Community Partnerships for Healthy Mothers and Children

COHORT 2 EVALUATION REPORT

September 29, 2017

ALTARUM

SOLUTIONS THAT MATTER. HEALTH CARE THAT WORKS.

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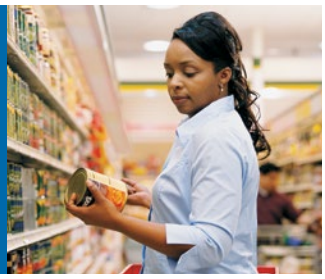
Executive Summary



Project Background and Overview

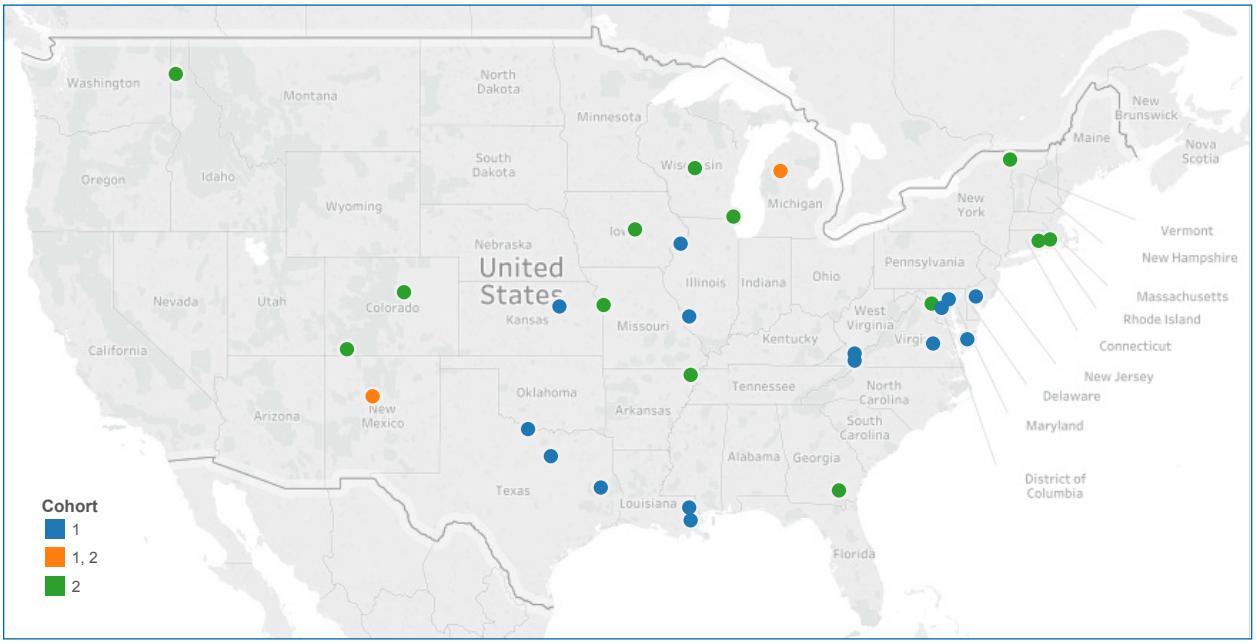
In 2014, the Centers for Disease Control and Prevention's Division of Community Health entered into a three-year cooperative agreement with the National WIC Association (NWA) to build and strengthen community infrastructure to implement population-based strategies to improve community health. Through this grant, and in partnership with the American College of Obstetricians and Gynecologists (ACOG), NWA supported local WIC agencies in efforts to reduce and prevent chronic disease by improving access to healthy food environments and improving access to prevention and disease management services.

Entitled Community Partnerships for Healthy Mothers and Children (CPHMC), this initiative was designed to implement community-driven plans to reduce chronic disease through policy, systems and environment (PSE) strategies. PSE strategies are typically high-level interventions focused on structures, systems and policies, communities and institutions. The use of PSE strategies represents a paradigm shift in public health from individual to population-based approaches. These population-based approaches consider determinants of health, which are direct causes and risk factors that have been demonstrated to influence the extent of a health problem. PSE strategies have the potential for a broader and more sustainable population impact than individually-oriented approaches.[1]

CPHMC was implemented through two cohorts of local WIC agencies in 18 states. The local WIC agencies were selected via an application process to work with community partners to establish or enhance coalitions, conduct community needs assessments, and prepare and implement an action plan with strategies to improve community health. The first cohort of 17 local WIC agencies conducted their projects during the period of January 1, 2015 through March 31, 2016, and the second cohort of 15 projects was conducted from February 15, 2016 through May 19, 2017 for 10 projects and through June 30, 2017 for 5 of them. Two agencies were funded in both cohorts. The CPHMC Cohort 2 comprised 15 organizations that operate WIC programs in 12 states. The majority of the organizations (9) are government-run health departments, one-third (5) are non-profit healthcare or community-based agencies, and one is an Indian Tribal Organization. Figure ES-1 shows locations of all agencies in both Cohort 1 and 2.

1 Centers for Disease Control and Prevention. *Health Equity Resource Toolkit for State Practitioners Addressing Obesity Disparities.* http://bit.ly/2A4SEmi

Figure ES-1. Locations of CPHMC Projects



Through the CPHMC project, NWA sought to achieve the following outcomes:

- Increased collaboration between national and community partners (e.g., between NWA and ACOG and between local WIC agencies and healthcare providers);
- Increased community capacity to implement PSE improvements;
- Increased messages on the importance of PSE improvements;
- Increased access to local community environments with healthy food or beverage options; and
- Increased opportunities for chronic disease prevention and care through local community and clinical linkages.

To accomplish these outcomes, NWA provided funding and offered training and technical assistance to the local agencies conducting the projects to support them in

1) Establishing community coalitions or collaborating with existing coalitions to determine community needs related to food environments and chronic disease prevention and care services,
2) Developing strategies for addressing needs, and
3) Building partnerships to implement the strategies. Local project leadership teams, comprising a project coordinator, healthcare provider and WIC client or patient advocate, spearheaded these activities in their communities.

Using results of the needs assessment, each Cohort 2 project prepared and submitted a community action plan (CAP) to NWA for review, feedback and approval. NWA provided a CAP template to assist local projects in formulating objectives, activities, timelines and measures. The CAP template included suggested secondary objectives for each of three outcomes or primary objectives. Primary objectives A and B allowed for selection

of unique secondary objectives based on the community's needs and priorities; primary objective C was standardized for all projects.

For each secondary objective included in the CAP, the local projects established targets for settings to be impacted (e.g., grocery stores, schools, hospitals) and for the estimated number of individuals to be reached, reflecting project staff best estimates and NWA input. Project teams then developed interventions and activities to accomplish each objective with consideration of community needs, resources, partners and other factors.

Figure ES-2. CPHMC Primary Objectives

A. Increase the number of people with access to environments with healthy food or beverage options.

B. Increase the number of people with improved access to opportunities for chronic disease prevention and care through community and clinical linkages.

C. Increase the number of public and partner messages showcasing CPHMC project efforts and achievements

Project Evaluation

NWA contracted with Altarum's Center for Food and Nutrition to conduct an evaluation of Cohorts 1 and 2 to understand the CPHMC project experience and factors that facilitated or hindered implementation of the project activities and achievement of objectives. A mixed methods approach was used to explore:

a. The extent to which local projects achieved increased collaboration across partners, increased capacity to implement PSE change, and increased messaging on project activities and PSE changes;

b. The extent to which projects achieved objectives to increase access to environments with healthy food or beverage options and increase opportunities for chronic disease prevention and care; and

c. How local projects pursuing common secondary objectives achieved their objectives, including identifying the activities and circumstances that lead to the most successful implementation, as well as challenges they experienced.

The primary data sources used for the evaluation included early and late-implementation web surveys and interviews completed with all project leadership teams and onsite visits with interviews and observations in a subset of eight projects. In addition, local project CAPs and progress reports were incorporated into the evaluation for all Cohort 2 projects.

Select Project Findings

A. Community Engagement and PSE Leadership

For many of the WIC agency staff involved in the CPHMC project, this was their first experience leading efforts to implement PSE activities to improve food and beverage environments or strengthen linkages to chronic disease prevention and care services. It was also a first large-scale effort to engage with partners to achieve these objectives.

Early in the project, it was necessary to either form a community coalition or join an existing coalition(s) that would work together on the project objectives. Coalition members served as a part of the project governance and provided advice to the team over the course of the project. Also in the early stage, the projects were required to conduct a community needs assessment and develop a CAP with secondary objectives and interventions targeting specific settings and populations in their community. Many of the secondary objectives selected by the projects required them to form partnerships with community providers, organizations and businesses with which they had not had much prior engagement. Partners were typically implementation sites or organizations that were the focus of the intervention implementation.

Eight local agencies integrated the project into an existing coalition or as a subcommittee of an existing coalition, such as a food access coalition, a chronic disease prevention coalition, a breastfeeding coalition, and a health disparities coalition. The other seven local agencies started new coalitions specifically for the project. At the end of the project, over half of the projects (57%) reported they experienced few challenges with building or working with their coalition and over three-quarters of project coordinators shared that they planned to continue to meet after the completion of the project. Over half of them also shared they were "very confident" that they had identified the important partners and stakeholders in their community, while 5 others were "somewhat confident," and one was neutral. Coalition members and partners who were interviewed during site visits were overwhelmingly positive about their experiences with the project, emphasizing the tangible outcomes they had achieved during the short grant period.

Figure ES-3. Key Evaluation Questions

- Were the projects implemented as intended?
- Did the projects achieve their objectives?
- How were coalitions and partnerships developed and maintained?
- What factors facilitated project implementation?
- What challenges were encountered and how were they addressed?
- How satisfied are project staff with the results?
- Which project efforts will continue and how?
- What lessons were learned and what recommendations do projects have for others interested in this type of work?

B. Project Implementation

At the end of the project, leadership team members shared their views regarding how successful they felt their projects were in implementing the interventions for secondary objectives and achieving successful project outcomes. A majority (9 out of 14) of project coordinators indicated that they felt they were extremely successful while over one-third (5 out of 14) felt that they were somewhat successful. None reported feeling neutral or not at all successful about their project initiatives.

Projects reported on progress with implementing their CAPs and with achieving the targets for settings and reach for secondary objectives. Based on project progress reports, across all Cohort 2 projects, just over one-third of the setting targets for

secondary objectives included in CAPs were achieved or exceeded (35%) and about two thirds of the reach targets (65%) were met or exceeded. Secondary objectives for Primary Objective A had a higher rate of success for meeting target settings (43%) and target reach (79%) as compared to Primary Objective B, which met 17% and 33% respectively. For targets not achieved, there was significant progress toward meeting the goals.

Key themes emerged across all Cohort 2 projects regarding staff perceptions on factors that contributed to project success or presented challenges. These themes are described in Table ES-1.

Table ES-1. Project Team Perceptions of Project Successes and Challenges

Successes	Challenges
Engagement of a committed and collaborative project team and coalition	Recruitment or retention of coalition members and partners
Cooperation and engagement of program partners	Staff and partner turnover
Support from leadership	Unrealistic project plans
	Project delays leading to inaction and disengagement among partners
	Burdensome or confusing administrative requirements

C. Project Implementation Successes

When discussing objectives that were implemented successfully during late-implementation interviews, project team members identified a number of strategies and interventions. Four examples representing the diversity of projects are described below.

- **Placement and Promotion Strategies for Healthy Foods:** Several projects worked to create onsite placement and promotion strategies for healthy foods through collaboration with local food banks, grocery stores and convenience stores. These strategies were executed in a variety of ways. For instance, several projects focused on promotion of healthy food items through signage, such as featured items each month, recipes, food demonstrations, and educational materials. One project worked to transition a food pantry to a self-selection format, offering additional healthy choices and recipes. Another project created a Healthy Foodbank Toolkit for Food Pantries to utilize in expanding efforts to promote healthy items during and after the project
- **New Farmers Markets, Food Banks and Mobile Grocers:** Approaches to new food access opportunities varied and included new farmers markets, free farm stands for WIC participants and low-income community members, and a mobile market. These sources were available at a variety of locations, such as Head Start programs, soup kitchens, WIC clinics and other public spaces. In addition to opening new locations, several projects worked with partners to develop, expand and coordinate services at local farmers markets. One project identified the need for a countywide app to better direct community members to the new farmers market as well as other area markets. The project also assisted a farmer to be certified to accept SNAP benefits and worked to create better signage for its area markets. Another project worked to promote and clarify the times when markets

were available. Several projects found that transportation was essential for access to their farmers markets, and one was able to locate new markets near bus stops to better serve the community.

- **Community Promotion and Business Support for Breastfeeding:** Increasing breastfeeding accommodation in local businesses was a priority among many projects, and several that worked on this objective reported success working with the business community. One project was able to support and certify 17 businesses as breastfeeding friendly, and worked with WIC peer counselors to institutionalize and expand the program beyond the end of the grant period. Several project coordinators reported building an important dialogue around the topic of breastfeeding in the community through promotional mechanisms, and two projects emphasized the importance of normalizing breastfeeding. Another project in an area with an American Indian population shared that it was able to connect with community and cultural values in breastfeeding communications.
- **Development of Strong Referral Networks:** Multiple projects shared achievements in clinical linkage activities and referral networks. Examples included training for healthcare providers on WIC services and referrals (often called "WIC 101") and onsite WIC enrollment and nutrition and breastfeeding support services. By strengthening providers' understanding and knowledge of the WIC program and local WIC services, their ability to connect their patients to services and resources was increased. Several program coordinators and partners noted that referrals between providers, programs and services improved as providers developed a better sense of local resources and opportunities. Five projects reported increases in participation at WIC clinics in the project communities ranging from a 1 to 20 percent increase from the beginning to the end of the project period. Strengthening referral networks and increasing awareness and understanding of WIC services may have contributed to the caseload growth.

D. Project Implementation Challenges

While there were many implementation successes, project team members also described objectives or activities that were difficult to complete or achieve during the project period.[ES-1] Three examples are described below. Due to the varying contexts and capacities of projects, activities that were highlighted as successful by some projects were found to be challenging for others.

- **Collaborating with Grocery and Corner Stores:** Multiple project coordinators shared challenges with activities that involved grocery and corner stores. Although the challenges varied, key factors included frequent employee turnover in grocery stores, which made it difficult to keep staff educated about the initiatives, as well as frequent inventory changes and the limited capacity or business instability in small corner stores. One project experienced difficulty in coordinating inventory in the store with promotions of healthy foods and recipes due to constantly shifting stock.

ES-1 As noted on Page 1, five Cohort 2 projects had an extended implementation period through June 30, 2017. During this extended period, three of the projects were able to address some of the challenges described in this section. Specifically, two projects were able to establish a community or school garden, while a third project increased the number of grocery stores with in-store placement and promotion strategies for healthy foods.

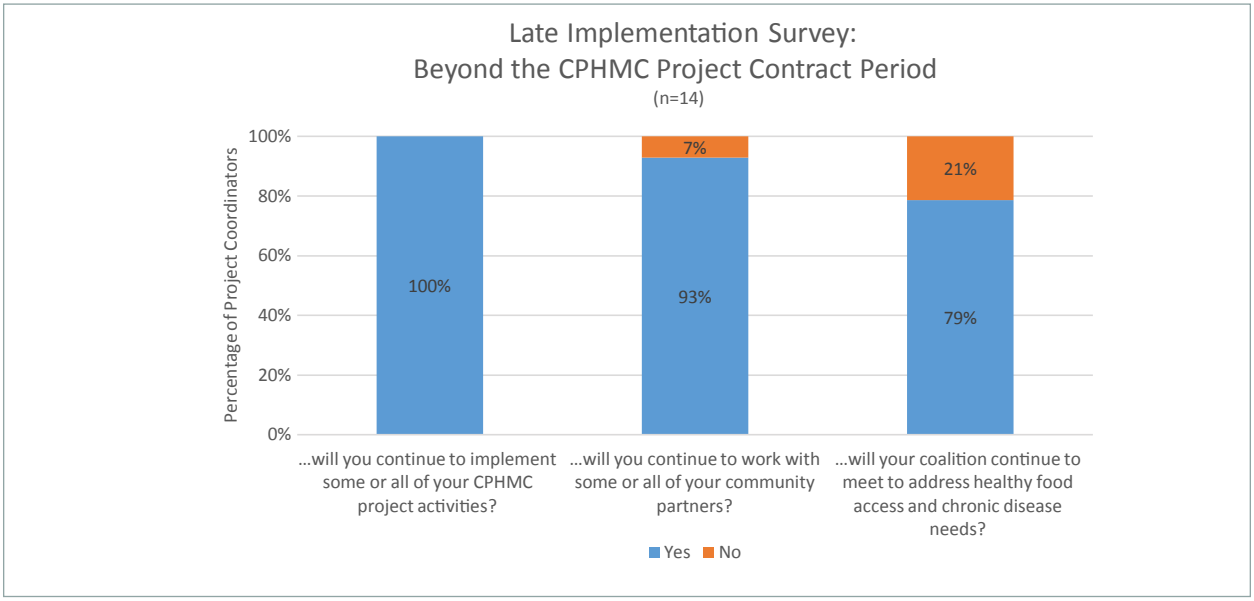
When working to improve healthy options at corner stores, one project found that community members shopped less frequently at corner stores than anticipated and were traveling greater distances to larger grocery stores. Further, the project also found that owners of small stores cannot take large risks, and as a result, were unable to engage in healthy food promotion activities. In this particular community, the project believed it would have been more effective working with larger stores rather than corner stores.

- **Developing Community Gardens:** While two projects had successes with new and existing community gardens, others struggled. There were issues related to locating and assuring reliable land access as well as navigating the short growing season during which to launch a program. Two projects found that the project period ending in May was an issue because they had to complete grant implementation just as gardening activities were beginning. Some projects shared that they still intended to pursue activities beyond the timeframe of the grant, while others shifted their focus to other secondary objectives.
- **Breastfeeding Activities:** As described in the previous section, several projects were successful in implementing activities to encourage businesses to support breastfeeding; however, other projects faced challenges in their efforts to do this. One project reported a clear lack of interest from the business community and came to the conclusion that the project would need to redirect its focus. Another saw interest, but struggled with businesses that lacked authority to make policy decisions for onsite services, e.g., retail chains and franchises. In some of these situations, the approval process for new policies was too slow and time-consuming to work through. Another project faced issues with discomfort in the community regarding breastfeeding in public, particularly with churches and grocery stores. Establishing processes for obtaining reimbursement for lactation services is another breastfeeding activity that was reported to be challenging. Projects that worked on this described complexity around insurance billing codes and requirements.

E. Sustainability of Project Outcomes

In addition to increased capacity to implement PSE improvements, Cohort 2 projects were charged with planning and implementing improvements that can be sustained beyond the project end. In the late-implementation survey, project leaders were asked "Will you continue implementing some or all of your CPHMC project activities beyond the contract period for your project?" As demonstrated in Exhibit ES-1, respondents from all 14 projects that completed the survey responded "yes." Further, a majority of projects (79%) reported that their coalitions will continue to meet beyond the end of the project and nearly all projects (93%) will continue to work with some or all of their community partners.

Exhibit ES-1. Late Implementation Survey Beyond the CPHMC Project Contract Period



F. Next Steps, Lessons Learned and Recommendations for Others

Leadership team members shared what they anticipate will be the next steps for their organizations and/or coalitions. Some described activities that will continue, including WIC referral strategies, community breastfeeding support activities, and the promotion of physical activity. Project coordinators were also asked if they had sought or intended to seek additional funding to carry project objectives forward, and two-thirds (65%) responded affirmatively.

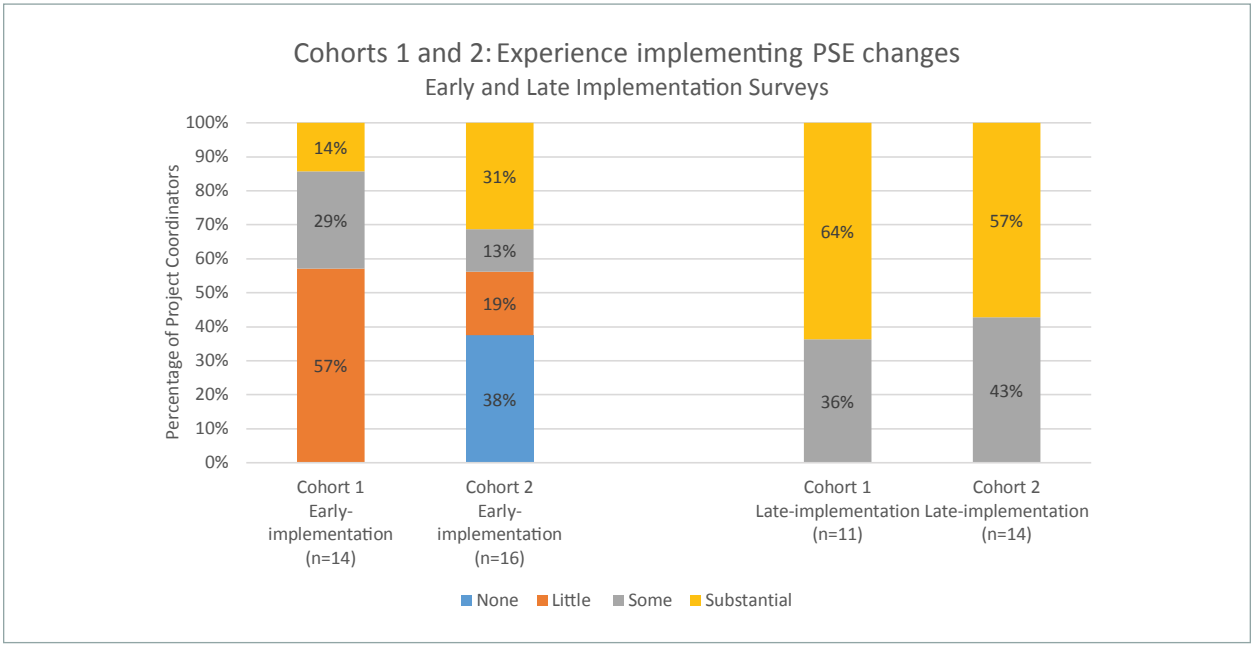
Project staff shared lessons learned and gave recommendations for other WIC agencies about working to address PSE change in their communities. Projects shared what they found to be most effective, such as focusing on sustainability and providing resources and best practices.

