. Program
guides chosen to assist the groups. People's internal beliefs, comfort levels, attitudes, and openness to the program.

5. Description of Evaluation: The evaluation consisted of a one page, ten minute, Likert scale survey distributed to each participant in the four sub groups and was filled out and handed in at the end of the breakout session.

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short-term Outcomes</th>
<th>Long-term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comm-</td>
<td>Educate health professionals about communication</td>
<td>Four strategic communication plans unique to each focus area</td>
<td>Change awareness of importance of communication</td>
<td>Increased communication to the greater La Crosse community about health initiatives in place/in progress</td>
</tr>
<tr>
<td>unication</td>
<td>Educate health professionals to use the toolkit to create strategic communication plans for sub groups</td>
<td></td>
<td>Change in knowledge, attitudes, beliefs and motivation</td>
<td></td>
</tr>
<tr>
<td>Toolkit</td>
<td>Educate health professionals on importance of communication to meet 2015 goal</td>
<td></td>
<td>Sub group strategic communication plans established</td>
<td></td>
</tr>
<tr>
<td>and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. Logic Model for Communication Toolkit
<table>
<thead>
<tr>
<th>Month</th>
<th>Project Steps to be Completed</th>
<th>Person Responsible</th>
</tr>
</thead>
</table>
| August 2010   | Begin graduate preceptorship  
Attend Population Health Committee meeting  
Assess Healthiest County 2015: La Crosse plan | Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick                                                    |
| September 2010 | Begin discussion on communication and media campaign for Healthiest County 2015 plan  
Decision to do graduate project rather than thesis  
Onsite graduate preceptorship interview with Dr. Gilmore and Catherine Kolkmeier-confirm graduate project potential  
Research on costs  
Begin interviews of key community leaders  
Confirm Dr. Gilmore as graduate project advisor  
Begin work on RSEL grant  
Meet with LMHSC communication committee  
Confirm toolkit approach | Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Amanda Nogle, Dr. Gary Gilmore, Catherine Kolkmeier |
| October 2010  | Present project proposal to LMHSC board  
Revise RSEL grant proposal  
Present project proposal to Population Health Committee  
Submit RSEL grant proposal  
Meet with Coulee Parenting Connection publisher  
Meet with Coulee Region Women publisher  
Meet with graphic designer  
Compile literature for literature review | Amanda Nogle, Dr. Gary Gilmore, Catherine Kolkmeier, Amanda Nogle, Joanne Sandvick |
| November 2010 | Meet with Health Summit planning committee  
Meet with La Crosse Magazine publisher  
Select and confirm advisory committee members  
Compile literature for literature review | Amanda Nogle, Joanne Sandvick, Catherine Kolkmeier, Amanda Nogle |
| December 2010 | Compile information for communication toolkit  
Meet with LMHSC communication committee  
Meet with advisory committee members  
Meet with Health Summit planning committee  
Attend Population Health Committee | Amanda Nogle, Joanne Sandvick, Amanda Nogle, Catherine Kolkmeier, Amanda Nogle |
<table>
<thead>
<tr>
<th>Month</th>
<th>Task</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2011</td>
<td>Compile information for communication toolkit</td>
<td>Amanda Nogle</td>
</tr>
<tr>
<td></td>
<td>Revise communication toolkit</td>
<td>Amanda Nogle, Graduate Advisory Committee, Dr. Gary Gilmore</td>
</tr>
<tr>
<td></td>
<td>Submit communication toolkit to graphic designer</td>
<td>Amanda Nogle, Joanne Sandvick</td>
</tr>
<tr>
<td></td>
<td>Meet with Health Summit planning committee</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td><em>Healthiest County 2015: La Crosse</em> article featured in Coulee Parenting Connection</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td>February 2011</td>
<td>Receive first rough draft from graphic designer</td>
<td>Amanda Nogle</td>
</tr>
<tr>
<td></td>
<td>Make revisions on communication toolkit draft</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Meet with graphic designer to go over revisions</td>
<td>Amanda Nogle</td>
</tr>
<tr>
<td></td>
<td>Attend Population Health Committee meeting</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Meet with Health Summit planning committee meeting meeting X2</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Create interactive presentation on <em>Healthiest County 2015: La Crosse</em> accomplishments</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Communication toolkit to printer</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Receive communication toolkit</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Work on Rotary presentation</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Work on Health Summit presentation</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Work on facilitator guide</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Hold facilitator training</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td>March 2011</td>
<td>Present to Downtown Rotary Health Summit</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Present to Susan Schuyler’s CST 460 class</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Complete graduate preceptorship</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Write findings and conclusion sections of graduate project paper</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td></td>
<td>Present to the Linking Education and Practice for Excellence in Public Health Nursing regional learning collaborative meeting (WELEAP)</td>
<td>Amanda Nogle, Catherine Kolkmeier, Joanne Sandvick, Kayla Brenner</td>
</tr>
<tr>
<td>April 2011</td>
<td>Graduate project oral defense</td>
<td>Amanda Nogle, Dr. Gary Gilmore</td>
</tr>
<tr>
<td></td>
<td>Present to Rotary North</td>
<td>Amanda Nogle, Catherine Kolkmeier</td>
</tr>
<tr>
<td>May 2011</td>
<td>Graduation</td>
<td>Amanda Nogle</td>
</tr>
</tbody>
</table>