Because participation in the coalition and project activities required buy-in from community members and organizations, project leadership shared experiences that helped "sell" their projects to the community. This included using concrete data, drawing from the needs assessment results, engaging community members in the dialogue, and finding community champions to serve as leaders. In addition to forging new relationships, projects noted the importance of maintaining relationships and keeping the project moving forward with partners and coalition members.

Comparison of Projects in Cohorts 1 & 2

While there was overlap in the project objectives for the two project cohorts, there were differences in their approach, partnerships and activities. Implementing the CPHMC project with two local agency cohorts allowed for lessons learned during the first cohort to inform and shape the processes and experience for the second group. Experiences from the agencies in the first cohort were shared with the second group of projects, and some Cohort 1 agencies provided peer support for those in the second cohort.

Exhibit ES-2. Cohorts 1 and 2: Experience Implementing PSE Changes



Project coordinators for Cohort 1 reported a greater amount of past experience with community engagement and PSE change implementation at the start of the project. However, by the end of the project, the results for both cohorts indicated substantial experience in both areas as shown in Exhibits ES-2 and ES-3.

Exhibit ES-3. Cohorts 1 and 2: Experience with Community Engagement

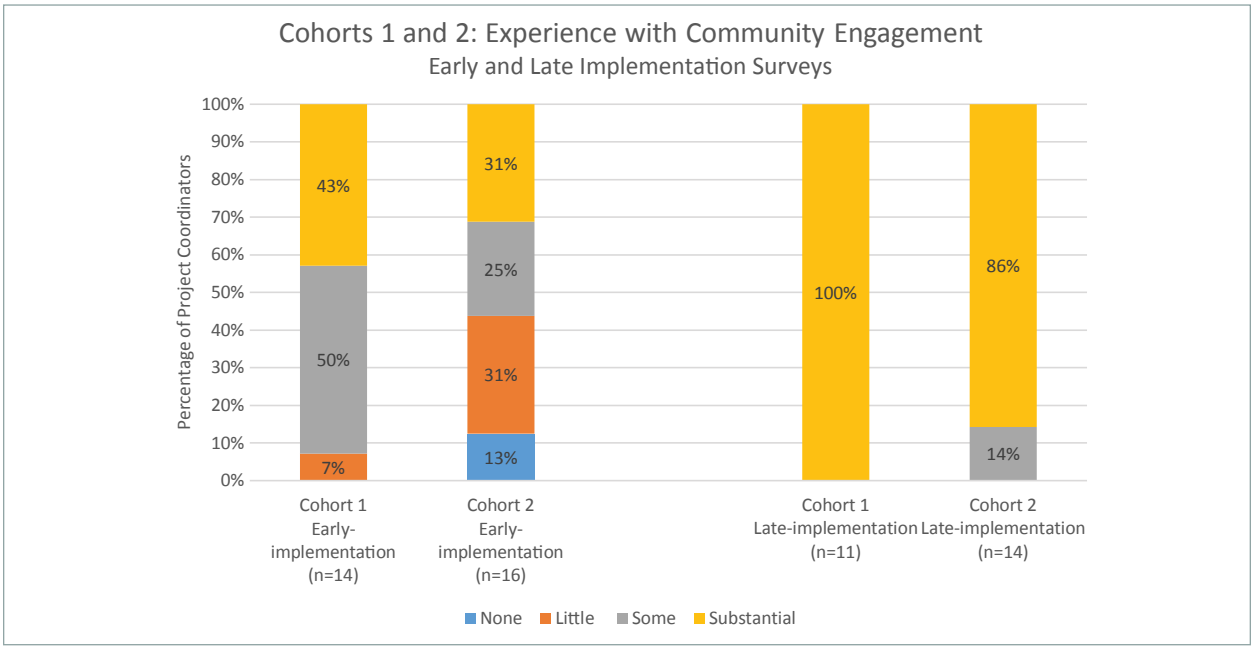


Table ES-2 shows project activities that were most successful for the two cohorts. The diversity of these successful project activities speaks to the variety of participating local agencies and the impact of coalitions and partners on targeting each community's unique contexts and needs.

Table ES-2. Key Project Successes, by Cohort

Cohort 1	Cohort 2
Strategies for healthy food in corner stores	Placement and promotion strategies for healthy foods
Comprehensive referral systems for WIC	New farmers markets, food banks, mobile grocers
New tools for identifying community food and healthcare resources	Water availability in schools
Partnerships for breastfeeding support	New businesses that promote and welcome breastfeeding
Healthy options in restaurants	Development of strong referral networks
Utilization of farmers markets and support for food banks/ pantries to access produce donations from farmers	Non-pharmaceutical prescriptions
	Comprehensive breastfeeding training for providers

The Table ES-3 lists some of the key challenges encountered by each cohort. For several objectives, one cohort found success while the other encountered barriers.

Table ES-3. Key Project Challenges, by Cohort

Cohort 1	Cohort 2
Working with schools	Breastfeeding activities
Increasing the number of WIC vendors	Working with farmers markets
Implementing "green prescriptions for healthy living" for healthy foods and lifestyles	Working with community gardens
Increasing businesses that provide accommodations for breastfeeding mothers	Transportation access
	Collaborating with grocery stores and corner stores

Conclusions

The findings from the evaluation of CPHMC Cohort 2 projects support the conclusions described below. These are consistent with the conclusions identified in the evaluation of Cohort 1.

1. **WIC can play an important role in creating partnerships to implement PSE changes for improving food and beverage environments and increasing linkages for chronic disease prevention and care.**

   The CPHMC project demonstrates clearly that WIC agencies can successfully lead or participate in community-based initiatives to implement PSE change. While WIC agencies may not have as much experience in PSE as some other organizations, they learn quickly and have access to community partners, such as grocery stores, farmers markets, hospitals, and health departments that can play a critical role in achieving PSE changes.

2. **Building strong community coalitions leads to successful implementation of interventions and sustainability of these efforts.**

   Project team and community coalition members emphasized the importance of a strong coalition with a commitment to implementing change. The coalition members were able to leverage and synergize each other's ideas and resources to accomplish common objectives while adding value to each other's efforts.

3. **CPHMC projects provide many useful resources and practical experience for other WIC agencies that are interested in community-based work.**

   The experiences, project examples and lessons learned from the agencies that participated in the project serve as an outline for local WIC agencies that want to work with others in their communities to improve food and beverage environments and improve or establish linkages in preventive health services and/or related efforts.

4. **WIC agencies that want to engage in PSE work should pursue opportunities to work with coalition and community partners that have resources and/or to identify new funding sources.**

   Collaboration with organizations that provide SNAP-Ed may be particularly effective because SNAP-Ed requires PSE efforts and provides funds and resources for PSE activities. There are also local, state and national foundations that fund PSE initiatives, with many of these sources targeted to food environment and healthy food access efforts. Ongoing sharing of successful collaborations or grants for these efforts within the WIC community may be beneficial.

5. **Some objectives and strategies require longer-term commitments.**

   Projects in both cohorts found that some interventions require more time to build partnerships and implement activities; these could not be completed in a period of 12 months or less. Setting realistic objectives and selecting strategies that can be accomplished within the time available are important for achieving goals and for maintaining morale and engagement of project staff and partners. An important planning step involves assessing timeframe feasibility to determine what can be reasonably accomplished.

6. **WIC agencies may encounter resistance or lack of support for engaging in community-based PSE efforts.**

   Sharing the outcomes of the CPHMC projects may help educate the USDA Food and Nutrition Service and the state and local WIC community about the important role WIC can play as a partner or leader in improving community food and beverage environments and linkages for chronic disease services. Improving the community that exists outside of the WIC clinic walls contributes to WIC's success in helping families adopt healthy behaviors and have positive pregnancy outcomes and healthy children.

7. **The NWA has increased its capacity to support expansion of WIC's role in the community.**

   The experience gained through the CPHMC project has strengthened the association's capabilities to work with local agencies to plan and implement community-based interventions. NWA staff have developed expertise in project and grant management and in delivering technical assistance to local agencies. In particular, NWA has gained significant experience with helping local agencies network and build partnerships with other organizations in their communities and to work collaboratively on interventions to improve the environment outside the WIC clinic walls. This capacity positions NWA to provide leadership for future efforts to expand WIC's role in promoting healthy communities throughout the nation.

I. Project Background and Overview

In 2014, the Centers for Disease Control and Prevention's Division of Community Health entered into a three-year cooperative agreement with the National WIC Association (NWA) to build and strengthen community infrastructure to implement population-based strategies to improve community health. Through this grant, and in partnership with the American College of Obstetricians and Gynecologists (ACOG), NWA supported local WIC agencies in efforts to reduce and prevent chronic disease by improving access to healthy food and beverage environments and access to prevention and disease management services.

This initiative was designed to implement community-driven plans to reduce chronic disease through **policy, systems and environment (PSE) strategies**.[1] PSE strategies are typically high-level interventions, focused on structures, systems and policies; communities; and institutions. The use of PSE strategies represents a paradigm shift in public health from individual to population-based approaches. These population-based approaches consider determinants of health, which are direct causes and risk factors that have been demonstrated to influence the extent of a health problem. PSE strategies have the potential for a broader and more sustainable population impact than individually-oriented approaches.[2] (Additional information about the terminology in orange font is included in the glossary.)

Entitled Community Partnerships for Healthy Mothers and Children (CPHMC), the project was implemented through two cohorts of local WIC agencies in 18 states. The local WIC agencies were selected via an application process to work with community **partners** to establish or enhance **coalitions,** conduct community needs assessments, and prepare and implement an action plan with strategies to improve community health. The first cohort of 17 local WIC agencies conducted their projects during the period of January 1, 2015 through March 31, 2016, and the second cohort of 15 projects was conducted from February 15, 2016 through May 19, 2017 for 10 projects and June 30, 2017 for 5 of them. Two agencies were funded in both cohorts.

NWA contracted with Altarum's Center for Food and Nutrition to conduct an evaluation of Cohorts 1 and 2 to understand the CPHMC project experience and factors that facilitated or hindered implementation of the project activities and achievement of objectives. This report describes the evaluation process and presents findings for Cohort 2, with comparison of findings for this group of local agencies with the evaluation findings for Cohort 1. The two local agencies that participated in both cohorts are included with Cohort 2.

1 A glossary of terminology for all terms shown in orange in this section is located on page 60.
2 Centers for Disease Control and Prevention. *Health Equity Resource Toolkit for State Practitioners Addressing Obesity Disparities.* http://bit.ly/2A4SEmi

CPHMC Outcomes and Objectives

Through the CPHMC project, NWA sought to achieve the following outcomes:

- Increased collaboration between national and community partners (e.g., between NWA and ACOG and between local WIC agencies and healthcare providers);
- Increased community capacity to implement policy, systems and environmental (PSE) improvements;
- Increased **messages** on the importance of PSE improvements;
- Increased access to local community environments with healthy food or beverage options; and
- Increased opportunities for chronic disease prevention and care through local community and clinical linkages.

To accomplish these outcomes, NWA provided funding and offered training and technical assistance to the local agencies conducting the projects to support them in 1) establishing community coalitions or collaborating with existing coalitions to determine community needs related to food environments and chronic disease prevention and care services, 2) developing strategies for addressing needs, and 3) building partnerships to implement the strategies. Local project leadership teams, comprising a project coordinator, healthcare provider and WIC client or patient advocate, spearheaded these activities in their communities.

Using results of the needs assessment, each Cohort 2 project prepared and submitted a community action plan (CAP) to NWA for review, feedback and approval. NWA provided a CAP template, included with this report as Appendix A, to assist local projects in formulating objectives, activities, timelines and measures. The CAP template included specific **objectives** with measurable results for the project period. There were three outcomes or **primary objectives** toward which all projects were required to work, which are outlined in the table. Primary objectives A and B allowed projects to determine unique **secondary objectives** based on the community's needs and priorities; primary objective C was standardized for all projects. Further, a list of secondary objectives was included with the CAP template with interventions to meet the primary objectives in a range of priority areas. Each project could select secondary objectives to help meet their primary objectives or propose alternative objectives. Table 1 shows examples of secondary objectives.

Table 1. Sample Project Objectives

Primary Objective A: Increase the number of people with access to environments with healthy food or beverage options.
• Increase the number of stores that sell healthy food and/or expand inventory of healthy food.
• Increase the number of restaurants with new healthy menu options and/or labeling to identify healthy choices.
• Increase the number of businesses that publicly promote/welcome breastfeeding.
• Increase the number of food banks with onsite placement and promotion of healthy foods.
Primary Objective B: Increase the number of people with improved access to opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages.
• Increase the number of medical providers and community organizations that are integrated into a strong referral network.
• Increase the number of non-profit organizations with providers or staff who receive basic training in WIC services and benefits or breastfeeding.
• Increase the number of new providers that give "prescriptions" for non-pharmaceutical interventions, e.g., exercise, healthy eating, enrolling in WIC.
Primary Objective C: Increase the number of public and partner messages showcasing CPHMC project efforts and achievements.
• Increase the number of public messages on CPHMC efforts and achievements by the end of the project period.

Table 2. Sample CAP

Primary Objective B: Increase the number of people with improved access to opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from 0 to 68,484 by the end of the project period.	
Secondary Objective B5. Increase the number of:	
• Hospitals with providers and/or staff who receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 2. • Primary care providers with providers and/or staff who receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 5. • Outside of school care providers with providers and/or staff who receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 4. • Government agencies with providers and/or staff who receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 2.	
Estimated number of people reached by the intervention	• Hospitals estimated reach: Hospital #1: 325 births/month and Hospital #2: 210 births/month for total of 535 births/month X 10 months = 5,350 • Primary care providers estimated reach: Group #1: 2,000/month and Group #2: 1,000/month for total of 3,000/month X 10 months = 30,000 • Outside of school care providers estimated reach: 715 • Government agencies estimated reach: 917/month X 10 months = 917
Description of reach calculation	• Hospitals: Hospital #1: 3,900 births/year; Hospital #2: 2,531 births/year • Primary care providers: Group #1: 2,000 pediatric patients/month; Group #2: 1,000 women of child bearing age/month • Outside of school care providers: 4 Head Start centers with 55% of 1,300 potentially eligible • Government agencies reach: 124,707 population of City X 8.82% receiving SNAP

Secondary Objective B5. Activities		
Activity Title	Description of Activity	Outputs/Measures
Assessment of target area contacts for WIC training	Determine organizations and providers to outreach and provide training within target community	List of organizations
Develop training and support materials	Develop training materials and materials to market WIC to providers	Training and support materials complete
Provide training to organizations and providers in target area	Schedule and implement training with organizations and providers	Training schedule and list of organizations and attendees
Create evaluation tool to be used post-training	Evaluate training provided	Report of evaluation results
Collect data for reports on referrals and caseload	Track number of referrals and caseload at area clinics	WIC data reports: referrals from and clinic caseload

For each secondary objective included in the CAP, the local projects established **targets** (realistic estimates) for **settings** to be impacted (e.g., grocery stores, schools, hospitals). They also calculated **reach** for the estimated number of unique individuals to be impacted in the project's target settings and community, reflecting project staff best estimates and NWA input. Project teams then developed interventions and activities to accomplish each objective with consideration of community needs, resources, partners and other factors. An example of a CAP for one secondary objective is shown in Table 2.

Throughout the project implementation period, Cohort 2 projects provided NWA with progress reports, project communications and "implementation stories." Along with other data collected from Cohort 2, these documents provided data for an evaluation of Cohort 2 outcomes.

Organization of Report

This report includes six sections, a glossary of terms and several appendices. Section 2 describes the evaluation methods and data collection activities. Section 3 presents the Cohort 2 local WIC agencies and projects funded through the CPHMC project. Evaluation findings are included in Section 4, with sub-section discussions on 1) coalition building and community engagement, 2) project implementation experience, and 3) capacity building, sustainability and lessons learned. Findings across the 31 projects in both cohorts are discussed in Section 5 and conclusions shared in Section 6. Terms bolded in orange are referenced throughout the report, and are included in the glossary. Appendices are also referenced throughout the report.

II. Evaluation Methods

A mixed methods approach was used to explore:

a. The extent to which local projects achieved increased collaboration across partners, increased capacity to implement PSE change, and increased messaging on project activities and PSE changes;

b. The extent to which projects achieved objectives to increase access to environments with healthy food or beverage options and increase opportunities for chronic disease prevention and care; and

c. How local projects pursuing common secondary objectives achieved their objectives, including identifying the activities and circumstances that lead to the most successful implementation, as well as the challenges they experienced.

Key evaluation questions are shown in Exhibit 1.

Data Sources

The primary data sources used for the evaluation are shown in Table 3 along with the time periods for data collection, a brief description of each data source, and number of projects/respondents included. Local project CAPs and progress reports were incorporated into the evaluation for all Cohort 2 projects, and 13 of the project leadership teams were asked to complete early and late-implementation web surveys and interviews. For the two agencies that were part of both cohorts, early implementation surveys and interviews conducted with them as part of Cohort 1 were included in this evaluation and they were asked to complete only the late-implementation survey and interviews. A subset of eight local projects participated in additional onsite interviews of project staff and community partners and observation of project activities and/or settings.

Exhibit 1. Key Evaluation Questions

- Were the projects implemented as intended?
- Did the projects achieve their objectives?
- How were coalitions and partnerships developed and maintained?
- What factors facilitated project implementation?
- What challenges were encountered and how were they addressed?
- How satisfied are project staff with the results?
- Which project efforts will continue and how?
- What lessons were learned and what recommendations do projects have for others interested in this type of work?