Figure 2. Timeline for Communication Toolkit
FINDINGS

The attendees of the Health Summit who participated in one of four breakout sessions were asked to fill out a Likert scale toolkit assessment evaluation at the close of the breakout session. Participants were provided a range in which they could evaluate the statements with on the toolkit assessment form; 1 meaning strongly disagree; 2 meaning disagree; 3 meaning neutral; 4 meaning agree; 5 meaning strongly agree. Participants were also given the chance to comment on how they will use communication tactics presented in the toolkit in their personal and professional life going forward. In addition, there was space provided at the bottom of the assessment to gauge specifically how participants will use the toolkit to create action, as well as space for general comments. A total of 80 evaluations were collected in all.
### Table 1. Communication Toolkit Evaluation Data

<table>
<thead>
<tr>
<th>Question Asked</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>The communication toolkit used in the breakout session was easy to understand.</td>
<td>4.14</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>The communication toolkit provided me with new information.</td>
<td>4.22</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>The information in the communication toolkit is accurate.</td>
<td>3.99</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Following the breakout session I found that the communication toolkit was useful to me.</td>
<td>3.83</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>I will incorporate <em>some</em> of the communication tactics presented in the communication toolkit in my <strong>personal</strong> life in the <strong>month</strong> following the health summit.</td>
<td>3.83</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>I will incorporate <em>some</em> of the communication tactics presented in the communication toolkit in my <strong>personal</strong> life at some point in the <strong>next year</strong>.</td>
<td>3.88</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>I will incorporate <em>some</em> of the communication tactics presented in the communication toolkit in my <strong>professional</strong> life in the <strong>month</strong> following the health summit.</td>
<td>4.15</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>I will incorporate <em>some</em> of the communication tactics presented in the communication toolkit in my <strong>professional</strong> life at some point in the <strong>next year</strong>.</td>
<td>4.29</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>My thoughts about the way I communicate with others about health initiatives has changed today.</td>
<td>3.64</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>The leader of my breakout group explained the purpose of the toolkit well.</td>
<td>4.16</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>The leader of my breakout group facilitated the group process well.</td>
<td>4.43</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>I feel my breakout group accomplished the intent of the breakout session.</td>
<td>4.18</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>I understand why it is important to communicate to the public about what my breakout group is accomplishing.</td>
<td>4.4</td>
<td>4.5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>I think it is important for my breakout group to refer back to the communication toolkit throughout the year following the 2011 health summit.</td>
<td>4.05</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>The way my breakout group communicates about the initiatives being accomplished as part of the <em>Healthiest County 2015: La Crosse</em> plan is important.</td>
<td>4.33</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 2. Personal Incorporation of Communication Tactics

<table>
<thead>
<tr>
<th>I will incorporate some of the communication tactics presented in the communication toolkit in my <em>personal</em> life in the <em>month</em> following the health summit. How?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Use data to enhance health promotion (7)</td>
</tr>
<tr>
<td>- Increase interpersonal communication with others (7)</td>
</tr>
<tr>
<td>- Don't know (3)</td>
</tr>
<tr>
<td>- Use information at my job (2)</td>
</tr>
<tr>
<td>- Already doing it! (1)</td>
</tr>
</tbody>
</table>

I will incorporate some of the communication tactics presented in the communication toolkit in my *personal* life at some point in the *next year*. How?

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Don't know (3)</td>
</tr>
<tr>
<td>- Use data to enhance health promotion (2)</td>
</tr>
<tr>
<td>- Increase interpersonal communication with others (2)</td>
</tr>
<tr>
<td>- Use information for graduate work (2)</td>
</tr>
<tr>
<td>- Get more familiar with Facebook (1)</td>
</tr>
</tbody>
</table>

Table 3. Professional Incorporation of Communication Tactics

<table>
<thead>
<tr>
<th>I will incorporate some of the communication tactics presented in the communication toolkit in my <em>professional</em> life in the <em>month</em> following the health summit. How?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Use it to enhance future communication (6)</td>
</tr>
<tr>
<td>- Use it to enhance health programming (e.g., physical activity programming, Suicide Prevention -- Initiative, STI subcommittee) (5)</td>
</tr>
<tr>
<td>- Increase interpersonal communication with others (2)</td>
</tr>
<tr>
<td>- Evaluating reach of communication (2)</td>
</tr>
<tr>
<td>- Use in graduate work (1)</td>
</tr>
<tr>
<td>- Probably (1)</td>
</tr>
</tbody>
</table>

I will incorporate some of the communication tactics presented in the communication toolkit in my *professional* life at some point in the *next year*. How?

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Use it to enhance health programming (e.g., STI subcommittee, COMPASS Prev. Network Coalition, -Suicide Prevention Initiative) (6)</td>
</tr>
<tr>
<td>- Use to enhance future communication (6)</td>
</tr>
<tr>
<td>- Graduate work (1)</td>
</tr>
<tr>
<td>- Probably (1)</td>
</tr>
</tbody>
</table>
Table 4. Toolkit Action Step

**One action step I plan to take with the toolkit...**

<table>
<thead>
<tr>
<th>Use It</th>
<th>Share It</th>
<th>Review It</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use it to create health promotion items/events (e.g., public service video, writing grants, health events, research projects) (11)</td>
<td>Share with others I work with; share with my organization (10)</td>
<td>Read and review it (4)</td>
<td>Great ideas and tactics generated... who will do them? Unsure? (2)</td>
</tr>
<tr>
<td>Use it to enhance future communication (9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use it when working with others to develop and create action (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use data/demographics (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5. Additional Comments

**Please provide any additional comments about the breakout session and/or toolkit:**

<table>
<thead>
<tr>
<th>Toolkit</th>
<th>Breakout Session</th>
<th>Health Summit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well done (3)</td>
<td>Well run and organized process; helpful (5)</td>
<td>Communication is too broad a topic and is already being worked on by the partners (3)</td>
</tr>
<tr>
<td>Great resource (1)</td>
<td>Breakout session should be organized differently (2)</td>
<td>Thank you (2)</td>
</tr>
<tr>
<td>Add page numbers to the back worksheet page to make toolkit more user friendly (1)</td>
<td>Confused about purpose of session (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Want more training and information on working with the media (1)</td>
<td></td>
</tr>
</tbody>
</table>
DISCUSSION

Conclusions

As a result of the findings, I am able to conclude that those who attended the Health Summit and filled out and submitted an evaluation form (hereafter ‘health summit attendees’) agreed the communication toolkit was a useful resource based on a five point Likert scale of agreement ranging from $1 = \text{strongly disagree}$, $2 = \text{disagree}$, $3 = \text{neutral}$, $4 = \text{agree}$ and $5 = \text{strongly agree}$. By taking an average of the evaluation scores, the quantitative data showed the Health Summit attendees agreed the communication toolkit provided them with new information and that they intend to use some of the communication tactics used in the toolkit in their professional life following the Health Summit. In addition, the Health Summit attendees agreed that their breakout session facilitator explained the purpose of the toolkit well, guided the group process well and also agreed that the breakout groups accomplished the purpose of the breakout session. Perhaps most importantly, the Health Summit attendees agreed that they understand why it is important to communicate to the public about what the Healthiest County 2015: La Crosse project partners are accomplishing—a core component of the purpose of the communication toolkit.