Table 3. Evaluation Data Sources

Data Source and Timeframe	Description	Projects Included
Local project CAPs and progress reports (throughout project period)	These documents provided background information and data for selected secondary objectives and project activities. The targets for settings and estimated reach for objectives in each project's CAP were compared to the setting and reach numbers reported through progress reports.	15 projects
Early-implementation survey of project leadership team (October – November 2016)	A short web survey of each project's leadership team members was fielded at the beginning of project implementation. The survey focused on project staff experience with coalitions, partnerships and policy, systems and environment change and their readiness to implement the activities in the CAP.	15 projects 36 completed surveys* (of 45 invited to respond)
Early- implementation interviews with project leadership team (November – December 2016)	Interviews with project coordinators and other members of the project leadership team were conducted by phone within the first four months of project implementation. These interviews focused on their experience with building coalitions and partnerships, CAP development, early implementation, and anticipated successes and/or barriers.	15 projects 15 completed interviews*
Onsite visits with interviews and observations (February – May 2017)	Onsite visits during the late-implementation period included interviews with project team members, project coalition members and partners, and other staff members in project organizations as well as observations of project activities and settings.	8 projects 8 completed visits
Late-implementation survey of project leadership team (April – May 2017)	A short web survey of each project's leadership team members was fielded near the end of project implementation. The survey focused on project staff experience during project implementation, success in achieving project objectives and sustainability.	15 projects 25 completed surveys (of 45 invited to respond)
Late-implementation interviews with project leadership team (April – May 2017)	Interviews with project coordinators and other members of the project leadership team were conducted during onsite visits or by phone near the end of project implementation. These interviews focused on project implementation and key successes and/or barriers, project sustainability, capacity built, and lessons learned.	15 projects 15 completed interviews

**Surveys and interviews for two projects were conducted during 2015 as part of Cohort 1.*

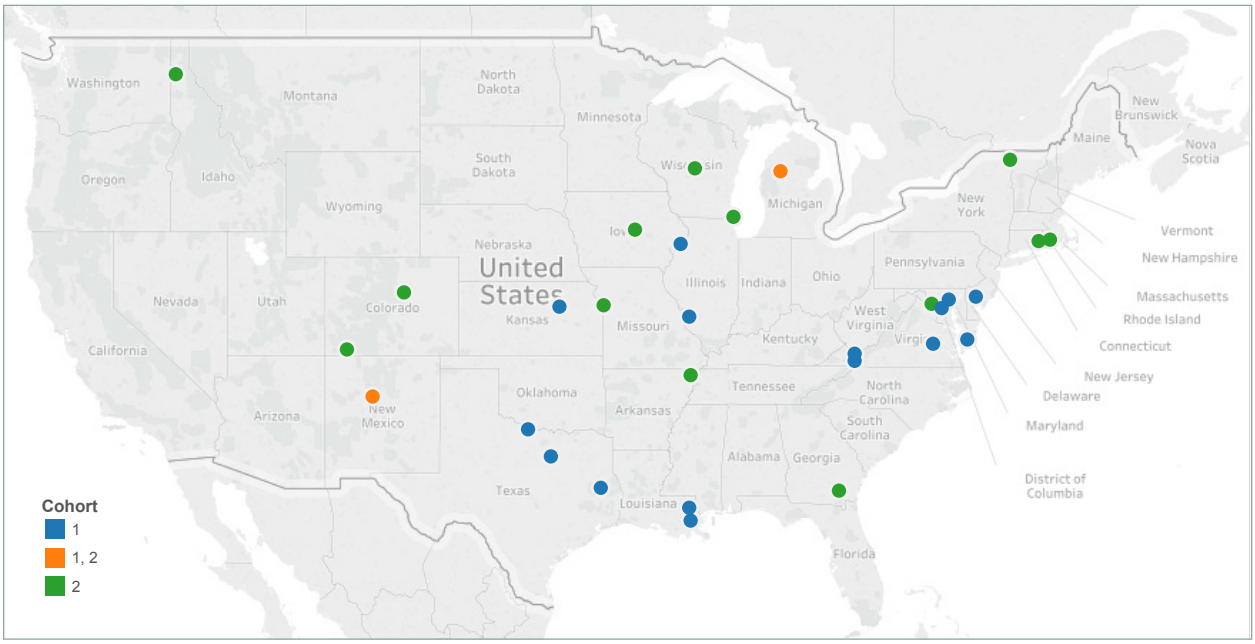
Analysis

Web survey responses were analyzed using Excel for tabulation of multiple choice and rating questions and compilation of qualitative responses. Interview responses were analyzed using QSR International NVivo, Version 11 to identify themes and select quotes to demonstrate themes or share recommendations from those interviewed. Observation summaries prepared from onsite visits were reviewed for examples of project activities and quotes from project partners.

III. Description of Cohort 2 Projects

The CPHMC Cohort 2 comprised 15 organizations that operate WIC programs in 12 states. The majority of the organizations (9) are government-run health departments, one-third (5) are non-profit healthcare or community-based agencies, and one is an Indian Tribal Organization. Exhibit 2 shows locations of all agencies in both Cohort 1 and 2. Table 4 presents further information about each of the Cohort 2 organizations.

Exhibit 2. Locations of CPHMC Projects



During the early implementation interviews, interviewees were asked to describe the team members involved in the project. Eight local agencies identified existing staff members to serve as project coordinators for their projects, while the other seven agencies hired individuals specifically for the role. Project coordinators who were existing staff members had a range of experience within the organization, with the majority having been employees for 1-2 years prior to the project (the longest-term employee had worked for the organization for 22 years). Job titles of project staff varied, including project manager, project coordinator, co-coordinator and project facilitator, but are referred to in this report as project coordinators or leadership. Some Cohort 2 organizations redirected existing staff to assist with project implementation while others brought on new employees to implement project activities or had a combination of existing and new staff. A majority of projects had WIC program staff directly involved in project implementation activities either as paid positions or in-kind support, such as

through participation on committees or workgroups. Examples of WIC staff who were involved in project implementation included WIC coordinator, WIC community planner, WIC dietitian and WIC breastfeeding peer counselor.

Table 4. Cohort 2 Organizations

Local Agency/Organization Name	Location	Organization Type
Clinton County Health Department	Plattsburgh, New York	Government
District Health Department 10 – Lake County	Cadillac, Michigan	Government
Dunklin County Health Department	Kennett, Missouri	Government
Five Sandoval Indian Pueblos, Inc.	Bernalillo, New Mexico	Indian Tribal Organization
Loudoun County Health Department	Leesburg, Virginia	Government
Mid-Iowa Community Action Agency	Marshalltown, Iowa	Non-profit
Panhandle Health District – Bonner County	Sandpoint, Idaho	Government
Racine Kenosha Community Action Agency	Kenosha, Wisconsin	Non-profit
San Juan Basin Public Health	Durango, Colorado	Government
Southeast Health District – Tattnall County, GA	Waycross, Georgia	Government
Thames Valley Community Action Agency	New London, Connecticut	Non-profit
Tri-County Health Department	Greenwood Village, Colorado	Government
Truman Medical Center	Kansas City, Missouri	Non-profit
Westbay Community Action Agency	Warwick, Rhode Island	Non-profit
Wood County Health Department	Wisconsin Rapids, Wisconsin	Government

As described previously, each CPHMC project prepared a CAP using a template provided by the NWA. The template was organized into three sections with one section per primary objective. Local projects identified secondary objectives for the first two primary objectives either by selecting suggested secondary objectives included in the CAP template or by developing others with input from NWA project staff. For the third primary objective pertaining to messaging and communication, all local projects were required to include the two secondary objectives in their CAP.

All local projects selected one or more secondary objectives for primary objectives 1 and 2. As shown in Table 5, some secondary objectives were selected by multiple

local projects while others were included in only one local project CAP; five secondary objectives were not selected by any project.

Table 5. Secondary Objectives in Project CAPs

Secondary Objectives	Total Projects Selecting
Primary Objective A: Increase the number of people with improved access to environments with healthy food and beverage options from 0 to target by the end of the project period.	
A.1: Increase the number of [grocery stores; convenience stores; food banks; mobile grocers] that sell healthy foods and/or expand their inventory of healthy foods in the target community from 0 to target.	2
A.2: Increase the number of [grocery stores; convenience stores; food banks] with new on-site and in-store placement and promotion strategies for healthy foods in the target community from 0 to target.	8
A.3: Increase the number of new [grocery stores; convenience stores; farmers markets; other—mobile grocers] that accept WIC in the target community from 0 to target.	3
A.4: Increase the number of new [grocery stores; convenience stores; farmers markets; other—mobile grocers] that accept SNAP in the target community from 0 to target.	2
A.5: Increase the number of new [grocery stores; convenience stores; farmers markets; other—mobile grocers] that offer cash or coupon incentives for purchase of healthy foods in the target community from 0 to target.	2
A.6: Increase the number of new [farmers markets; food banks; other—mobile grocers] in the target community from 0 to target.	4
A.7: Increase the number of [restaurants/bars; hospitals; other—please specify] with new healthy menu options and/or using nutrition labeling to identify healthy menu options in the target community from 0 to target.	2
A.8: Increase the number of new K-12 schools that implement healthy vending and concession practices in the target community from 0 to target.	0
A.9: Increase the number of new K-12 schools that make plain drinking water available throughout the day at no cost to students in the target community from 0 to target.	1
A.10: Increase the number of new [hotels/motels; entertainment venues; grocery stores; restaurants/bars; other—please specify] that publicly promote/welcome breastfeeding in the target community from 0 to target.	5
A.11: Increase the number of new [K-12 schools; outside of school care providers; dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; faith based organizations; worksites; prisons; group homes; government agencies; military facilities; veteran facilities; other—please specify] that develop and/or implement policies to support breastfeeding in the target community from 0 to target.	6
A.12: Increase the number of new community gardens and/or increase the number of existing community gardens that are strengthened in the target community from 0 to target.	3
A.13: Increase the number of [cities; counties] with improved public transportation options for accessing healthy food and beverage environments in the target community from 0 to target.	0
A.14: Increase the number of [outside of school care providers; group homes; other—please specify] that offer healthy food and beverage options in the target community from 0 to target.	3
A.15: Increase the number of [K-12 schools; other—please specify] that increase SNAP enrollment from 0 to target.	1
A.16: Increase the number of [K-12 schools; outside of school care providers; substance abuse facilities; faith based organizations; worksites; prisons; group homes; government agencies; military facilities; veteran facilities; other—please specify] that develop and implement a healthy cooking and/or nutrition curriculum from 0 to target.	0

Secondary Objectives	Total Projects Selecting
Primary Objective B: Increase the number of people with improved access to opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from 0 to target by the end of the project period.	
B.1: Increase the number of new [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; cities; counties; non-profit organizations; worksites; farmers markets; grocery stores; other—please specify] referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to target.	0
B.2: Increase the number of new [other—WIC agencies] reimbursed by Medicaid and/or private insurance for (a) nutrition services provided by nutrition staff (including weight management, diabetes management, etc.), (b) breastfeeding services provided by WIC staff, and/or (c) new chronic disease prevention and management services that already have existing billing codes in the target community from 0 to target.	2
B.3: Increase the number of new [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; cities; counties; non-profit organizations; worksites; farmers markets; grocery stores; WIC agencies; other—please specify] that are integrated into a strong referral network* in the target community from 0 to target.	7
B.4: Increase the number of new [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; other—please specify] that make “prescriptions” for non-pharmaceutical interventions like exercise and WIC in the target community from 0 to target.	7
B.5: Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; non-profit organizations; worksites; other—please specify] with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to target.	10
B.6: Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; non-profit organizations; worksites; other—please specify] with providers and/or staff that receive cultural competency training in the target community from 0 to target.	1
B.7: Increase the number of new [dental offices; health insurance companies; hospitals; mental illness providers; pharmacies; primary care providers; other—please specify] that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to target.	1
B.8: Increase the number of [cities; counties] with improved public transportation options for accessing chronic disease prevention and management services in the target community from 0 to target.	0
Primary Objective 3: Increase the number of public and partner messages showcasing CPHMC project efforts and achievements from 0 to 24 by the end of the project period.	
C.1: Increase the number of public messages on CPHMC efforts and achievements from 0 to 12 by the end of the project period.	15
C.2: Increase the number of partner messages on CPHMC efforts and achievements from 0 to 12 by the end of the project period.	15

IV. Findings

FINDINGS: COALITION BUILDING AND COMMUNITY ENGAGEMENT

Since the primary focus of WIC is to provide nutrition services directly to participants, working on community-based PSE activities is a relatively new endeavor for many local WIC agencies. The most common community-based activity for local WIC agencies is to establish referral systems with Head Start, healthcare providers and community service organizations. Other WIC agencies have undertaken efforts to improve the retail food environment for WIC participants through policy and environmental activities with grocery stores; however, these efforts are often led at the WIC State agency level rather than by local agencies. Some agencies have worked on initiatives to expand farmers markets in low-income communities or strengthen community breastfeeding support through changes in hospital policies or efforts related to worksite breastfeeding accommodation for working mothers, but such activities are the exception rather than the norm. For many of the WIC agency staff involved in the CPHMC project, this was their first experience leading efforts to implement PSE activities to improve food and beverage environments or strengthen linkages to chronic disease prevention and care services. It was also a first large-scale effort to engage with partners to achieve these objectives.

As the first step in coalition building and community engagement, local projects were required to develop a project leadership team comprising local WIC agency staff, a healthcare provider and a WIC participant or patient representative. Although ACOG provided assistance with identifying a healthcare provider for the team, recruiting a provider who could commit time to the project was a challenge for some projects. Next, it was necessary to either form a community coalition or join an existing coalition(s) that would work together on the project objectives. Coalition members served as a part of the project governance and provided advice to the team over the course of the project. Finally, the projects were required to conduct a community needs assessment and develop a CAP with secondary objectives targeting specific settings and populations in their community.

Many of the secondary objectives selected by the projects required them to form partnerships with community providers, organizations and businesses with which they had not had much prior engagement. Partners were typically implementation sites or organizations that were the focus of the intervention implementation. For example, projects selected objectives targeting:

- Local employers to provide support for breastfeeding employees or provide space within the business for customers to breastfeed;
- Farmers and food retailers to develop new farmers markets, mobile markets or other approaches to increase healthy food access;
- Hospitals and healthcare providers to improve breastfeeding support through changes in policies and practices; and
- Food banks and pantries to increase healthy food choices and promotion of those choices through recipes and signage.

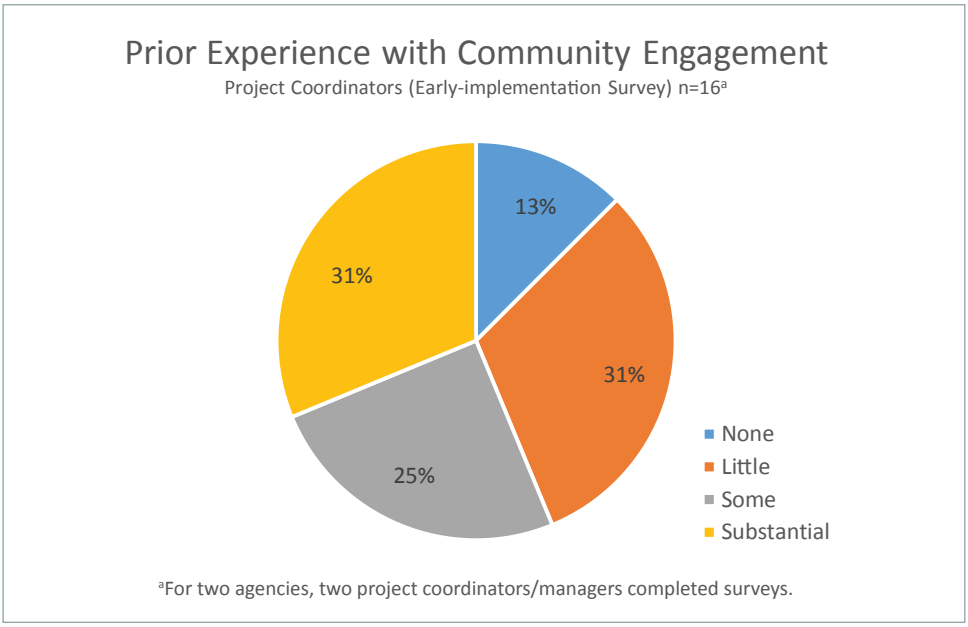
One aspect of the evaluation was to examine how well-prepared the local project teams were to form partnerships and conduct these new PSE activities. Questions were included in both the early implementation survey and interviews to gather information from project leadership teams including:

- Experience with community engagement and building coalitions and partnerships;
- Experience with implementing PSE; and
- Pre-implementation attitudes pertaining to how well their coalition and partnerships would work to support their efforts in achieving project objectives.

A. Project Team Prior Experience with Community Engagement and PSE

Community engagement and coalition building in support of the CPHMC project were critical steps in the development and implementation of the CAP. Local projects were encouraged to join existing, relevant coalitions in their communities or establish a new coalition for the project if there were no existing coalitions. In the early implementation survey, project team members were asked about their prior experience with community engagement, which was defined in the survey as "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest or similar situations to address issues affecting the well-being of those people." As shown in Exhibit 3, 56% of the respondents who indicated they were project coordinators or managers had little or some experience in this type of

Exhibit 3. Prior Experience with Community Engagement



activity while 31% indicated that they had substantial experience. Only 13% reported having no prior experience with community engagement. The healthcare providers on leadership teams (n=6) reported similar experience levels, with most (66%) indicating they had little or some experience with community engagement.

Examples of community engagement experience shared in the early surveys by project leadership reflected a range of roles and experiences prior to the project initiation. Those with substantial experience reported:

"I'd been a community organizer in this community prior to taking on this role, and I also worked in stakeholder engagement prior to that."

"Participated in a CDC Transformation Grant for lowering incidence of chronic disease through a local health department. Familiar with some of the sustainable/ environmental/community coalition methods of implementing the strategies. Was involved with the survey of community members, coalition work, and intervention selection."

"I have chaired various coalitions over the past 10 years (local and state) and much of the success of the coalitions has been through community engagement. I work in public health, so in order to do the work we do to elicit change, we need to work collaboratively with community partners."

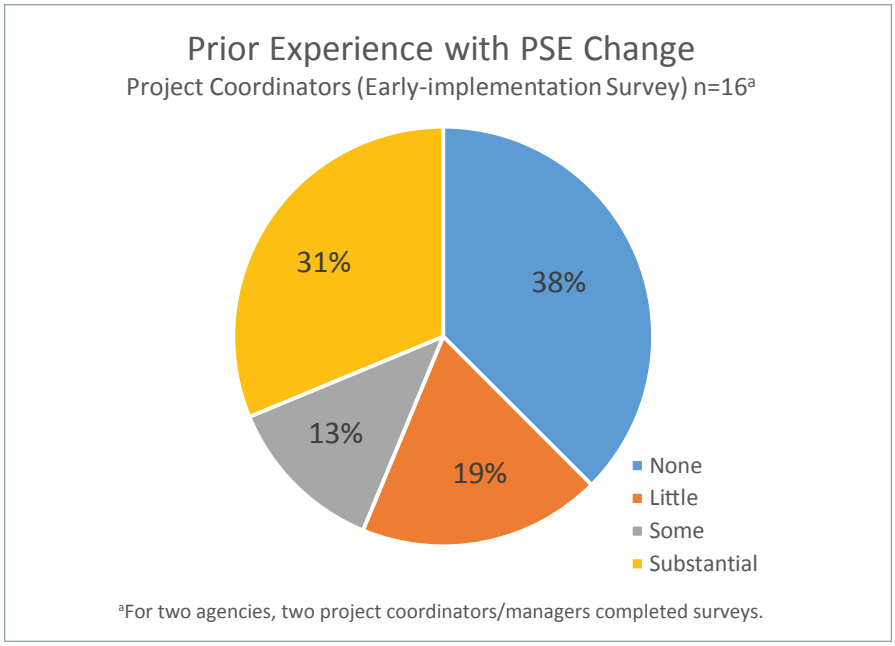
Some project coordinators were much newer to community engagement, with academic experience being their primary background.

"I am fresh out of college so I had education on this… not professional experience."

"This was my first position in public health and also my first position involved with community engagement."

Prior to the CPHMC project, the project leadership team members also had differing levels of experience in implementing projects focused on PSE. As illustrated in Exhibit 4, in the early-implementation survey, just over one-third (38%) of the project

Exhibit 4. Prior Experience with PSE Change



coordinators reported that they had no experience implementing PSE activities. Another third (32%) had little or some experience, while 31% reported having substantial experience. For healthcare providers (n=6), the percentages followed a similar distribution, with 33% reporting no experience implementing PSE and the remainder reporting little, some or substantial experience.

Comments related to experience with PSE from project coordinators include:

"My position at the health department focuses on creating PSE changes in the areas of nutrition and breastfeeding."

"I was new from college and hadn't yet entered the full time workforce."

"As a breastfeeding peer counselor there were a few times I took part in meetings with the local hospital encouraging improvement on their breastfeeding policies."

B. Project Team Confidence

Early in the project, the project coordinators were asked about their confidence in being able to create community coalitions that had the right mix of organizations and that would support project implementation. Four areas were examined, including how confident they were that:

- The project's needs assessment identified key needs in the community;
- The important partners and stakeholders were identified in the community;
- The project had developed or could develop partnerships that would support the goals and activities of the project; and
- The projects goals and activities were easily explainable to community partners and stakeholders.

Over half of the project coordinators (n=16) reported on the pre-implementation survey that they were "very confident" that the needs assessment identified key needs in the community (56%) and three-quarters (75%) reported that they believed they had identified important partners and stakeholders. Three-quarters of project coordinators also responded that the project had developed or could develop partnerships to support goals and activities of the project and that the project's goals and activities could be explained to partners and stakeholders.

This high level of confidence in building and working with community partners is an important factor in the early stage of PSE projects. Given that the experience level in community engagement and with PSE was somewhat limited for many project team members, going into the project with a positive attitude likely helped to get these projects off to a good start. The solid foundation and attitudes of project staff early in the project may have contributed to the positive results described later in this report.

Positive experiences with engaging partners and building a coalition were shared by project coordinators during both early- and late-implementation interviews.

"Partners are very engaged, excited, and involved. Most of coalition partners live and work in their communities. They know their communities very well, which is extremely helpful for the project."

"It has been the people that have been added to our coalition after the fact that have been most helpful. They weren't really on our target of key stakeholders, and they have been really the most helpful."

"I think they stayed engaged [because] we didn't just go do our own thing, but they had the opportunity to engage in that conversation and what we should prioritize as a coalition."

"We were a sub-committee of a coalition that already existed…the people that work in health districts have been there for a while so they had all these relationships that they were kind enough to share with us. They had a ton of experiences as well… they've been working on [PSE] longer than we have, so they shared lessons learned and pointed us in the right direction."

C. Experience with Building and Maintaining Coalitions

As noted previously, engaging others in the community to participate in a coalition and as project partners was a key foundational activity for these projects. Coalition members recruited for the project included representatives of organizations within the community who provide services to similar client groups, whose goals or activities were similar to the CPHMC objectives or who could contribute to the overall planning and implementation of the project objectives. Examples include Head Start programs, YMCAs, food banks/pantries, SNAP-Ed programs, healthcare providers or clinics, farmers market sponsors, and others that joined with the WIC agency to plan and implement project objectives and activities.

At the time of the early-implementation interviews, all projects had already established coalitions for their CPHMC projects. Eight local agencies integrated the project into an existing coalition or as a subcommittee of an existing coalition, such as a food access coalition, a chronic disease prevention coalition, a breastfeeding coalition, and a health disparities coalition. The other seven local agencies started new coalitions specifically for the project. When asked to describe the strategies they used to build and maintain their coalitions, the majority of project coordinators who created new coalitions shared that they came together initially with a few key partners and then identified additional individuals or organizations that would be a good fit for strategic partnerships and

alignment of goals. Projects described using one-on-one calls and other outreach activities to bring in new stakeholders and several commented on the importance of empowering coalition members to invite others who they believed should be at the table. One project described this as a "member plus one" approach; and projects that used that strategy noted it was highly successful.

> *"I got my team leaders out of the [first meeting]…I encouraged them to bring at least one person to the first coalition meeting. We have grown from 7 to – we now have 55. That is something I would highly recommend, and it just happened naturally... Now everybody on the coalition is thinking about, who's not at the table, what voice is not being heard? Who knows someone who might know someone that would represent it…which keeps things fresh, keeps new ideas coming, and keeps the [coalition] founders engaged."*

Still, not all projects felt that building or joining a large coalition was best for their projects. One coordinator shared that she felt the project was more successful with a smaller, tighter coalition.

> *"We kept it a little bit smaller core group, which I think was really a smart choice for us, because there are so many coalitions out there…they were all informed of our group. They all knew we were here. They all knew our goal. These other coalitions outside of our coalition, so yeah, kind of like support groups for our coalition. ...we really kept it smaller in order to make sure we weren't continually talking about something that just wasn't happening yet, if that makes sense."*

When asked about resources for building and working with coalitions, many projects noted that NWA's training and materials on strategies for partner engagement were helpful.

> *"NWA provided a list of 'these would be the type of people that would belong in a coalition' and we looked at that, and then we started to ask around about who might fit in these different categories. So we tried really hard to make sure we had diversity in our coalition based on that guidance. And I think there was some nice training around coalition building."*

Two projects mentioned developing an infographic for coalition members as a way to share information about the project and help members better understand the coalition's objectives and expectations. Other activities and methods of engaging coalition members in understanding the project and role were also described.

> *"We created a 1-page infographic about the grant. In addition to an invitation, they received an infographic so that they would very easily see that this is what the grant was about and decide on their participation."*

"I like the activity [the coordinator did] at one of the coalition meetings where [she] put up on the board a bunch of different sectors in the community and people wrote what they fell under. Then you could see where the gaps were. Then, I think it was good to have the coalition members suggest people to fill in those gaps, and then have the coalition member be the one that reached out to them – someone that they knew so it wasn't a cold call."

In early-implementation interviews, project team members were asked how receptive and involved coalition partners had been while planning and implementing project activities. The majority of projects shared that most of their members had been supportive of project goals and eager to engage in the work once they joined the coalitions. As mentioned above, just over half of the coalitions existed prior to the CPHMC project. This existing support and infrastructure may have helped with engaging coalition members, as described by one project team member.

"We had an existing Chronic Disease Prevention Coalition that has already established strong community partnerships. The project has allowed us to expand into subcommittees to work on the objectives, which has brought additional partners to the table."

The projects were asked about the issues or challenges they faced when working with their coalitions. Project coordinator responses from the Cohort 2 late-implementation survey indicate that more than half (57%) did not encounter barriers relative to building a new coalition or integrating into an existing coalition, while just under half did (43%). Primary issues described by those that experienced challenges included 1) time constraints associated with developing a coalition and working with the coalition to implement project goals and objectives, 2) challenges with members committing to the coalition (particularly with healthcare providers) and finding times when all members are available to participate, and 3) alignment with members' interest, capacity, priorities, and project timelines.

"We've been using our existing coalition members on the strategies where they fit in…I can't imagine [starting a coalition from scratch] – it's been so overwhelming with the time."

"We were very sensitive to what made sense for our community members, but it didn't always match the timeline for the project."

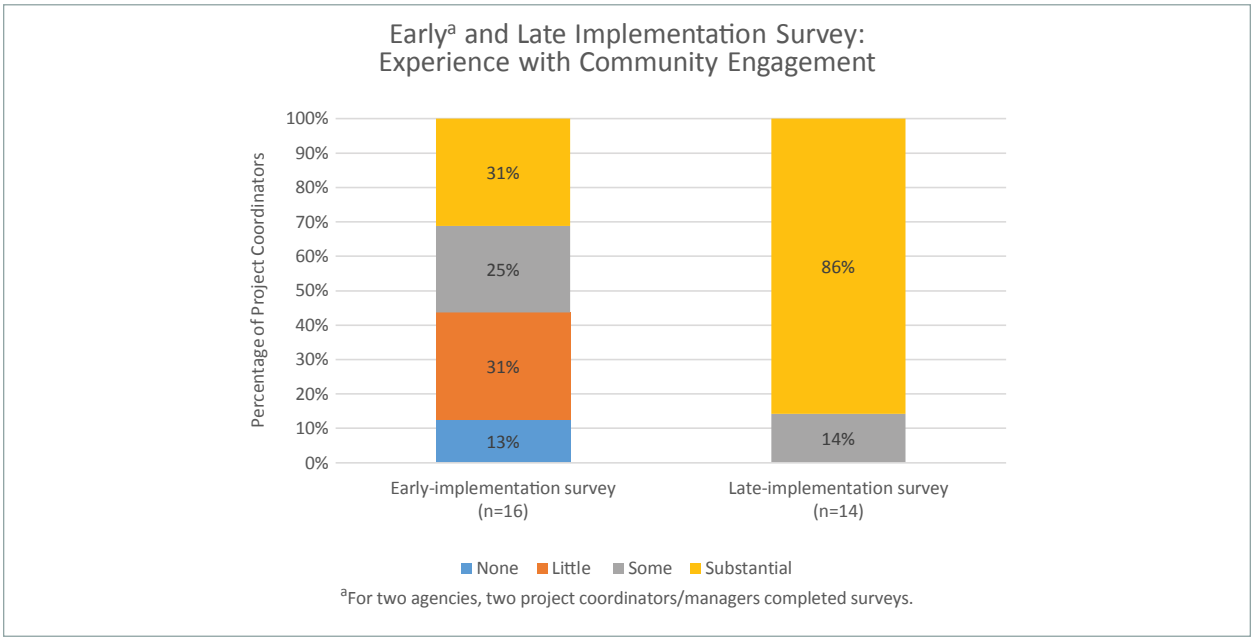
"Although our OB/GYN provider was pretty consistently there, we started with pediatricians there too, and the feedback I got was, 'it's just hard to come,' and, 'If you schedule way far out I can try to arrange my schedule.'"

"Our focus changed more than once over the course of the effort. So that kind of speaks to why the coalition didn't really gel, because there were different focuses."

"Some people became disenchanted when the money wasn't available in the beginning or their ideas/agenda wasn't chosen."

At the conclusion of project implementation, project team members were asked a question similar to the one they had answered on the early-implementation survey regarding the level of experience they had in the area of community engagement. As shown in Exhibit 5, a strong majority of project coordinators (12 out of 14 respondents) indicated on the late-implementation survey that they now felt that they had substantial experience in community engagement.

Exhibit 5. Early and Late Implementation Survey: Experience with Community Engagement



The late-implementation survey also asked project teams if their coalitions would continue to work together upon completion of the CPHMC project. Over three-quarters (79%) of project coordinators shared that they planned to continue to meet after the completion of the project, with 21% expressing uncertainty. Many positive impressions on coalition successes and future efforts were shared and are described later in this section. Comments from two projects reflect their expectation about continuation of coalitions.

> *"I am transitioning our coalition, because we've gained so much momentum and we have so many members and it's great for our community and I want to keep it…[the city] received some funding…and they are going to use my coalition as their health advisory board."*

> *"The coalition just went through the strategic planning process… it's a very strong coalition, and I hadn't even been at the last two meetings…they just move forward, follow the agenda, make things happen, and people come…they're making connections with other organizations to implement their projects."*

While most projects were optimistic about the future of the coalitions that worked on the CPHMC project, some shared concerns around sustainability due to uncertain funding and leadership.

"I'm fully funded by this grant so I don't even have a guaranteed job after late June… I'd like to say yes, and we'll continue to work on topics that we've been pursuing, but I think in all honesty that we may not meet as a coalition unless we get that funding."

D. Experience with Engaging Partners to Implement PSE Changes

In addition to coalition members, the projects needed to engage community partners to support and/or implement project activities. Engaging community partners is often more challenging than working with coalition members because the partners must typically be involved in making the desired PSE changes within their own settings to facilitate project success. In other words, they often must change "the way they do business."

In the late-implementation survey, project coordinators were asked if they had identified the right partners in order to be successful. Responses were positive—just over half (8 of 14 respondents) shared they were "very confident" that they had identified the important partners and stakeholders in their community, while 5 others were "somewhat confident," and one was neutral. One shared that her past experience in community engagement was beneficial.

"I think because I had 10 years of volunteer work already in the community, some key people who then could invite others who I didn't know at all, trusted that I wouldn't be doing something that wasn't well thought out or that I wasn't going to stick behind, I'm sure that made a difference."

"Our partners/stakeholders are committed to continuing the work begun in the grant so I feel they were appropriate choices."

Project team members were also asked in late-surveys if they encountered challenges in trying to engage partners or stakeholders to assist with their project. There were three primary challenges with partners, some of which were similar to challenges described for engaging coalition members.

1. A majority of respondents shared challenges related to time constraints, e.g., partners had competing priorities, different expectations about timelines and limited capacity to attend meetings or participate in activities. Several projects mentioned in particular that they wished they had more consistent participation from healthcare providers, but recognized that their time was limited.

"Even with our connection with the nurse practitioner, to get into the physicians' offices, to do a 10-minute update on WIC and health department services and explain how we'd like to use the Rx for Healthy Families referral system was a challenge."

"Time. We wanted to move our partnerships and our work along for the grant period, but our partners weren't working on the same timeline."

"It would have been beneficial to have more engagement from the healthcare community. The interest was there and the intentions were good, but it…[the provider's] time was constrained and she gets pressed for time because of the lack of OB/GYN providers in [our county]."

2. Three projects discussed a lack of trust or a reticence to join in partnerships or be part of the coalition, particularly in the early project phase. Some of these challenges were overcome through persistence and a commitment to building trust.

"I will say, it was kind of hard to get people on board. Our community has a lot of social programs… and a lot of community engagement. Starting a new group and project and asking people to take part – people were wary of one more group, one more meeting. We were really kind of having to prove that this is going to be worthwhile to the people who would take time out of their day and work with us."

"Having the coalition back us was the biggest challenge we overcame…[we gained their trust by] showing up at every meeting, having conversations outside of the meeting, checking in with them throughout the month, going to their projects and their events that they were holding, and just showing them that the work was getting done, regardless of the coalition doing it themselves or not. Once we started showing them how many businesses wanted to be breastfeeding-friendly, they really started to get the idea 'wow, we're really going to make a change, and this is going to be a great change for the community.' "

3. Sustained participation of partners and follow through were noted to be challenges. In some cases this was due to challenges committing to or following up on tasks; in others it was related to factors such as partnerships dissolving or a hospital filing for bankruptcy.

"Getting our coalition and partners on board was a little difficult because they didn't understand the idea of actively working on projects, versus updating each other every month on what they've done."

One project discussed how it had been able to achieve better follow-through.

"Accountability. We finally, after about 6 months in, we'd end our meetings with a to-do list, and we'd all name it, so if I was in charge of farmers market dates, I'd put my name on, sign off, so that I could put my name on it, and I could sign off, so that at the next meeting they could say, okay Sarah, where are we with this?"

E. Perspectives of Coalition Members and Partners

As a part of the eight site visits for Cohort 2, coalition members and partners were interviewed to learn their perspectives on project successes and challenges. Interviews were conducted with staff from Cooperative Extension offices, pediatric practices, Head Start programs, business owners, the YMCA, librarians, farmers market organizations, and others.

Coalition members and partners were overwhelmingly positive about their experiences with the project, emphasizing the tangible outcomes they had achieved during the short grant period. The overall value of participation took many forms.

"It would probably have taken us 10-12 years to get that kind of level of collaboration we got with this project, and I so believe that. I just saw the road we were on—I'll call it the 'fits and starts'. We were getting conversations, and we were heading in a direction, but we were spinning, we were spinning….and this [project] allowed us to just go. It was awesome."

"It was just such a positive thing, a positive movement for our community….I'll say for all these different perspectives – it benefitted the farmers, it's benefitting the doctors, the WIC clinic and the community, the customers that are taking advantage of all of it…all around it was a neat experience for me and for the community as a whole."

"It's been a great partnership. The two mobile grocery stores allow us to ensure that low-income families that live in underserved areas have access to healthy foods. Our coalition members stepped up by volunteering their sites for mobile grocery store stops, thus providing their clients with reliable access to fresh fruits and vegetables."

Some coalition members and partners described skills and knowledge they had gained from being part of the project.

"I took part in a lot of coordinating with grocery stores and tours and participants. Getting out of my comfort zone, teaching a lot. I found it to be very empowering in my own life too – knowing I can do this."

"I've enjoyed the experience. That's one of the meetings that I like going to just because of the energy alone – that kind of feeds me too. It pushes me to pursue other things that I may never, I probably never would have pursued, because I did not have the interaction from these folks."

Many comments centered on the relationships and partnerships that were fostered, which they felt were invaluable and would last beyond the end of the project.

"The coalition is a networking meeting, it brings together people from different groups – then we can share ideas, somebody will say, 'oh, I can get involved with that, you can do that.'"

"Networking and building partnerships…that's what worked for all of our different work groups. The grocery stores could connect with teaching kitchens, and the teaching kitchen then connected with the farmers markets…just that full circle."

"It was so important – for providers to have a way better understanding of all the services that WIC provides beyond that [food] check… [Providers] always came away with…a better, or more positive, or more enhanced view of the WIC program."

FINDINGS: PROJECT IMPLEMENTATION EXPERIENCE

The evaluation of CPHMC Cohort 2 project implementation assessed the following five areas:

- Achievement of project setting and reach goals established in the CAP;
- Perception of project staff regarding how well they achieved their secondary objectives;
- Project successes;
- Challenges faced by projects and if/how they were overcome; and
- Extent to which projects felt satisfied with project outcomes.

This section summarizes the collective findings across Cohort 2 projects. Individual project outcomes and success stories can be found on the Greater with WIC website at www.greaterwithwic.org. A profile of each project is included in Appendix C.

A. Success in Achieving Target Setting and Reach Goals

As described in the Section I of this report, Cohort 2 projects set a goal or target for the number of settings they anticipated they would affect through each secondary objective selected. Each project also provided an estimate of the number of people who would be reached. Projects then reported on the number of settings and the number of people reached through implementation of project activities. Table 6 shows the overall success of the Cohort 2 projects in achieving setting and reach goals for secondary objectives. For three objectives, setting and reach numbers achieved were not reported.

It is important to note that settings and reach are independent variables. Unlike direct services where the number of settings will impact directly the number of people served, PSE changes target a broad group of people in a particular area. For example, if a project wanted to improve the community's access to healthy foods in a specific area, it may have targeted three stores in which to increase the availability of healthy foods. If only two of the stores implemented the intervention, the entire community may still have been reached; while they did not meet their target for settings, they may have met their target for reach.

Across all Cohort 2 projects for objectives reported, just over one-third of the setting targets were achieved or exceeded (35%) and about two thirds of the reach targets (65%) were met or exceeded. Secondary objectives for Primary Objective A had a higher rate of success for meeting target settings (43%) and target reach (79%) as compared to Primary Objective B, which met 17% and 33% respectively. For targets not achieved, there was significant progress toward meeting the goals. Section B following Table 6 presents project staff perspectives on achieving objectives and target goals.

Table 6. Target Setting and Reach Goals and Results

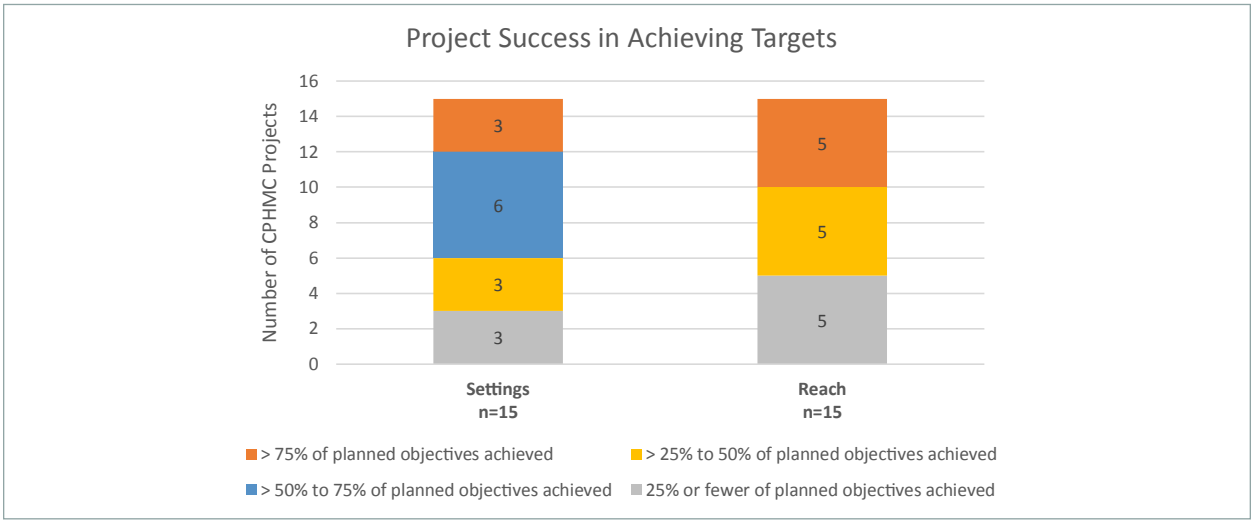
Secondary Objective	Number of Agencies	Target Settings	Target Reach	Settings Achieved	Reach Achieved	Target Settings Met?	Target Reach Met?
Primary Objective A: Increase the number of people in <target community> with improved access to environments with healthy food and beverage options from 0 to <target> by the end of the project period.							
Increase the number of [grocery stores; convenience stores; food banks; mobile grocers] that sell healthy foods and/or expand their inventory of healthy foods in the target community from 0 to target.	2	15	9352	26	3136	Yes	No
Increase the number of [grocery stores; convenience stores; food banks] with new onsite and in-store placement and promotion strategies for healthy foods in the target community from 0 to target.	8	35	416366	24	421085	No	Yes
Increase the number of new [grocery stores; convenience stores; farmers markets; other—mobile grocers] that accept WIC in the target community from 0 to target.	3	6	15339	1	50	No	No
Increase the number of new [grocery stores; convenience stores; farmers markets; other—mobile grocers] that accept SNAP in the target community from 0 to target.	2	2	38213	1	167268	No	Yes
Increase the number of new [grocery stores; convenience stores; farmers markets; other—mobile grocers] that offer cash or coupon incentives for purchase of healthy foods in the target community from 0 to target.	2	5	77753	17	133406	Yes	Yes
Increase the number of new [farmers markets; food banks; other—mobile grocers] in the target community from 0 to target.	4	11	191943	8	226743	No	Yes
Increase the number of [restaurants/bars; hospitals; other—please specify] with new healthy menu options and/or using nutrition labeling to identify healthy menu options in the target community from 0 to target.	2	19	72460	18	102857	No	Yes
Increase the number of new K-12 schools that make plain drinking water available throughout the day at no cost to students in the target community from 0 to target.	1	81	74400	91	78600	Yes	Yes
Increase the number of new [hotels/motels; entertainment venues; grocery stores; restaurants/bars; other—please specify] that publicly promote/welcome breastfeeding in the target community from 0 to target.	5	71	285762	69	597749	No	Yes
Increase the number of new [K-12 schools; outside of school care providers; dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; faith based organizations; worksites; prisons; group homes; government agencies; military facilities; veteran facilities; other—please specify] that develop and/or implement policies to support breastfeeding in the target community from 0 to target.	6	145	27396	120	18016	No	No

Secondary Objective	Number of Agencies	Target Settings	Target Reach	Settings Achieved	Reach Achieved	Target Settings Met?	Target Reach Met?
Increase the number of new community gardens and/ or increase the number of existing community gardens that are strengthened in the target community from 0 to target.	3	11	2737	15	38159	Yes	Yes
Increase the number of [outside of school care providers; group homes; other—please specify] that offer healthy food and beverage options in the target community from 0 to target.	3	22	20752	13	21020	No	Yes
Increase the number of [K-12 schools; other—please specify] that increase SNAP enrollment from 0 to target.	1	80	74000	1	78000	No	Yes
Increase the number of [K-12 schools; outside of school care providers; substance abuse facilities; faith based organizations; worksites; prisons; group homes; government agencies; military facilities; veteran facilities; other—please specify] that establish a new healthy food home delivery program.	1	1	1000	1	1000	Yes	Yes
Total		**504**	**1,307,473**	**405**	**1,887,089**		
Primary Objective B: Increase the number of people in <target community> with improved access to opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from 0 to <target> by the end of the project period.							
Increase the number of new [other—WIC agencies] reimbursed by Medicaid and/or private insurance for (a) nutrition services provided by nutrition staff (including weight management, diabetes management, etc.), (b) breastfeeding services provided by WIC staff, and/or (c) new chronic disease prevention and management services that already have existing billing codes in the target community from 0 to target.	2	2	8668	0	0	No	No
Increase the number of new [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; cities; counties; non-profit organizations; worksites; farmers markets; grocery stores; WIC agencies; other—please specify] that are integrated into a strong referral network* in the target community from 0 to target.	7	192	511471	170	484879	No	No
Increase the number of new [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; other—please specify] that make “prescriptions” for non-pharmaceutical interventions like exercise and WIC in the target community from 0 to target.	7	72	530737	64	576922	No	Yes

Secondary Objective	Number of Agencies	Target Settings	Target Reach	Settings Achieved	Reach Achieved	Target Settings Met?	Target Reach Met?
Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; non-profit organizations; worksites; other—please specify] with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to target.	10	292	1135034	160	432986	No	No
Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; non-profit organizations; worksites; other—please specify] with providers and/or staff that receive cultural competency training in the target community from 0 to target.	1	10	49628	12	175605	Yes	Yes
Increase the number of new [dental offices; health insurance companies; hospitals; mental illness providers; pharmacies; primary care providers; other—please specify] that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to target.	1	1	120	0	0	No	No
Total		**569**	**2,235,658**	**406**	**1,670,392**		

Across all projects, the total target numbers for settings and reach for each secondary objective in the CAP were compared with data on settings and reach achieved in project reports. For settings, nine projects (60 achieved over half of their targets for settings, while six (40%) achieved half or less of their setting targets. For reach, five projects (33%) achieved more than half of their reach targets for secondary objectives and ten projects achieved half or fewer. Exhibit 6 shows the number of projects that were able to achieve their planned targets for settings and reach.