Important insight about the communication toolkit emerged from the qualitative data of the evaluation. A significant number of attendees noted that they would use the communication toolkit in the future to create health promotion items and events (e.g., public service video, writing grants, health events, research projects). Also, attendees
noted they would use the communication toolkit to enhance future communication, particularly their interpersonal communication. Many wrote that they planned to share the communication toolkit with their organization and co-workers. Some criticisms emerged in the qualitative data such as confusion about the purpose of the breakout session and frustration with the breakout session organization. Also, some felt that communication was already being addressed and they would rather focus on other needs of the *Healthiest County 2015: La Crosse* plan. Overall, the comments on the evaluation forms were generally positive and complimentary about the usefulness and purpose of the communication toolkit and breakout sessions.

**Discussion: Professional**

As a health educator I gained a great deal of experience in health planning, programming and promotion. By coupling my graduate preceptorship experience with my graduate project work I was able to observe and participate in an established health promotion program—the *Healthiest County 2015: La Crosse* project. The timing of the project and my graduate preceptorship couldn’t have been more ideal for aligning my strengths as an individual and professional. The *Healthiest County* project was just beginning its third year as I joined the effort. A communication plan had been identified as a need for the project but at that time no steps had been taken to begin one. My graduate project began as an idea, a ‘what if…’ thought, after a meeting about the *Healthiest County* plan. The thought persisted and ended up, as I’ve just described in the methods section, becoming the communication toolkit. Seeing the communication toolkit through from an idea to reality was an undeniably valuable professional learning experience.
As a result of creating the communication toolkit, I learned essential skills in health planning. From the beginning of the project to the end, I was leading the planning process and plotting the timeline for creation of the toolkit. I understood that in order for a communication plan to be effective I would need to make sure it was reflective of the community the communication would be created for. I planned various meetings with community leaders to gain information about their perceived impression of community needs and what kind of communication the community responds well to. I assessed the needs of the community and effective communication practices through these meetings.

As the project lead, I was responsible for securing funding for the communication toolkit. I wrote and submitted a Research Service Education Leadership (RSEL) grant proposal to the UW-La Crosse graduate studies office; the proposal was funded and as a result I gained experience managing a grant. There were unforeseeable issues that I handled as the grant manager, such as ensuring the proper payment processing for a university employee. Because the RSEL grant funds are university dollars a university employee cannot receive payment for a service unless the payment is processed through an ‘extraordinary payment’ (EOP) process. This process applies the grant payment to a university employee’s payroll; wherein taxes and benefits are factored out of the grant payment just as regular wages would be. I also gained experience managing the grant through completion by providing follow up materials and meeting grant funding obligations by participating in the UW-La Crosse Celebration of Research day.

Adhering to deadlines was also a skill in health planning that I gained from this project. Meeting the deadline for the graphic designer was essential to ensure the communication toolkit would be printed in time for the Health Summit. Planning for
deadlines happened during the timeline plotting for the project. I learned how important it is to allow a realistic amount of time for completion for each component of a project.

As a result of creating the communication toolkit, I learned essential skills in health programming. Perhaps one of the most important things I learned by going through the process of creating the toolkit was that if there isn’t effective application of a good product, it doesn’t matter how well done the product is. I believe it was the Health Summit that made the communication toolkit effective. Without the programming to deliver the product there would have been no background education for participants, no opportunity to answer questions and discuss concerns, and no way to apply the collaborative process the toolkit was created for. The Health Summit was the key factor in allowing strategic communication plans to emerge from the partners who ultimately need to employ them. In addition, the toolkit allowed each of the four focus groups to create strategic communication plans tailored to their topic. Each focus area is very different in terms of the scope of work, presence in the community and position within the Healthiest County 2015: La Crosse executive plan. One strategic communication plan for all four focus areas wouldn’t have been as effective as four separate communication plans specific to the goals and needs of each group. The breakout sessions at the Health Summit were designed to divide the four focus areas and allow the partners to collaborate and discuss communication needs for their topic area.

In terms of health programming, I also learned how essential it is to be organized and to pay attention to detail. There are many components that go into creating an event or program with the intent of enhancing health. A considerable amount of health programming engages a particular population on a one-time basis. The
organization and detail of health programming, then, is of critical importance in health education and promotion. In the case of the Health Summit, details such as coffee during registration, a comfortable room temperature and an appropriate volume during presentations can be the difference between a message received and a message not received. If program planners are spending their last few minutes taking care of major components of the program that could have been addressed at an earlier date, they won’t have the time to dedicate to ensure the small, although important, details are taken care of. When health educators only have one chance to reach a specific population, the details can determine the success and/or effectiveness of a program.

As a result of creating the communication toolkit, I learned essential skills in health promotion. I believe the one component of health promotion that is the most important is leadership. As part of my presentation to the Health Summit attendees, I stated that it is we (health educators and professionals) who are responsible for creating the culture of health in our communities. We’re responsible not because we’re paid to do work, but because we’ve chosen to dedicate our careers to health, because we have a passion for health and wellness and because we have the knowledge and the power to make a positive difference in the lives of others. If we, as health educators and professionals are not energetic and excited about creating a positive culture of health, than why would anyone else be energetic and excited about health? I believe it is the positive attitude and energy of leaders that can become infectious among others and ultimately lead to change. Leadership, and particularly leaders working with collaborations, need to be able to consider health planning, programming and promotion in the context of the ‘big picture,’ it is when leaders are able to effectively share that
vision with collaborative partners that they then have the potential to inspire buy-in and create synergy. Leadership sets the tone of any group of people working together. Health educators and professionals need to truly understand this if they want to generate the results they hope for.

I have also learned through this experience that effective health promotion should strive to reflect the community the health program or promotion is intended for. Health educators cannot expect a ‘canned’ program or message to be as effective within a community as a program or message that includes recognizable elements of that community. For example, at the core of the communication toolkit and, as I expressed in my presentation at the Health Summit, everyone living in La Crosse County has already made a significant healthy choice that they can be proud of; and that is they made the choice to live here, in La Crosse County, an environment that is already very healthy. Granted, there is still work to do in La Crosse County. However, my point is that if people hear that they’ve already made one of the healthiest choices they may ever make for themselves, they might believe they have the ability to make other healthy choices. When health educators and professionals build self-efficacy at the community level and generate a ‘we’re all in this together’ mentality, it is then that the community can take on a project like Healthiest County 2015: La Crosse as their own rather than a change agent prescribing health for them. As mentioned, La Crosse County is already a very healthy environment. I believe the Healthiest County 2015: La Crosse project shouldn’t necessarily only be about changing the environment, but rather changing the communities’ perspective about what health is and what health means to us as a community. If health educators and professionals can change the way people think about
health and their everyday environment, I believe changes in behavior will naturally follow.

**Discussion: Personal**

As a La Crosse community member and a MPH graduate candidate it was incredibly rewarding to work with the LMHSC and the Population Health Committee on the *Healthiest County 2015: La Crosse* project. I knew early on in the graduate program experience that I wanted my culminating graduate project/thesis work to make a positive difference in my community. Without a doubt I was able to couple my passion for the La Crosse community and health with my communication toolkit project; and I believe the end product emanates both passions. Through this process I have gained the satisfaction and feeling of accomplishment that results when hard work, passion, education and teamwork come together and result in something more, something better, than what any of those components could achieve alone. I am very proud of what I was able to accomplish with my graduate project.