Exhibit 6. Project Success in Achieving Targets



Projects that were integrated with an existing coalition were compared to those that had to build a new coalition to explore whether joining a coalition may be an advantage in achieving targets. The results for overall achievement of setting and reach targets for the eight projects that had an existing coalition were very similar to the results for the seven projects that started a coalition for the project. While joining an existing coalition can be beneficial relative to less time spent recruiting members and organizing, efforts to integrate a new project into a coalition that has history with other objectives and priorities requires time for building relationships and connections with the coalition.

B. Project Staff Perceptions

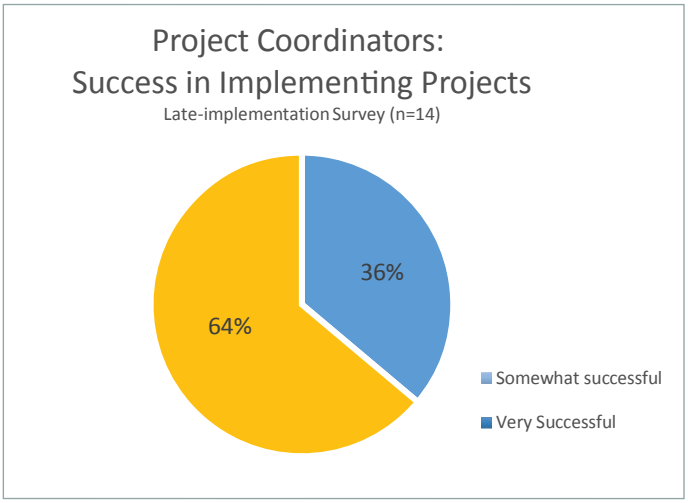
Project team members were asked on the late-implementation survey how successful they felt their projects were overall in implementing the interventions for secondary objectives and achieving successful project outcomes. As illustrated in Exhibit 7, a majority of project coordinators (9 out of 14) indicated they felt they were extremely successful, while over one-third (5 out of 14) felt that they were somewhat successful. None reported feeling neutral or not at all successful about their project initiatives.

Key themes emerged across all Cohort 2 projects regarding factors that contributed to project success. These themes were reported through late-implementation surveys and interviews and are described below.

1. **Engagement of a committed and collaborative project team and coalition.** This topic resonated across a majority of projects as an important strategy for eliciting topical expertise, connecting with the community and accomplishing goals through shared efforts. Project coordinators shared that it was important to build trust among project coalition members and to work toward shared priorities and goals in which members were able to actively participate. They also noted that committed coalition members were a key component to sustainability.

"Having doctors on our workgroups and former city developers, and farmers, and dieticians, having all of those different perspectives…it's just so important to make it work. I think that lends itself to the sustainability of it, because if this organization no longer has funding to support the workgroup, you have all of these other people who are invested in it….to see it go forward."

Exhibit 7. Project Coordinators: Success in Implementing Projects



"Having those two [WIC participants] as a part of these leadership team meetings has been fantastic. And I think we've done things differently and come up with ideas differently because they sit here with us every single time we meet. They are wonderful. We maybe go a different direction, and they're like, 'No, we don't really think that. We would never use that. Don't do that.'"

"Our coalition has been a thriving coalition for several years…whenever we wanted to implement something it moved forward very quickly."

2. **Cooperation and engagement of program partners.** Many of the project successes were attributed to the willingness, commitment and capacity of community partners to participate in project activities. Partners that were identified as being very supportive included farmers markets, grocery stores, Cooperative Extension programs, WIC clinics, and food banks. Healthcare providers were often noted to be challenging to engage due to time constraints; however, when projects achieved success in engaging healthcare partners, they noted them to be highly successful and influential. The engagement of certain partners often dictated the focus of secondary objectives and influenced project success.

"For the prescription pad, getting a better sense of providers' perspectives by having them on the team has opened up my eyes to what they need and what they're seeing at their clinics."

"Because we were able to partner with [our local] University, we had this whole team of students and they were wonderful. So it was a way to staff projects that we just wouldn't have been able to do without that partnership, so they were really a key to our success."

3. **Support from leadership.** Several project teams cited organizational support as important in their success and instrumental in keeping their projects moving forward. Projects in agencies with strong leadership and support reported they were more equipped to meet project objectives than those in agencies that were short-staffed or unable to provide support. This was noted to be particularly significant when the project contract and funding were delayed as some agencies were able to offer interim funding. One project reported that support from its state health department contributed to success.

> *"Because we've been able to accomplish so much, it's really shifted the health department's focus in understanding that we have to be thinking about population health, health in all policies, and how to work that into the structure that we currently have…We have a lot of support from the health director for all of these initiatives and they're a priority for him also."*

> *"Our state department of public health was a really great partner. Our breastfeeding coordinators were really involved and provided a lot of insight and suggestions that were really helpful. They're the WIC breastfeeding coordinators…who were invested in our project."*

While project team members identified key factors that contributed to success, there were a number of factors that presented challenges to meeting project objectives. Some are reflected in prior sections detailing issues with coalitions and partnership development, while others relate to administrative processes and project management. Below are some of the common challenges expressed by project coordinators.

4. **Recruitment or retention of coalition members and partners.** As discussed previously, the most common barrier was a limitation in others' available time or capacity to participate. This included an inability to attend coalition or other project meetings or lack of follow through on activities outside of meetings.

> *"There are a lot of nonprofit organizations in our community, and a lot of ongoing collaborative efforts, coalitions, task forces, etc. This is certainly an asset, but I think it was also a challenge because people are wary of joining yet another coalition and committing to yet another regular meeting."*

> *"Coordinating times to meet with local pharmacies and daycare centers was challenging at times due to busy schedules and lack of staffing."*

> *"I think with this current budget climate that everybody…needs to make sure that they're okay, they're doing the right thing, and they're working on things they know funding will continue on. You know, we're out there saying, while you're doing all that, why don't you write a new HR policy to become a breastfeeding friendly worksite. And it's like, that's a great idea, we'll get to that – later."*

"[It's] a challenge here for the healthcare provider and …for the nurse practitioner getting release time to come to meetings, to go to the trainings…when you have only one healthcare provider in a county, they're busy."

5. **Staff and partner turnover.** Turnover occurred both within local agencies and with coalition and community partners.

"My director left halfway through the project….the WIC director. We had hired two part timers and one left a few months into the project…and that was just so hard as we're putting them out in the community to do this work and have their face be known, and then to have all of this turnover…."

6. **Unrealistic project plans.** Several projects mentioned that they selected too many objectives or the wrong objectives in the project planning phase. Three projects specifically mentioned that they wish they had scaled back the number of objectives they chose for the project and that they had been naïve about how challenging it would be to undertake everything they set out to do.

"[If we'd had] somebody saying 'you're really taking on a lot of objectives, and you might want to scale that down' that would've been helpful… but honestly, NWA said 'you should have one full-time person on [the project], and they were right."

"We were required to select our objectives from a pre-set list before we conducted the community needs assessment. This caused us to have to change focus [after the needs assessment] which impeded the progress and we essentially wasted our time on activities not relevant to our end focus."

Similarly, some projects said they felt the one-year timeline was too tight to fully undertake the project activities they hoped to accomplish.

"I feel we should be given more time with the grant to be able to get more accomplished."

"We were hindered by the timeline of this grant and a budget delay."

"It was a lot of work in a short period of time."

7. **Project delays leading to inaction and disengagement among partners.** Nearly all projects mentioned that delays in funding were frustrating. This was most challenging for smaller agencies that were unable to support the project financially prior to the contract being in place. Some project coordinators found it hard to maintain relationships with coalition members and partners and keep them engaged when project activities were delayed.

"Delay in funding in year one frustrated some coalition members because we could not move forward with projects. Those coalition members no longer participate."

"Coalition members started to fade away….people are tired talking about it. They're like, 'We don't get anything done.'"

"If I'm going to ask my partners to engage in this work with me, I need to be really clear about what it is, what my expectation is of them, what I'm bringing to the table, and what I need them to bring to the table – and I haven't felt comfortable being able to articulate this to them [until we had the funds approved]."

"That delay was hard because my agency was not able to front money, so we were able to start conversations with community partners and members and say, 'We're gonna do this – but we're not sure when.' That certainly takes away from your credibility…."

8. **Burdensome or confusing administrative requirements.** About one-third of projects mentioned that grant reporting requirements were excessive and may have distracted them from project work. Some projects also said that the guidelines regarding acceptable project activities and expenditures were confusing. Several noted that they received helpful support from NWA; however, the required forms were confusing and unwieldy.

"Administrative requirements such as reporting and conference calls and meetings were not clear when we started the project - we would have hired more staff to handle this. Also, the form for monthly reporting only focused on 'sites implemented'. This was not compatible with our work effort."

"I feel like we spent a ton of time and energy on the administrative portions of this grant, but not a lot on the implementation – there is so much required, and it's so complex, and there's so much rigmarole and training, but it's training on how to complete the tasks, how to do the requirements, how to use the portal, how to use the forms."

"We had a lot of back-and-forth with the budget process, things that we thought we could submit for this grant, they said wasn't allowed. And that was really challenging from my perspective. At one point I just asked – can you just tell me what IS allowed…"

C. Project Implementation Successes

When discussing objectives that were implemented successfully during late-implementation interviews, project team members identified a number of strategies and interventions. Examples are described here with more included in the project profiles located in Appendix C.

Placement and Promotion Strategies for Healthy Foods

Several projects worked to create onsite placement and promotion strategies for healthy foods. Projects achieved success in these efforts through collaboration with local food banks, grocery stores and convenience stores. These strategies were executed in a variety of ways. For instance, several projects focused on promotion of healthy food items through signage, such as featured items each month, recipes, food demonstrations, and educational materials. One project worked to transition a food pantry to a self-selection format, offering additional healthy choices and recipes. Another project created a Healthy Foodbank Toolkit for Food Pantries to utilize in expanding efforts to promote healthy items during and after the project.

"The Healthy Food Bank Toolkit for the food pantries has really been received positively and is in demand. The toolkit is now up on the TCHD website, is soon to be up on the Hunger Free Colorado website, has been promoted across the state in the Hunger Free Food Pantry newsletter, and is going up on the NWA website."

"We found a grocer willing to work with us and we came up with a creative idea that has really worked in our community."

While project coordinators were pleased with their success in promoting healthy food, one project pointed out that, although they had increased access to healthy foods in their food pantries, the short timeframe for the project did not provide the opportunity to explore how this affected the selections made by clients. They suggested that future efforts build on what was started with this project in order to better support behavior change, and they intended to monitor participant behavior after the end of the project.

"The work that we've done is already influencing access to healthy foods, but we need people to actually be taking those healthy foods. So for us, we were increasing healthy foods in food pantries, but there hasn't necessarily been enough time when we would have seen a change in behavior yet…behavior change takes longer."

New Farmers Markets, Food Banks, Mobile Grocers

Multiple projects were successful in initiating new sources for healthy foods. Approaches to new food access opportunities varied and included new farmers markets, free farm stands for WIC participants and low-income community members, and a mobile market. These sources

were available at a variety of locations, such as Head Start programs, soup kitchens, WIC clinics, and other public spaces.

In addition to opening new locations, several projects worked with partners to develop, expand and coordinate services at local farmers markets. One project identified the need for a countywide app to better direct community members to the new farmers market as well as other area markets. The project also assisted a farmer to be certified to accept SNAP benefits and worked to create better signage for their area markets. Another project worked to promote and clarify the times when markets were available. Several projects found that transportation was essential for access to their farmers markets, and one was able to locate new markets near bus stops to better serve the community.

"With our Head Start, we increased access to healthy food with our free farm stand."

"Food access for us is a huge issue over here, and transportation is a big issue. So I think one of the successes, and one thing we learned, was you have to be very strategic about where you place your farmers markets because you want to make sure it's accessible for everybody."

"People wrote in a lot of surveys to [our organization] themselves just saying, how [farmers markets] really helped them in the summertime to access fresh fruits and vegetables….that they couldn't go to grocery stores, they normally go to gas stations [to buy food]."

Water Availability in Schools

One project sought to make water accessible in school classrooms. While the objective was intended for K-12, the school with which it partnered chose to start with children enrolled in the Head Start program as the team felt this age group would be most amenable to establishing the behavior of drinking water rather than other, less healthy beverages. Further, they were hopeful that these young students would continue this healthy behavior as they age. The school moved forward with a comprehensive strategy; the program included the purchase of durable water bottles for each student, the development of a graphic character, Captain Hydro, and the creation of a short video promoting drinking water. Each classroom committed to designated water breaks throughout the day and customized the water bottles for each child, allowing children to take ownership of their bottles.

The initiative required participation and engagement of many players in the school, including Head Start leadership, classroom teachers and cafeteria staff, along with additional financial support from a foundation. This collaboration was noted to be instrumental to the program's success and school officials indicated they expect it will continue with future students. The project also helped inspire changes in school wellness policies.

"I think we were most successful in improving drinking water access in the community because we had a great partnership with Head Start, and have been able to write all day water access into the updated wellness policy proposal for the entire school district. Our work has helped put the need the water promotion on many community stakeholders' radars."

Community Promotion and Business Support for Breastfeeding

Increasing breastfeeding accommodation in local businesses was a priority among many projects, and several that worked on this objective reported success working with the business community. One project was able to support and certify 17 businesses as breastfeeding-friendly, and worked with WIC peer counselors to institutionalize and expand the program beyond the end of the grant period. Several project coordinators reported building an important dialogue around the topic of breastfeeding in the community through promotional mechanisms, and two projects emphasized the importance of normalizing breastfeeding. Another project in an area with an American Indian population shared that they were able to connect with community and cultural values in breastfeeding communications.

Among those projects that found success with breastfeeding objectives, it was often noted that breastfeeding support was one of the easier and less resource-intensive objectives to achieve. They also reported that community promotion and support for breastfeeding was expected to continue to grow.

"Many of the organizations who had not thought about the importance of promoting breastfeeding started to think about why it is important and some began to publicly promote [breastfeeding]."

"The breastfeeding project to normalize breastfeeding is going well. We have many businesses signed up to be breastfeeding friendly…. billboards are in production, websites and articles etc. We have broken barriers with WIC and hospital communications, as well as many other things and there is a buzz now where it was silent."

"We're trying to get it in the forefront of peoples' minds, so that they think of breastfeeding when they think of chronic disease prevention."

While many project reported success, others faced challenges with regard to achieving partnerships with local businesses and advancing breastfeeding promotion. These issues will be discussed in Section D.

Development of Strong Referral Networks

Multiple projects shared achievements in clinical linkage activities and referral networks. Examples included training for healthcare providers on WIC services and referrals (often called "WIC 101") and onsite WIC enrollment and nutrition and breastfeeding support services. By strengthening providers' understanding and knowledge of the WIC program and local WIC services, their ability to connect their patients to services and resources was increased. Several program coordinators and partners noted that referrals between providers, programs and services improved as providers developed a better sense of local resources and opportunities. Five projects reported increases in participation at WIC clinics in the project communities ranging from a 1 to 20 percent increase from the beginning to the end of the project period. Strengthening referral networks and increasing awareness and understanding of WIC services may have contributed to the caseload growth.

"It was so important – for those providers to have a way better understanding of all the services that WIC provides beyond that [food] check."

"Breastfeeding was identified as a top issue facing mothers and children in our county, and many [providers] were eager to help create new supports within our community."

"Some of the partners did not know what WIC was – they didn't know what WIC entailed. And so, I think the WIC program here gained a lot more respect than it had before and we're seeing a large number of referrals coming in. We had over a 100 participant caseload increase since November of last year, which is huge for us because in our state nobody is increasing their caseload. Our providers are aware now of exactly what WIC is, and they're referring people through the partnerships, even our mental health providers with our non-pharmaceutical prescriptions."

Non-Pharmaceutical Prescriptions

Multiple projects worked to integrate non-pharmaceutical prescriptions into healthcare and community service organizations. Some of these projects worked to integrate prescriptions for physical activity, mental health services and healthy food, while others focused more specifically on fresh fruit and vegetables. Prescriptions were also utilized for referrals to a mobile market program.

Projects approached the development and implementation of prescription pads in different ways. In interviews, two projects emphasized the importance of piloting the pads with a small number of doctors to ensure that the prescriptions would successfully meet the needs of practitioners and patients. In this process, doctors proved to be important allies in the development phase, offering feedback and helping with the recruitment of other providers. One project had a work group, comprising WIC staff, a physician, home health workers, and a YMCA manager, to collaboratively develop the prescription pad and a protocol, including a motivational interview script for use in a clinical setting. Another project leveraged ideas from an existing prescription pad from another state.

> *"When we were doing the prescription pad, the main thing we said was 'I don't want to just do nutrition'. Yes, nutrition is important, but it's not everything – without movement or mental wellness, you're not going to get anywhere. I can't think of a section of health we haven't touched. We didn't touch pharmaceuticals, but we did that on purpose, we wanted a more holistic practice."*

> *"One of our objectives was a WIC Rx, so that providers would use that. Well, we had to use the term "provider" very loosely because – our wellness coordinator wanted to use those, our care navigators at the federally qualified health centers wanted to use them, the parks people want to use them. So, there's been nice participation and involvement with 'this is what it should be, what do we need on here so that this can be useful for all these different people?' "*

> *"We looked to other states that had it, so again we weren't starting from scratch. Minnesota had an Rx pad that they had shared. We looked at some other samples from cohort one. Other than that, we put our own spin on it, our own [County] logo, and locations on the back."*

Though projects reported being largely successful with non-pharmaceutical prescriptions, there were some issues reported. One project experienced what the coordinator described as a "turf war" due to a separate non-pharmaceutical prescription pad that was previously launched in the community. The prior efforts had faced some significant challenges, leading providers to be skeptical and the prior non-pharmaceutical program leader feeling that the project was trying to compete with its work. Another project wasn't able to accomplish fully what it set out to do because of time limitations, but had many interested community partners and expected to be able to proceed in the future. Another site was able to launch its WIC Rx and hoped to implement an evaluation, but was unable to do so during the project period.

Strengthening Breastfeeding Support in Healthcare Settings

Several project coordinators shared their successes in increasing breastfeeding support capabilities among healthcare providers. This was carried out by some projects through organizing Certified Lactation Counselor (CLC) training for staff in pediatric offices, youth clinics and WIC offices. As a result, multiple pediatric offices and clinics are able to offer onsite lactation services and expand the breastfeeding support network for mothers in their communities. Pediatric offices shared that this training enabled them to better support mothers through conversations about breastfeeding initiation and streamlined access for mothers for assistance with breastfeeding concerns. One pediatric office added Skype consultations for mothers who are unable to come to the office.

"We always found that, with a newborn baby, having those extra appointments were really challenging. Maybe she had a C-section and couldn't drive, or whatever. Being able to streamline into one visit at our practice has been very helpful."