In addition to creating a graduate project that has impacted my community, I thoroughly enjoyed getting to know and working with the LMHSC staff, Population Health Committee members, my Graduate Advisory Committee and Advisor, LMHSC board members, and the numerous other individuals I met during the process of creating the communication toolkit. Every time I met and got to know individuals of this community I learned something new about La Crosse; their stories and reasons for choosing to live and work here continually reaffirmed to me why this community is worth investing in. Having had the opportunity to meet so many individuals during the process of creating the communication toolkit was truly a joy. Also, having had the
opportunity to present on the topic of communication to over 100 area health educators and professionals was undeniably a benefit to me personally and professionally. I firmly believe that the start of my professional career will branch off as a result of connections I made through this experience; and, perhaps the connections I’ve made will continue to be a benefit to me and my career as years advance.

Lastly, as a result of this experience I know that I have made the correct career choice. My passion and energy for public health and health communication only continued to grow as I advanced through the process of creating the communication toolkit. Also, my belief in myself and my ability to be a quality health educator and promoter grew as well. As a direct result of this experience I feel well prepared and equipped to begin my career in the field of public health.

Recommendations

I recommend using a toolkit format for education and health promotion application purposes to anyone working with a collaborative effort. A toolkit, with proper instruction on how to use it, can provide an audience with varying backgrounds the basic information needed to get everyone ‘on the same page.’ This can become critical when everyone’s participation is needed to achieve goals. The communication toolkit may build the efficacy of health professionals concerning communication about the Healthiest County 2015: La Crosse project, and as mentioned in the discussion and conclusions section, contribute to shifting perceptions and therefore lead to sustained behavior change. The toolkit provides the ‘tools’ necessary to act in a particular way.

A toolkit used in the context that my communication toolkit was used, allows the group to become a part of the process of action. When people are a part of the process of
creating something and have the opportunity to include their input, they are more likely to take ownership in the end result. In my case, the communication toolkit helped many individuals create strategic communication plans together. The hope is that because the plans were created by the people who need to use them, they will more likely implement the plans because they have ownership in the plan. The communication plans were not created for them, but rather they were provided the tools to create the plan themselves.

A toolkit can be very effective when the information within it needs to be accessed multiple times. A well designed toolkit has the potential to become a resource guide for health educators and professionals. In the communication toolkit designed for the LMHSC Health Summit, I made sure to include worksheets throughout so that as ideas and plans for communication were discussed in the breakout sessions group members would be able to write them down. As these health educators and professionals refer to the communication toolkit throughout the upcoming year, they will be able to see how their notes align with the steps of the toolkit and be reminded of the plan they helped create; the worksheet pages can also trigger thoughts about some of the details discussed during the dialogue that they may have forgotten since attending the Health Summit.

I would recommend that anyone who wants to create a toolkit start well in advance of the time they want it completed and ready for use. A timeline is absolutely necessary if deadlines are a part of the process. An effective toolkit must be well thought out and details are of utmost importance. The design and layout of the toolkit is as important as the information within it. Keep information basic and the pages 'clean' and organized. I also recommend using photographs and graphics that reflect the population who will be using the toolkit. I was able to use photographs from the La Crosse Area
Visitor’s Bureau to enhance the communication toolkit that I put together. I attempted to create a local feel in the communication toolkit using La Crosse County photographs so that the attendees of the LMHSC Health Summit would register a familiarity when looking at it. I believe this may have helped reinforce that there are real people and real faces behind the La Crosse County statistics used in the first section of the toolkit; hopefully helping attendees realize that the work they do and the plans they created at the Health Summit matter and are important.

One last recommendation I would make is to allow plenty of time for revising the toolkit. Revisions can take much longer than one might anticipate. Make sure to get a variety of inputs during the revising process, particularly inputs from a representation of the population the toolkit is intended for. In hindsight, I believe I could have benefited from organizing a focus group during the information collection and design process. Also, seek out input and constructive criticism and try not to take any criticism personally. There is always room for improvement. And remember, the end product will reflect the time, energy and thought one puts into it.
REFERENCES


APPENDIX A

COMMUNICATION TOOLKIT EVALUATION FORM
Toolkit Assessment

Please check the breakout session you attended:

- Chronic Disease
- Injury and Violence Prevention
- Mental Health
- Infectious Disease Prevention

From your vantage point, please fill out the following survey using the numbers on the scale provided below. Your responses will help determine the effectiveness of today’s break out session and toolkit.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
<td></td>
</tr>
</tbody>
</table>