"Our county benefited by becoming more breastfeeding friendly through this grant. We have 68 new CLCs who are out there supporting and talking about breastfeeding."

Some projects described success in changing breastfeeding policies and practices in healthcare settings. One project stationed a WIC lactation consultant at a pediatric clinic to provide breastfeeding support and enroll in WIC eligible patients referred by physicians. Based on the positive experience, the clinic intends to continue having a lactation consultant in the future. Another project described strengthening the breastfeeding support network in its community.

"We were most successful implementing the breastfeeding policies with our primary care providers. We expanded this and made this a system level change among public health, WIC, clinics, and hospital staff. We wanted to ensure we were all operating as one cohesive system. We were so successful because we had all key partners at the table and took our time with the process. We didn't rush it and we are continuing to ensure we have all gaps in services addressed, which typically means adding new partners."

Restaurant Initiatives

Several projects worked to address healthy eating for meals consumed outside of the home. These projects worked to enhance menu options at local restaurants and improve menu labeling and promotion to help customers recognize and select healthy items. The approaches varied and required different levels of effort from project teams and restaurants.

One project chose to recognize publicly restaurants that offer and promote at least three options that fit within the recommendations for the U.S. Dietary Guidelines. Another project took a more hands-on approach utilizing a Registered Dietitian to work directly with the businesses to identify healthy items on their menus with a nutritional analysis for verification. After identifying healthy menu options, promotion of these choices was important to increase customer awareness. Different promotional efforts were used, depending on what the restaurant partner was willing to implement.

> *"The restaurant owners didn't really want stickers on their menus. So, we made tabletop displays, which actually I think worked out better. We highlighted the foods on one side of this tabletop display, and on the other side, we explained what the program was. We put one on every table."*

While several projects had success, one project shared that its approach to conducting nutritional analysis for menus was time consuming and would be expensive to scale up. The project was considering future opportunities to help fund such initiatives on a larger scale, such as a fee-for-service approach. Another challenge shared was that it was sometimes difficult to work with small restaurants due to the restaurants' limited capacity and resources.

> *"[One restaurant] agreed to participate in the healthy menu labeling, but their staffing resources are so limited. It's one person and a cook…it's hard for them to find time for marketing the healthy [items]."*

Messaging on Project Efforts

All projects were required to implement secondary objectives pertaining to messaging and communication regarding project activities. The projects in Cohort 2 were very successful in accomplishing these objectives with over 246 million media impressions throughout the course of their projects. These media impressions were achieved through 914 media placements in local newspapers and on local television, radio, social/ digital media, and other outlets. A sample Tweet from the Clinton County, NY Health Department's Action for Health Consortium CPHMC project is on the right.

D. Project Implementation Challenges

Project team members were asked in late-implementation interviews about objectives or activities that were difficult to complete or achieve during the project period.[3] Examples are described below. Due to the varying contexts and capacities of projects, activities that were highlighted as successful by some projects were found to be challenging for others.

Collaborating with Grocery and Corner Stores

Multiple project coordinators shared challenges with activities that involved grocery and corner stores. Although the challenges varied, key factors included frequent employee turnover in grocery stores, which made it difficult to keep staff educated about the initiatives, as well as frequent inventory changes and the limited capacity or business instability in small corner stores. One project experienced difficulty in coordinating inventory in the store with promotions of healthy foods and recipes due to constantly shifting stock. Although two projects working with grocery stores to promote healthy food choices felt their grocery promotion efforts had been successful overall, they expressed concerns about sustainability.

"[The grocery manger is] constantly burdened – his staff turns over, so to keep his staff current with what it is that we're doing, we turn over the product every two weeks and so we have to keep the communication with him and that's a challenge cause we're all busy."

"Our grocery stores were successful, however, hard to maintain… obviously they're dependent on purchases, and maybe not necessarily as concerned about, you know, that people are purchasing healthier foods. Maybe they're just kind of interested more in the costs and things like that…it was a success, I'd say, but it was a little bit harder for the long term sustainability just because of whether it's management changing or not having as many people in the grocery store setting that are concerned about this or seeing the value in the shelf labels."

When working to improve healthy options at corner stores, one project found that community members shopped less frequently at corner stores than anticipated and were

3 As noted on Page 1, five Cohort 2 projects had an extended implementation period through June 30, 2017. During this extended period, three of the projects were able to address some of the challenges described in this section. Specifically, two projects were able to establish a community or school garden, while a third project increased the number of grocery stores with in-store placement and promotion strategies for healthy foods.

traveling greater distances to larger grocery stores. Further, the project also found that owners of small stores cannot take large risks, and as a result, were unable to engage in healthy food promotion activities. In this particular community, the project believed it would have been more effective working with larger stores rather than corner stores.

> *"Definitely working with the corner stores was the most difficult for us. We realized pretty quickly that we set our target high, but when we got into the community we realized that we don't have corner stores like they do in New York City or Philadelphia or Chicago... More people were getting their food from grocery stores than they were from the corner stores."*

Working with Farmers Markets

Several projects faced challenges with achieving their objectives with farmers markets. Barriers included issues with city permits, thin profit margins leading to low farmer interest or capacity, and the short hours of markets, which limited opportunities for collaboration. Although these were not always insurmountable barriers, they proved to be more time consuming to work through than project coordinators had anticipated. Activities were still underway for several projects to fully launch new markets as the projects were wrapping up.

> *"We did have a small farmers market going, but we didn't have as many vendors around here right now that were interested. We've done radio ads, called meetings, used social media, we tried to get it out there, but we're having a low number…we have 2-3 people. It's a Saturday morning, 8-11 which we feel like is a horrible time. We're really trying to change a lot of things for them and bring in more people and it's not working on the timeframe we want it to."*

Developing Community Gardens

While two projects had successes with new and existing community gardens, others struggled. There were issues related to locating and assuring reliable land access as well as navigating the short growing season during which to launch a program. Two projects found that the project period ending in May was an issue because they had to complete grant implementation just as gardening activities were beginning. Some projects shared that they still intended to pursue activities beyond the timeframe of the grant, while others shifted their focus to other secondary objectives.

"Once all of the approvals were in place, the weather turned and it has been basically snowing/raining ever since. We are still waiting for the weather to improve to implement our community gardens as planned."

"The original site for our garden is no longer an option."

"Finding locations that would be approved for the gardens was the most difficult part of the process."

Breastfeeding Activities

As described in the previous section, several projects were successful in implementing activities to encourage businesses to support breastfeeding; however, other projects faced challenges in their efforts to do this. One project reported a clear lack of interest from the business community and came to the conclusion that the project would need to redirect its focus. Another saw interest, but struggled with businesses that lacked authority to make policy decisions for onsite services, e.g., retail chains and franchises. In some of these situations, the approval process for new policies was too slow and time-consuming to work through. Another project faced issues with discomfort in the community regarding breastfeeding in public, particularly with churches and grocery stores.

"Some people – some businesses did not want to become breastfeeding-friendly, just because some people have the idea that it's not appropriate, and they see it as more sexualized. So there were some businesses that weren't interested in partnering with us or in becoming breastfeeding-friendly."

"If it was more of a corporate business, they had limited ability to make that decision for themselves. They would have to refer on to the corporate office. And that's just a lot of hoops to jump through for that."

Establishing processes for obtaining reimbursement for lactation services is another breastfeeding activity that was reported to be challenging. Projects that worked on this described complexity around insurance billing codes and requirements.

"Billing for breastfeeding support in the clinic setting has been the most challenging. [Our health department] was not set up for billing multiple insurance companies and [Our state] Medicaid policy does not allow for RD, IBCLC to bill independently… working on alternative ways to still accomplish this but is a very slow process."

Transportation Access

Three projects found that transportation was a barrier for community residents to access healthy food and beverages and healthcare services, and they were unable to overcome this during the project period. While the projects did not have specific objectives related to transportation, they learned that it was a barrier that needed to be addressed to improve healthy food access. They considered different methods, ranging

from increasing transit options to bringing the food to the communities that lacked transportation. Although these projects were unable to change transportation options in their communities during the project period, one did have success in overcoming the transportation barrier by strategically placing services along bus routes.

"Food access is a huge issue over here, and transportation is a big issue. One of the successes, one thing we learned, is that you have to be very strategic about where you place your farmers markets because you want to be sure it's accessible for everybody…They were able to come right here – there's a bus stop right in front of [the agency] so it made it accessible for them."

"Our biggest need, and I know it's a struggle all over, is transportation. So we have a lot of services, and we have all of these programs in place, but transportation can be a huge issue for people to be able to utilize them, even if they know where they are, they can't get to them sometimes, and we don't have any public transit or anything here."

"There are probably some transportation needs that we didn't see a way to solve that feasibly through our grant work. It would be awesome to implement a mobile market that could drive to different places since we are pretty rural. Most people do have cars…but people don't have money for gas, so they have a car but they only make one trip into [town] throughout the week."

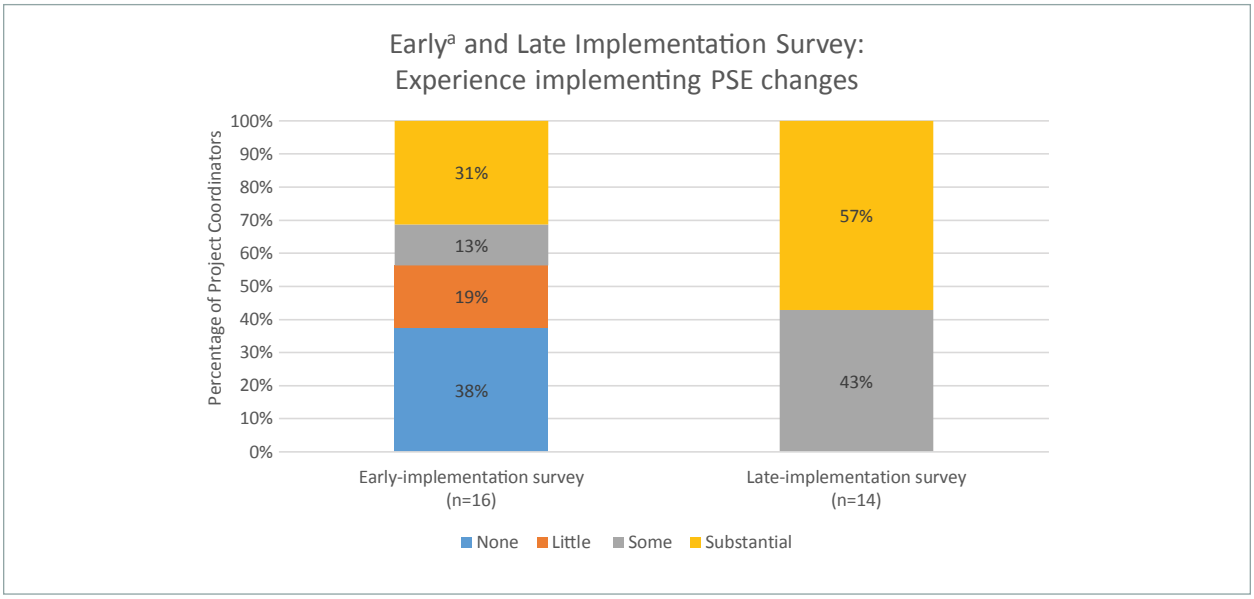
FINDINGS: CAPACITY BUILDING, SUSTAINABILITY AND LESSONS LEARNED

A. Staff and Organizational Capacity

As described previously, a goal of the CPHMC project is to increase community capacity to implement PSE improvements. For many of the staff involved in local projects, this was their first experience leading a project that required them to build or strengthen partnerships and identify and address community needs through strategies beyond the normal scope of WIC program operations. Project team members embraced this opportunity and implemented multiple strategies to achieve objectives aimed at improving food and beverage environments and enhancing linkages to chronic disease prevention and care.

As shown in Exhibit 8, while PSE experience was limited for most project coordinators at the beginning of the project, the majority of them (8 out of 14) indicated on the late-implementation survey that they now felt that they had substantial experience in PSE change. The experience they gained through working with partners to accomplish project objectives contributed to this growth in expertise to implement PSE changes.

Exhibit 8. Early and Late Implementation Survey: Experience Implementing PSE Changes



Local project coordinators, team members and managers were asked to share ways the project helped them build personal and organizational capacity for conducting PSE work. Project coordinators who participated in interviews at the end of the project described the knowledge and skills they had acquired personally in PSE work.

"I really learned how to do a needs assessment from the ground up, which was so important, and which I think is important for any career. Just being in the nonprofit world we need to be cognizant of our population, who we're serving, what our directives are…you really need to have the people that you're serving at your table to be able to put their input in."

"I will say at the beginning I didn't even know what people were talking about [with PSE] so they would use language like even in technical assistance. To me that means something very different and I've learned what it means in this process, so I guess that's another skill I've acquired. Public health lingo."

Several project coordinators identified ways the project enhanced their capabilities with community engagement, sharing descriptions of how the project helped them learn about coalition building and working with community partners.

"Getting that experience with managing a project with the organization skills required to keep the coalition together"

"All of the training about coalition building, coalition development, and partnership development was really helpful for me."

"It really set me up well to know kind of the ins and outs of how coalitions work, the whole, building a coalition and maintaining, and some of the strategies and planning for sustainability early on; different sectors of the community that you have to engage with. That was really a perfect way to prepare me for the work that I'm doing now."

"I learned the value of including a community member – which was also our biggest challenge – because there's no point of making change in the community when community members aren't interested in the new change."

"I've gained a lot of skills and a lot of knowledge locally, so I am now connected in my community more deeply than I was before."

Project teams also shared the ways in which the work benefitted their organizations.

"We've learned to make that connection, with coalition members…to reach out to people who we have common ground with."

"We're definitely more engaged with a lot of community partners than we were before this, for sure. There's a lot of people that I know now that I didn't know a year-and-a-half ago…I think that's going to continue to grow even more."

"I think the networking has just been invaluable, and not only for us to learn from them, but for them to learn about us and what we do."

"We gained so many relationships within the community that we didn't even know were there. It really forced us to go out into the community to see what kind of resources were there and who could partner with us."

Project coalition members and community partners also commented on benefits of participating in the CPHMC project. This included greater awareness of prevention and public health efforts and of WIC program services, increased collaboration and communication within their organizations, and new connections with other organizations in their communities.

"Communication and getting everyone at the table, I think is huge. We've adopted that [at our organization]. Before we used to just have meetings with the department that you work in, we all didn't get together, we were kind of in a silo. Now we have what we call a team umbrella meeting once a month where every single department gets together, instead of just two heads at the table, we have like 25…we're more connected."

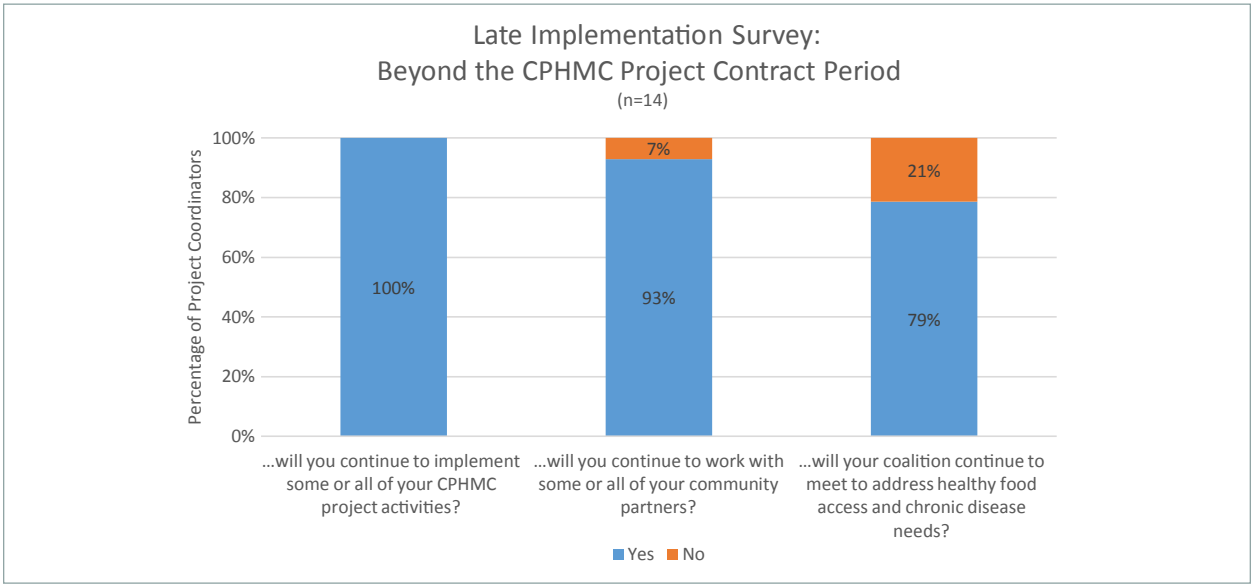
"With the success story piece…that was really helpful in learning that we have to share these stories, how to be more concise in what we're saying, too."

"I learned a lot about what else is going on in the country, and how to figure out how to adapt it to where we are, and where our community is – that was probably my favorite part."

B. Sustainability of Project Outcomes

In addition to increased capacity to implement PSE improvements, Cohort 2 projects were charged with planning and implementing improvements that can be sustained beyond the project end. In the late-implementation survey, project leaders were asked "Will you continue implementing some or all of your CPHMC project activities beyond the contract period for your project?" As demonstrated in Exhibit 9, respondents from all 14 projects that completed the survey responded "yes."

Exhibit 9. Late Implementation Survey Beyond the CPHMC Project Contract Period



Late-implementation interviews included questions around systemic change and project sustainability. Project staff shared new approaches and systems that will continue beyond the end of the project, including outreach and referral systems for WIC, improvements in internal and external communications, and new outreach strategies.

"Our biggest system-level change, our new system that we created would be our breastfeeding system, in that our clinic and hospitals, and public health and WIC are all communicating now. We developed a communication system, a referral system, so that we're bridging those gaps, and really utilizing each other's services to have an all-encompassing program, our lactation care system."

"With our grocery stores and farmers markets we have quarterly meetings now, where we're more hands-off and allowing them to take on the work. We're really changing the system so public health isn't necessarily the lead at the table… community partners are taking ownership of this work too, and making it more sustainable."

"I think that outreach has been way more substantial than what we had before. I think outreach before meant you dropped off pamphlets. Now, outreach is a whole lot about education."

"I think one of the biggest systems that we've implemented…and we expanded through all of our 10 counties, is the prescription pad project. We started that in the one county…we went in all of our 10 counties."

C. Sustaining Coalitions and Partnerships

As detailed in Exhibit 9, a majority of projects (79%) reported that their coalitions will continue to meet beyond the end of the project. Many projects expected that their coalitions will continue to meet and work on activities started by the project or new activities.

"Many of the coalition members are invested in seeing this coalition work continue."

"The work isn't done. Projects are in different stages of planning."

"We will continue to work together and find new goals to address."

"Our coalition will continue to meet and we will continue to serve on community partners' committees and be a presence at their events."

"We will continue to implement the projects we have begun and will add additional projects now to help decrease childhood obesity in our county."

"This coalition will keep going and will continue to do this important work in the community. We all seem committed to the premise that PSE should be part of our jobs, and building on this successful program makes the most sense."

Also shown in Exhibit 9, project team members shared in the late-implementation survey that nearly all projects (93%) will continue to work with some or all of their community partners. In late-implementation interviews, several project coordinators shared ways of building community-based leadership to ensure the longevity of the efforts.

"When we set up our quarterly grocery store manager meetings and farmers market manager meetings, we knew going into this that we were setting it up, but we were setting it up for them to continue it, not for us to continue it. So we slowly weaned ourselves out of those meetings and they ran with it."

"Early on in the coalition, you know, I was kind of in the mindset… 'I have to do all of this, I need to make sure this is happening,' and I had to let go of some of that and allow the coalition members to take on some of those responsibilities because in the long run, obviously, the grant funding ends and…it probably would have died off because there wouldn't have been as much engagement and involvement from the community itself."

D. Next Steps

In late-implementation interviews, project team members shared what they anticipate will be the next steps for their organizations and/or coalitions following the end of the project. Some described activities that will continue. Project coordinators were also asked if they had sought or intended to seek additional funding to carry project objectives forward, and two-thirds (65%) responded affirmatively.

"In the physical activity subcommittee, they want to move forward with piloting two safe routes to schools, making them really bike friendly. Initially they were thinking about pursuing grant funding for that, but they don't even care if they have grant funding…..they're just going to move forward with piloting at two schools."

"We will definitely work on the breastfeeding-friendly initiative. Our WIC referrals, we are trying to expand that. The 101 trainings we've done for WIC, those will just be taken on by WIC staff. Our WIC referrals go with it, but we will also be trying to expand WIC referrals to other programs and agencies, which won't be difficult to do, and won't take much funding to do it."

"[We'll continue] the baby café, the nurturing station, the food insecurity resource card, our toolkit to encourage businesses to become breastfeeding friendly worksites will live on through our two health districts and our state health department website."