1. ______ The communication toolkit used in the breakout session was easy to understand.
2. ______ The communication toolkit provided me with new information.
3. ______ The information in the communication toolkit is accurate.
4. ______ Following the breakout session I found that the communication toolkit was useful to me.
5. ______ I will incorporate some of the communication tactics presented in the communication toolkit in my personal life in the month following the health summit.
6. ______ I will incorporate some of the communication tactics presented in the communication toolkit in my personal life at some point in the next year.
7. ______ I will incorporate some of the communication tactics presented in the communication toolkit in my professional life in the month following the health summit.
8. ______ I will incorporate some of the communication tactics presented in the communication toolkit in my professional life at some point in the next year.
9. ______ My thoughts about the way I communicate with others about health/health initiatives has changed today.
10. ______ The leader of my breakout group explained the purpose of the toolkit well.
11. ______ The leader of my breakout group facilitated the group process well.
12. ______ I feel my breakout group accomplished the intent of the breakout session.
13. ______ I understand why it is important to communicate to the public about what my breakout group is accomplishing.
14. ______ I think it is important for my breakout group to refer back to the communication toolkit throughout the year following the 2011 health summit.
15. ______ The way my breakout group communicates about the initiatives being accomplished as part of the Healthiest County 2015: La Crosse plan is important.

One action step I plan to take with the toolkit...

Please provide any additional comments about the breakout session and/or the toolkit (use back if necessary):
2011 Health Summit Facilitator Guide

Roles:

Facilitator—Group Discussion:

Facilitator—Transcriber/Time Keeper:

Allocated time: 120 minutes 9:40 a.m. – 11:40 a.m.

Outline:

9:40 a.m.

Thanks for attending!

Introductions – name and organization

The goal for the next hour is to:

1. Go through the steps of the communication toolkit

2. Brainstorm ideas for communication

3. Construct a communication plan for the group

4. Fill out an evaluation form

9:50 a.m.

Guide participants through the steps of the communication toolkit.

a. Explain the purpose of each step.

10:00 a.m.

Next we will be brainstorming some ideas on communication.

a. What messages does the group want to communicate overall?

b. What messages do the organizations communicate already?

c. Are there other messages that need to be delivered? Does the message need to change?

10:15 a.m.

First activity: Brainstorm 3 audiences the group would like their communication to focus on.

a. Make sure to consider the customers/clients of the organizations represented in the group.
b. Make sure to consider the audiences that may be in most need of your group’s message.

c. Make sure to consider the audiences the group is already communicating with.

Timekeepers: Collect and begin to summarize into categories on poster paper.

10:30 a.m.

Second activity: Brainstorm 3 tactics for communicating the message.

   a. What ways does your selected audiences receive messages?
   b. What media connections do those of you in the group already have?
   c. Consider the strengths of the organizations represented (monetary, personnel, experience).
   d. Don’t forget we all have an incredible amount of power to share messages through interpersonal communication.

Timekeepers: Collect and begin to summarize selected tactics on poster paper.

10:50 a.m.

Third activity: Brainstorm considerations for timing.

   a. What is already occurring in the community that could boost your communication efforts?

   b. Consider National Awareness Months.

Timekeepers: Collect and begin to summarize on poster paper.

11:05 a.m.

Fourth activity: Brainstorm the packaging of the above items.

   a. What audience?
   b. What tactic?
   c. When?

Timekeepers: Compile one worksheet from the back of the toolkit with the above information.

11:20 a.m.

Fifth activity: Discuss evaluation: how, when, who, what?

   Will they...
a. Evaluate the process? (they as group members fill out survey about what they did, how it went, etc.)

b. Evaluate number of possible impressions? (tracking the news media communication)

c. Evaluate the community? (survey clients/customers/employees)

11:30 a.m.

Hand out toolkit evaluation forms.

11:40 a.m.

Facilitator and timekeepers: Collect toolkit evaluation forms.

Thank you for your thoughtful discussion. Please transition back to large group.

Timekeepers: take evaluations to Mandy.

Facilitators: be prepared with master worksheet to share the plan with whole group during wrap up session.