"The nutrition subcommittee is talking about making a food council and advocating for a food hub in the area."

"We did a lot of great work and we're going to continue all of our efforts with PSE strategies…we're proud of it."

E. Lessons Learned and Recommendations for Others

Through a combination of late-implementation surveys and interviews, project staff shared lessons learned and gave recommendations for other WIC agencies about working to address PSE change in their communities. Projects shared what they found to be most effective.

"The CPHMC project itself really drove home sustainability and a coalition. I think that makes so much sense to me at the end of the project. Now I know why they were so adamant about it, because that's what's going to continue this project going forward, we only have such a short amount of time, it's very important to create established relationships to make sure everything moves forward."

"The workgroup strategy has been very effective – it has helped people take ownership of their own issues and helped motivate people."

"Bring in resources and best practices, but don't bring in 50 page reports because they're not going to read them, provide highlights. Be respectful of their time."

Because participation in the coalition and project activities required buy-in from community members and organizations, project leadership shared experiences that helped "sell" their projects to the community. This included using concrete data, drawing from the needs assessment results, engaging community members in the dialogue, and finding community champions to serve as leaders.

"What can we do to build a culture of health in this community? That was always my question I'd ask…This community, we need to raise our benchmarks. That was it, really, the selling point."

"The team here did a comprehensive community needs assessment so I was able to pull out some of those data points even when I was meeting with store directors. 'We rank 64 out of 72 for our county health rankings. You get 11 dollars allocated per adult for fruits and vegetables, 8 for kids', I broke those numbers out. They want to make those sales."

"Always making sure that you have a champion in that organization who can lead that work within the organization. They know the organization better than you do, and you don't want to be stuck doing all of that work. We just don't have the capacity – especially in public health – …to take on all that work. We need to be able to get them started and then having them champion that work in their organization to move that work forward."

"We had to have our partners have major buy in, knowing that they did this for a reason and not just because Public Health is coming in and making them do this."

Projects also described strategies they used to build new relationships with community partners and coalition members.

"Think of the not-so-obvious partners... especially with small, rural communities, there's people that have lived and worked and retired in the community and, they've been there their whole lives, they have multiple generations that have lived in this community. And those are the people that you want to make sure you're engaging with and talking to….because they care. It's their community that they've known and they've lived in forever, for their whole lives, and they're passionate about what happens..."

"The biggest thing is just making sure you're being creative with who you're connecting with and also including people that are…the community-selected stakeholders. They may not necessarily be the mayor, but they're someone that the community or certain neighborhoods see as a leader because they are just invested and they just have so much passion for their town or their community."

In addition to forging new relationships, projects noted the importance of maintaining relationships and keeping the project moving forward with partners and coalition members.

"Maintaining transparency. If you have very clear objectives, if people walk away with—I call them action commitments—'okay you're charged with this'. Then the next meeting we go back to this. Holding them accountable, and celebrating those wins. Short term ones and long-term ones too."

"Get a group of people together who are the right people, and go through the process of the needs assessment process together so that you have buy in, so that when you're working on things you know that these are the things you want to be working on, and you know your partners are invested on them. Be team players…"

"Communication is key. I always tell everyone we're in the people business. If you don't have the relationships and the rapport, then you don't have a coalition."

"Making many partnerships and making strong partnerships...it really trickles into the community because they're able to provide different resources, including [access to] the target population."

Project team members shared many "how to" suggestions for conducting community projects, including replicating successful efforts, working collaboratively with partners, and drawing from existing resources.

"I think it all goes back to the needs assessment. I think you have to do a thorough needs assessment to figure out what your population is really looking for, where is the gap. I think that's where you start."

"What I would recommend is that you really do need dedicated full-time staff on the project if you're going to have any impact."

"Use examples of things that other people have done, and try to implement it instead of…recreating the wheel. …It is more helpful to see how they did something, and maybe duplicate it, or change it up a little bit and use in your community versus just completely starting from scratch."

"Try not to be too focused on the goal you set forth, because sometimes it may change, and learn to go with those changes as well. Be flexible, not just so strong willed that 'this is the way it has to be done' because sometimes other things come out of it."

Lastly, project team members reflected on their experience with the CPHMC project. Comments related to both the rewards and the challenges of taking part in the project. Despite the challenges, project teams overwhelmingly found the experience to be positive and were pleased with the results.

The following quotes represent critiques from project team members. Frustrations centered mostly on the administrative processes for contracts and reporting, delays in funding and the short timeline of the grant.

"The time given to turn around the contract was unrealistically short. There was no way we were going to be able to make those deadlines. We're in government here, and to turn around a contract in anything less than 6 weeks is unrealistic."

"When we didn't [get access to the funds] —it took some of the wind out of the sails, you know? And the frustration of not being able to get the things going that we needed… trying to borrow from Peter to pay Paul."

"We had to spell out details of our CAP before – when our coalition was just reviewing the needs assessment together. Everything happened too fast in my opinion…."

"That template report - was a template that didn't fit our situation…since we're only dealing with two or three sites…and 'don't count last month, just count now'. So pretty much it's like zero, zero, zero, and then you feel like a failure. I think that, to me, it was very demoralizing."

"I think the amount of work requested for such a small amount of funding has been overwhelming, because it hasn't just been the project work. It's been 'attend five conferences out of state, attend multiple Webinars, these sorts of things."

The following comments represent positive feedback about the project. Many interviewees were proud of their achievements and the increased community engagement and partnerships.

"I look back to where I was a year ago and it just was a wild ride that we've been on – so much training and support and development."

"I think we did some good alignment with other programs. You know, we're always aware of what others are doing, but really trying to connect that internal alignment, too. So, I think it wasn't more capacity, but making people aware of, "Wow, you guys do more than WIC."

"I'd just like to thank everyone who made this grant opportunity available, and we've definitely been able to do some great things in our community with this grant. We definitely want to sustain this work and we've built it into our organization and within our partnerships, so that we can sustain this work."

"I constantly tell people I love the grant. Just for me personally, I really have always felt that we need to be out in the community more, and this grant pushes that, so I think that was just outstanding."

Further, many reported positive experiences related to the NWA project team offering prompt and helpful feedback, sharing guidance throughout the project, and being readily available.

"I thought that the final TA workshop in Denver was outstanding and a good strategy to assist cohort members to share ideas and view successes."

"I love the opportunities they've presented…Webinars are sort of targeted to the specific strategies that you might be using, so you have the choice. You can attend this one, learn some more or not, based on what you're doing. That has been really helpful. I really enjoyed that."

"I think the National WIC team was incredibly helpful. Usually if we sent an email or had a question, we had an answer in an hour or two. In all the calls we had, they were super supportive. It's actually been a lot of fun. Super demanding, don't get me wrong, and it pushed us and stretched us, but I'm really glad that we were selected and got to do it."

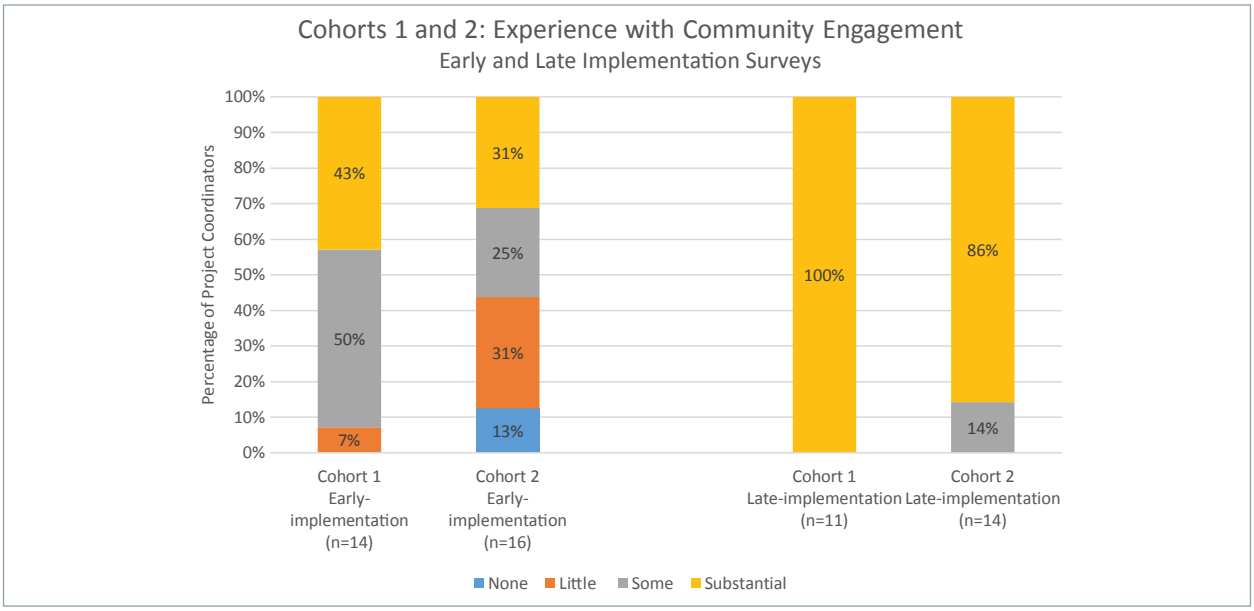
V. Comparison of Projects in Cohorts 1 & 2

The local agencies in the two project cohorts differed with regard to prior experience with community-based PSE efforts. While there was overlap in the project objectives for the two groups, there were differences in their approach, partnerships and activities. The following sections compare selected features of the projects in the two cohorts

A. Project Coordinator Experience

As mentioned previously, the two cohorts were similar in size, with 17 projects in Cohort 1 and 15 in Cohort 2, and two projects participated in both cohorts. There were differences in the levels of prior experience between agencies in the two cohorts, which was anticipated based on the criteria and process used to select the agencies for the two cohorts. For example, project coordinators for Cohort 1 reported a greater amount of past experience with community engagement at the start of the project, as shown in Exhibit 10. However, by the end of the project, the results for both cohorts were similar, with all or a strong majority indicating substantial experience with community engagement. This indicates that agencies in both cohorts increased their capacity for community-based work as a part of the CPHMC projects.

Exhibit 10. Cohorts 1 and 2: Experience with Community Engagement

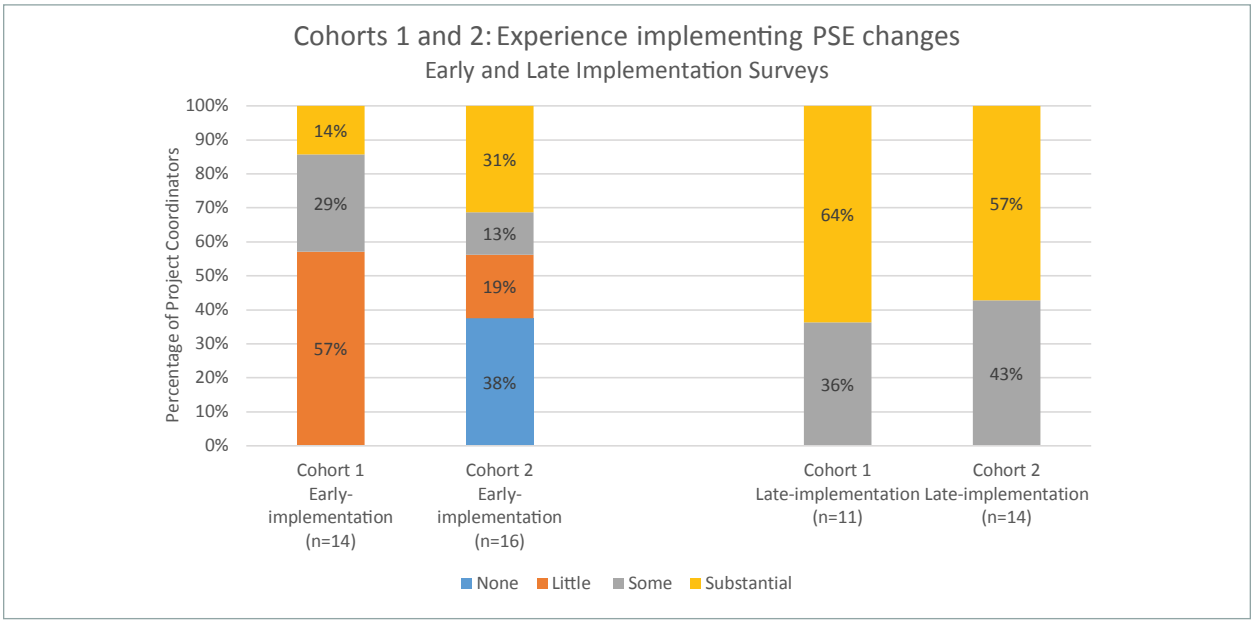


Similarly, with PSE experience, project coordinators from Cohort 1 reported having higher levels of experience with PSE change implementation than Cohort 2, with all coordinators having at least a little PSE experience in Cohort 1 and 38% reported none in Cohort 2. Once again, by the end of the project, levels of experience were

similar between the two cohorts, with all respondents indicating that they had some or substantial experience implementing PSE changes, as shown in Exhibit 11.

Implementing the CPHMC project with two local agency cohorts allowed for lessons learned during the first cohort to inform and shape the processes and experience for the second group. For Cohort 2, the NWA project team made changes in the process for selecting local agencies, in project administration/management processes, in technical assistance and support approaches, and in suggested project objectives and activities. Experiences from the agencies in the first cohort were shared with the second group of projects, and some Cohort 1 agencies provided peer support for those in the second cohort.

Exhibit 11. Cohorts 1 and 2: Experience Implementing PSE Changes



B. Sharing Lessons Learned

Cohort 2 project coordinators felt that they had the opportunity to gain knowledge from Cohort 1's successes and approaches. Several of them shared that they were glad to be able to learn from Cohort 1 through conversations, resources and reports. Project coordinators also valued the opportunities to meet with and share experiences and ideas with their peers in both cohorts.

"The opportunity to get these trainings and conferences…it puts meat on the bones for people, to get a sense of 'oh this is what they mean, this is how we're going to do it' – speaking with Cohort 1, the CDC conference."

"I was in Denver in early September, and it was nice to see the other recipients from Cohort 1 and 2, to learn from them, because a lot of us are doing the same thing… that's been nice too to hear best practices or to receive resources. They just sent a report from the previous Cohort 1 …on some of the best practices because it looks like everyone had their own struggles."

"I really appreciated the recommended survey questions of WIC clients, that were the required ones, but also those compiled from Cohort 1. We selected a lot of that."

Cohort 2 project teams suggested that additional resources from the first cohort may have been beneficial during the start of their projects. These included needs assessments, sample budgets and more lessons learned by Cohort 1 during project implementation.

"If [the coordinator] could've seen an example of a needs assessment that Cohort 1 had, it would've been helpful to see and visualize it."

C. Project Objectives and Activities

The two cohorts selected a diverse set of secondary objectives for their CPHMC project work; however, there was common ground in some of the top-selected objectives and activities. While the secondary objectives shifted slightly between the two cohorts, both Cohorts 1 and 2 had a large number of projects working on tools and resources to create awareness of healthy foods in the community as well as increasing the number of settings that receive basic training in WIC services and benefits.

Table 7. Top Secondary Objectives Selected, by Cohort

Cohort 1	# of Projects
Increase the number of [sites] using new tools or resources to create awareness of how to access healthy food options in the community	10
Increase the number of [sites] with providers and/or staff that receive basic training on WIC services and benefits in the target community	8
Increase the number of [sites] using new tools or resources to improve awareness of available chronic disease prevention and management services in the community	7
Increase the number of [retail environments] with new onsite and in-store placement and promotion strategies for healthy foods in the target community	7
Cohort 2	**# of Projects**
Increase the number of [sites] with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community	10
Increase the number of [retail environments] with new onsite and in-store placement and promotion strategies for healthy foods in the target community	8
Increase the number of new [sites] that are integrated into a strong referral network in the target community	7
Increase the number of new [sites] that make "prescriptions" for non-pharmaceutical interventions like exercise and WIC in the target community	7

Table 8 shows project activities that were most successful for the two cohorts. The diversity of these successful project activities speaks to the variety of participating local agencies and the impact of coalitions and partners on targeting each community's unique contexts and needs.

Table 8. Key Project Successes, by Cohort

Cohort 1
Strategies for healthy food in corner stores
Comprehensive referral systems for WIC
New tools for identifying community food and healthcare resources
Partnerships for breastfeeding support
Healthy options in restaurants
Utilization of farmers markets and support for food banks/pantries to access produce donations from farmers
Cohort 2
Placement and promotion strategies for healthy foods
New farmers markets, food banks, mobile grocers
Water availability in schools
New businesses that promote and welcome breastfeeding
Development of strong referral networks
Non-pharmaceutical prescriptions
Comprehensive breastfeeding training for providers

Table 9 lists some of the key challenges encountered by each cohort. For several objectives, one cohort found success while the other encountered barriers. These will be examined more closely in the next section.

Table 9. Key Project Challenges, by Cohort

Cohort 1
Working with schools
Increasing the number of WIC vendors
Implementing “green prescriptions for healthy living” for healthy foods and lifestyles
Increasing businesses that provide accommodations for breastfeeding mothers
Cohort 2:
Breastfeeding activities
Working with farmers markets
Working with community gardens
Transportation access
Collaborating with grocery stores and corner stores

D. Successes and Challenges: Cohort Comparison

Three examples of activities undertaken by projects in both cohorts provide insights into factors that contributed to success and of the common challenges experienced across projects.

Healthy Food in Corner Stores

Projects in both cohorts aimed to increase healthy food options in corner stores or promote healthier choices in those businesses. Cohort 1 projects reported more success overall in these efforts. One factor in its success may have been the synergy with partners that were already working on corner store initiatives. They described working with efforts underway or joining existing coalitions whose priorities were to increase access to healthy foods in corner stores. Cohort 2 projects were more likely to be "starting from scratch" in corner store work and reported struggling with a range of logistical challenges that are likely inherent in working with small retail businesses, e.g., employee turnover, frequent changes in product inventory, and general instability of small businesses that operate with a small profit margin. Some Cohort 2 projects also learned that new programs, such as healthy food promotion, were not a high priority for small stores in their community. Further, one project learned that corner stores were not used extensively by the target population, which preferred to find transportation to larger grocery stores.

> *"Definitely working with the corner stores was the most difficult for us. We realized pretty quickly that we set our target high, but when we got into the community we realized that we don't have corner stores like they do in New York City or Philadelphia or Chicago... More people were getting their food from grocery stores than they were from the corner stores." – Cohort 2 Project*

This was in contrast with a Cohort 1 project that reported a reliance on corner stores in its community due to the lack of larger stores in the area and transportation barriers to get to other stores.

> *"People in our community have to go a long way to find a large grocery store. There are many here that don't have reliable transportation, or are unable to make the long trip on a bus. They rely on being able to use local corner stores, and now they have access to healthier options." – Cohort 1 Project*

The difference in experience for these two projects highlights the importance of understanding community shopping practices and preferences when considering corner store interventions. It also underscores the importance of the transportation system and how it impacts community members' purchasing patterns.

Non-pharmaceutical Prescriptions

Cohort 1 projects reported that implementing non-pharmaceutical prescriptions was challenging. While some projects found interested partners, there were challenges with healthcare provider receptivity and with integrating the "green prescriptions" into healthcare and community organization services. One Cohort 1 project noted it had rushed into development of the prescription pad and should have sought more input and resources for this activity.

> *"I think after the first year, we're really going to focus on re-doing our green prescription objective. I think we're going to really need to understand what that concept is and maybe find another resource, somebody who has already done this and see how they did it to make sure that we fully understand where we need to go with this, and how we can engage our community partner. Walking in there and telling the doctor, 'We want your staff to do this' or 'We want you to do this' is not going to be very helpful unless we can come in there with some meaningful information and processes and some successes in other communities, which will help to convince the doctor that this is really important for our community." – Cohort 1 Project*

Projects in the second cohort had more success with non-pharmaceutical prescriptions, which some attributed to using an inclusive approach. For example, these projects worked closely with multiple partners, such as healthcare providers, WIC staff and home health workers, to develop the prescription pads to ensure that "end users" had an opportunity to share their ideas and feedback on the format and content of the pads. Cohort 2 projects also reported starting with a pilot to gather input from providers and address issues with the pads before full implementation. One project in Cohort 2 attributed its success to researching non-pharmaceutical prescription models used in other communities and adapting a successful example for their project.

Breastfeeding Friendly Businesses

In both cohorts, some projects were successful in activities related to increasing breastfeeding friendly businesses in their communities while others experienced challenges in these efforts. Overall, projects in Cohort 2 reported more success with this and several noted that this activity was a "lower resource" activity for them relative to other project activities. Some projects in Cohort 1 reported difficulties with engaging small businesses that have limited time available and that needed to be "sold" on the value of making their businesses breastfeeding-friendly.

> *"We found that working with local business takes a lot of time. They are very busy, and it is hard to get time with the owners or managers to talk about breastfeeding. While some were interested, they were not in a position right now to make any changes. Others just did not see the value." – Cohort 1 Project*

Projects in Cohort 2 approached this through multiple channels, including increasing breastfeeding visibility, working on approaches to normalize breastfeeding in the community, and working with businesses and their local associations. For example, one project achieved success with increasing the number of breastfeeding friendly businesses through collaborating with a "healthy business challenge" program organized by the local Chamber of Commerce. Another project noted success with launching a tiered breastfeeding-friendly business certification process that motivated competition between businesses to be recognized as a "certified" business.

"Getting the breastfeeding businesses certified was one of the easiest [objectives], we just asked the businesses and got the ball rolling with it. You just [complete] the paperwork, send it in, and you get certified. We had three levels, so it had to be bronze, silver or gold. Most people were willing to be breastfeeding friendly…they also wanted to compete with each other, 'if they're going for gold, we're going for gold." – Cohort 2 Project

VI.Conclusions

The findings from the evaluation of CPHMC Cohort 2 projects support the conclusions described below. These are consistent with the conclusions identified in the evaluation of Cohort 1.

1. **WIC can play an important role in creating partnerships to implement PSE changes for improving food and beverage environments and increasing linkages for chronic disease prevention and care.**

   The CPHMC project demonstrates clearly that WIC agencies can successfully lead or participate in community-based initiatives to implement PSE change. While WIC agencies may not have as much experience in PSE as some other organizations, they learn quickly and have access to community partners, such as grocery stores, farmers markets, hospitals, and health departments that can play a critical role in achieving PSE changes.

2. **Building strong community coalitions leads to successful implementation of interventions and sustainability of these efforts.**

   Project team and community coalition members emphasized the importance of a strong coalition with a commitment to implementing change. The coalition members were able to leverage and synergize each other's ideas and resources to accomplish common objectives while adding value to each other's efforts.

3. **CPHMC projects provide many useful resources and practical experience for other WIC agencies that are interested in community-based work.**

   The experiences, project examples and lessons learned from the agencies that participated in the project serve as an outline for local WIC agencies that want to work with others in their communities to improve food and beverage environments and improve or establish linkages in preventive health services or related efforts.

4. **WIC agencies that want to engage in PSE work should pursue opportunities to work with coalition and community partners that have resources and/or to identify new funding sources.**

   Collaboration with organizations that provide SNAP-Ed may be particularly effective because SNAP-Ed requires PSE efforts and provides funds and resources for PSE activities. There are also local, state and national foundations that fund PSE initiatives, with many of these sources targeted to food environment and healthy food access efforts. Ongoing sharing of successful collaborations or grants for these efforts within the WIC community may be beneficial.

5. **Some objectives and strategies require longer-term commitments.**

   Projects in both cohorts found that some interventions require more time to build partnerships and implement activities; these could not be completed in a period of 12 months or less. Setting realistic objectives and selecting strategies that can be accomplished within the time available are important for achieving goals and for maintaining morale and engagement of project staff and partners. An important planning step involves assessing timeframe feasibility to determine what can be reasonably accomplished.

6. **WIC agencies may encounter resistance or lack of support for engaging in community-based PSE efforts.**

   Sharing the outcomes of the CPHMC projects may help educate the USDA Food and Nutrition Service and the state and local WIC community about the important role WIC can play as a partner or leader in improving community food and beverage environments and linkages for chronic disease services. Improving the community that exists outside of the WIC clinic walls contributes to WIC's success in helping families adopt healthy behaviors and have positive pregnancy outcomes and healthy children.

7. **The NWA has increased its capacity to support expansion of WIC's role in the community.**

   The experience gained through the CPHMC project has strengthened NWA's capabilities to work with local agencies to plan and implement community-based interventions. NWA staff have developed expertise in project and grant management and in delivering technical assistance to local agencies. In particular, NWA has gained significant experience with helping local agencies network and build partnerships with other organizations in their communities and to work collaboratively on interventions to improve the environment outside the WIC clinic walls. This capacity positions NWA to provide leadership for future efforts to expand WIC's role in promoting healthy communities throughout the nation.

Glossary

Coalition: A collection of individuals and organizations working together to achieve specific goals.[1] Coalitions were a required component of this project, and were engaged in the needs assessments, selecting secondary objectives for the projects, and supporting implementation of project activities.

Determinants of Health: The direct causes and risk factors which, based on scientific evidence or theory, are thought to influence directly the level of a specific health problem. These may be defined as the "upstream" factors that affect the health status of populations and individuals. Roughly divided into the social environment (cultural, political, policy, economic systems, social capital, etc.), the physical environment (natural and built), and genetic endowment. The determinants of health affect both individual response (behavior and biology) and the prevalence of illness and disease.[2]

Messages are unique stories and or perspectives showcasing the project. Each unique message may include several activities. For example, one story may result in 3 separate activities—being shared as a blog post, on Facebook, and on Twitter.

Objectives: The specific, measurable results that an implementing agency would like to see occur during a particular timeframe.

> **Primary Objectives** describe the projected results of the CPHMC project's three main strategies: Improving access to environments with healthy food and beverage options; improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages; and increasing the number of public and partner messages showcasing CPHMC project efforts and achievements. In 2014, the Centers for Disease Control and Prevention's Division of Community Health entered into a three-year cooperative agreement with the National WIC Association (NWA) to build and strengthen community infrastructure to implement population-based strategies to improve community health. Through this grant, and in partnership with the American College of Obstetricians and Gynecologists (ACOG), NWA supported local WIC agencies in efforts to reduce and prevent chronic disease by improving access to healthy food environments and improving access to prevention and disease management services. Each project was instructed to plan to reach at least 50% of their geographic population through the primary objectives.
>
> **Secondary Objectives** describe the interventions that fall into the above three categories of primary objectives and were chosen to help projects meet their primary objectives. The sum of the reach of the secondary objectives, accounting for overlap, was expected to equal the total projected reach of each corresponding primary objective. Projects tracked progress towards secondary objectives to calculate their progress towards the primary objectives.

Partner is an individual, organization, business or agency that is engaged in implementing an intervention. Partner is also an audience type for messages—those who can be reached via partner communications networks such as listservs, newsletters, partners' blogs, and partners' social media.

Policy Systems and Environment (PSE) Strategies: Policy, Systems and Environment strategies may include: Policy Interventions, such as a law, ordinance, resolution, mandate, regulation, or rule (formal or informal); Systems Interventions, such as changes that impact all elements of an organization, institution, or system; and Environmental Interventions, such as those that involve physical or material changes to the economic, social, or physical environment.[3]

Reach is an estimate of the number of unique individuals impacted by a project objective in a certain geographic region, e.g., in the target community. Reach only counts one person one time and will never be more than the total population of settings.

Settings are sites where the work takes place. All CPHMC projects were in a designated geographic area and working in the community at a jurisdiction level (county, city, municipality or neighborhoods). Settings could include more specific places (schools, worksites, hospitals, or childcare centers), depending on particular project goals.

Target is the ending point for a project's measurement of change and is meant to capture a realistic estimate of growth during the project period.

1 The Centers for Disease Control and Prevention. https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/pdf/sustainability_guide.pdf

2 The Centers for Disease Control and Prevention. https://www.cdc.gov/nphpsp/pdf/glossary.pdf

3 Building Strong Community Partnerships for Healthy Mothers and Children. https://s3.amazonaws.com/aws.upl/nwica.org/quinney-harris-presentation-sunday-may-17.pdf

Appendix A: Community Action Plan Template

Community Partnerships for Healthy Mothers and Children (CPHMC) Project
Community Action Plan (CAP) Template

BACKGROUND

COMMUNITY ACTION PLANS

Community Action Plans (CAPs) are a required component of this CDC-funded project. The CAP is the work plan that you will use for the intervention implementation phase of the project. The CAP is organized into objectives (primary and secondary) and activities. Objectives are the specific, measurable results that you would like to see occur within a particular timeframe. For the purposes of this project, the timeframe will be the project period. Activities are tasks that are completed throughout the project to achieve the objectives. The activity descriptions are the series of more detailed steps that need to occur to complete an activity.

PRIMARY OBJECTIVES

Primary objectives A and B describe the projected **reach** of the two main strategies for this project: 1) improving access to environments with healthy food and beverage options; 2) improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages. Reach is an estimate of the number of unique individuals you impact in a certain geographic region. Additionally, primary objective C describes the communications efforts showcasing CPHMC project achievements related to the first two strategies.

Primary Objective A: Increase the **number of people** with improved access to environments with healthy food and beverage options from 0 to target by the end of the project period.

Primary Objective B: Increase the **number of people** with improved access to opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from 0 to target by the end of the project period.

Primary Objective C: Increase the **number of public and partner messages** showcasing CPHMC project efforts and achievements from 0 to 24 by the end of the project period.

Each agency must select Primary Objective A, Primary Objective B, or both of these objectives to include in their CAPs. Please keep in mind that all agencies are required to reach a total of at least 50% of their geographic population with one or both of these Primary Objectives.

Additionally, each agency must include Primary Objective C in their CAPs. This objective's measurement is **messages**.

SECONDARY OBJECTIVES

The **secondary objectives** are directly related to the interventions that fall under each primary objective. Your coalition will select the secondary objectives that your project will focus on related to primary objectives A and B. These objectives may or may not be written in the form of reach. Regardless, all secondary objectives related to primary objectives A and B need to describe how to arrive at a reach calculation. For example, in the below objective, the unit of measurement is the number of stores. From here, reach of the intervention can be calculated.

Secondary Objective A.8: Increase the number of new K-12 schools that implement healthy vending and concession practices in the target community from 0 to 1.	
Estimated number of people reached by the intervention	1,000
Description of **reach** calculation	Number of students attending the school.

It is important to calculate reach for all secondary objectives related to primary objectives A and B regardless of the main unit of measurement for the secondary objectives because reach is the unit of measurement for the primary objectives. The sum of the reach for the related secondary objectives, accounting for overlap, should equal the total projected reach of the corresponding primary objective. You will regularly keep track of progress towards your secondary objectives to calculate your progress towards the primary objectives. For example:

> Secondary Objective A.1 Reach+ Secondary Objective A.2 Reach + Secondary Objective A.3 Reach + Secondary Objective A.4 - Overlap = Primary Objective A Reach

Additionally, you are required to include 2 secondary objectives related to primary objective C in your CAPs. Both secondary objectives related to primary objective C are measured in **messages**. Messages are unique stories or perspectives showcasing your project. Please note that each unique message may result in several activities. In fact, you are encouraged to share your unique messages through a variety of channels. For example, one story may result in 3 separate activities—being shared as a blog post, a Facebook post, and a Tweet.

All words that appear **green and bold** are ones that you will need to fill in with numbers or words.

Please see Appendix A for a list of relevant secondary objectives. Please see the "Defining Reach" power point for more guidance on how to calculate reach.

GLOSSARY

Please see Appendix B for a glossary of terms. Any word that appears **red and bold** in this document can be found in the glossary.

Coalition Name
Community Action Plan (CAP)

Geographic Details:
Target Community: _____
Population of target community: _____

Primary Objective A: Increase the number of people in <**target community**> with improved access to environments with healthy food and beverage options from 0 to **target** by the end of the project period.

Secondary Objective A.1: Increase the number of: ☐ Grocery stores that sell healthy foods and/or expand their inventory of healthy foods in the target community from 0 to **target**. ☐ Convenience stores that sell healthy foods and/or expand their inventory of healthy foods in the target community from 0 to **target**. ☐ Food banks that sell healthy foods and/or expand their inventory of healthy foods in the target community from 0 to **target**. ☐ Mobile grocers that sell healthy foods and/or expand their inventory of healthy foods in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Grocery stores estimated reach: ☐ Convenience stores estimated reach: ☐ Food banks estimated reach: ☐ Mobile grocers estimated reach:
Description of reach calculation	☐ Grocery stores reach calculation: ☐ Convenience stores reach calculation: ☐ Food banks reach calculation: ☐ Mobile grocers reach calculation:

Secondary Objective A.1					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**

A.1.1					
A.1.2					
A.1.3					
A.1.4					
A.1.5					
A.1.6					
A.1.7					
A.1.8					
A.1.9					
A.1.10					

Secondary Objective A.2: Increase the number of:

- Grocery stores with new on-site and in-store placement and promotion strategies for healthy foods in the target community from 0 to **target**.
- Convenience stores with new on-site and in-store placement and promotion strategies for healthy foods in the target community from 0 to **target**.
- Food banks with new on-site and in-store placement and promotion strategies for healthy foods in the target community from 0 to **target**.

Estimated number of people reached by the intervention	☐ Grocery stores estimated reach: ☐ Convenience stores estimated reach: ☐ Food banks estimated reach:
Description of reach calculation	☐ Grocery stores reach calculation: ☐ Convenience stores reach calculation: ☐ Food banks reach calculation:

Secondary Objective A.2					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.2.1					
A.2.2					
A.2.3					
A.2.4					
A.2.5					
A.2.6					
A.2.7					
A.2.8					
A.2.9					

A.2.10					

Secondary Objective A.3: Increase the number of new: ☐ Grocery stores that accept WIC in the target community from 0 to **target**. ☐ Convenience stores that accept WIC in the target community from 0 to **target**. ☐ Farmers' markets that accept WIC in the target community from 0 to **target**. ☐ Mobile grocers that accept WIC in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Grocery stores estimated reach: ☐ Convenience stores estimated reach: ☐ Farmers' markets estimated reach: ☐ Mobile grocers estimated reach:
Description of reach calculation	☐ Grocery stores reach calculation: ☐ Convenience stores reach calculation: ☐ Farmers' markets reach calculation: ☐ Mobile grocers reach calculation:

Secondary Objective A.3					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.3.1					
A.3.2					
A.3.3					
A.3.4					
A.3.5					

A.3.6					
A.3.7					
A.3.8					
A.3.9					
A.3.10					

Secondary Objective A.4: Increase the number of new: ☐ Grocery stores that accept SNAP in the target community from 0 to **target**. ☐ Convenience stores that accept SNAP in the target community from 0 to **target**. ☐ Farmers' markets that accept SNAP in the target community from 0 to **target**. ☐ Mobile grocers that accept SNAP in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Grocery stores estimated reach: ☐ Convenience stores estimated reach: ☐ Farmers' markets estimated reach: ☐ Mobile grocers estimated reach:
Description of reach calculation	☐ Grocery stores reach calculation: ☐ Convenience stores reach calculation: ☐ Farmers' markets reach calculation: ☐ Mobile grocers reach calculation:

Secondary Objective A.4					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**

A.4.1					
A.4.2					
A.4.3					
A.4.4					
A.4.5					
A.4.6					
A.4.7					
A.4.8					
A.4.9					
A.4.10					

Secondary Objective A.5: Increase the number of new:	
☐ Grocery stores that offer cash or coupon incentives for purchase of healthy foods in the target community from 0 to **target**. ☐ Convenience stores that offer cash or coupon incentives for purchase of healthy foods in the target community from 0 to **target**. ☐ Farmers' markets that offer cash or coupon incentives for purchase of healthy foods in the target community from 0 to **target**. ☐ Mobile grocers that offer cash or coupon incentives for purchase of healthy foods in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Grocery stores estimated reach: ☐ Convenience stores estimated reach:

	☐ Farmers' markets estimated reach: ☐ Mobile grocers estimated reach:
Description of reach calculation	☐ Grocery stores reach calculation: ☐ Convenience stores reach calculation: ☐ Farmers' markets reach calculation: ☐ Mobile grocers reach calculation:

Secondary Objective A.5					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.5.1					
A.5.2					
A.5.3					
A.5.4					
A.5.5					
A.5.6					
A.5.7					
A.5.8					
A.5.9					

A.5.10					

Secondary Objective A.6: Increase the number of new: □ Food banks in the target community from 0 to **target**. □ Farmers' markets in the target community from 0 to **target**. □ Mobile grocers in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	□ Food banks estimated reach: □ Farmers' markets estimated reach: □ Mobile grocers estimated reach:
Description of reach calculation	□ Food banks reach calculation: □ Farmers' markets reach calculation: □ Mobile grocers reach calculation:

Secondary Objective A.6					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.6.1					
A.6.2					
A.6.3					
A.6.4					
A.6.5					
A.6.6					

A.6.7					
A.6.8					
A.6.9					
A.6.10					

Secondary Objective A.7: Increase the number of: ☐ Restaurants/bars with new healthy menu options and/or using nutrition labeling to identify healthy menu options in the target community from 0 to **target**. ☐ Hospitals with new healthy menu options and/or using nutrition labeling to identify healthy menu options in the target community from 0 to **target**. ☐ Other—<**please specify**> with new healthy menu options and/or using nutrition labeling to identify healthy menu options in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Restaurants/bars estimated reach: ☐ Hospitals estimated reach: ☐ Other—<**please specify**> estimated reach:
Description of reach calculation	☐ Restaurants/bars reach calculation: ☐ Hospitals reach calculation: ☐ Other—<**please specify**> reach calculation:

Secondary Objective A.7					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.7.1					
A.7.2					

A.7.3					
A.7.4					
A.7.5					
A.7.6					
A.7.7					
A.7.8					
A.7.9					
A.7.10					

Secondary Objective A.8: Increase the number of new K-12 schools that implement healthy vending and concession practices in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	
Description of reach calculation	

Secondary Objective A.8					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.8.1					

A.8.2					
A.8.3					
A.8.4					
A.8.5					
A.8.6					
A.8.7					
A.8.8					
A.8.9					
A.8.10					

Secondary Objective A.9: Increase the number of new K-12 schools that that make plain drinking water available throughout the day at no cost to students in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	
Description of reach calculation	

Secondary Objective A.9					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**

A.9.1					
A.9.2					
A.9.3					
A.9.4					
A.9.5					
A.9.6					
A.9.7					
A.9.8					
A.9.9					
A.9.10					

Secondary Objective A.10: Increase the number of new:

- ☐ Hotels/motels that publicly promote/welcome breastfeeding in the target community from 0 to **target**.
- ☐ Entertainment venues that publicly promote/welcome breastfeeding in the target community from 0 to **target**.
- ☐ Grocery stores that publicly promote/welcome breastfeeding in the target community from 0 to **target**.
- ☐ Restaurants/bars that publicly promote/welcome breastfeeding in the target community from 0 to **target**.
- ☐ Other—<**please specify**> that publicly promote/welcome breastfeeding in the target community from 0 to **target**.

Estimated number of people reached by the intervention	☐ Hotels/motels estimated reach: ☐ Entertainment venues estimated reach: ☐ Grocery stores estimated reach: ☐ Restaurants/bars estimated reach: ☐ Other—<**please specify**> estimated reach:
Description of reach calculation	☐ Hotels/motels reach calculation: ☐ Entertainment venues reach calculation: ☐ Grocery stores reach calculation: ☐ Restaurants/bars reach calculation: ☐ Other—<**please specify**> reach calculation:

Secondary Objective A.10					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.10.1					
A.10.2					
A.10.3					
A.10.4					
A.10.5					
A.10.6					
A.10.7					
A.10.8					

A.10.9					
A.10.10					

Secondary Objective A.11: Increase the number of new: ☐ K-12 schools that develop and/or implement policies to support breastfeeding in the target community from 0 to **target**. ☐ Outside of school care providers that develop and/or implement policies to support breastfeeding in the target community from 0 to **target**. ☐ Hospitals that develop and/or implement policies to support breastfeeding in the target community from 0 to **target**. ☐ Mental illness providers that develop and/or implement policies to support breastfeeding in the target community from 0 to **target**. ☐ ☐ Other—<**please specify**> that develop and/or implement policies to support breastfeeding in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ K-12 schools estimated reach: ☐ Outside of school care providers estimated reach: ☐ Hospitals estimated reach: ☐ Mental illness providers estimated reach: ☐ Pharmacies estimated reach: ☐ Primary care providers estimated reach: ☐ Faith based organizations estimated reach: ☐ Worksites estimated reach: ☐ Prisons estimated reach: ☐ Group homes estimated reach: ☐ Government agencies estimated reach: ☐ Military facilities estimated reach: ☐ Veteran facilities estimated reach: ☐ Other—<**please specify**> estimated reach:
Description of reach calculation	☐ K-12 schools reach calculation: ☐ Outside of school care providers reach calculation: ☐ Hospitals reach calculation: ☐ Mental illness providers reach calculation:

	☐ Pharmacies reach calculation: ☐ Primary care providers reach calculation: ☐ Faith based organizations reach calculation: ☐ Worksites reach calculation: ☐ Prisons reach calculation: ☐ Group homes reach calculation: ☐ Government agencies reach calculation: ☐ Military facilities reach calculation: ☐ Veteran facilities reach calculation: ☐ Other—<**please specify**> reach calculation:

Secondary Objective A.11					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.11.1					
A.11.2					
A.11.3					
A.11.4					
A.11.5					
A.11.6					
A.11.7					
A.11.8					

A.11.9					
A.11.10					

Secondary Objective A.12: Increase the number of new community gardens and/or increase the number of existing community gardens that are strengthened in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	
Description of reach calculation	

Secondary Objective A.12					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.12.1					
A.12.2					
A.12.3					
A.12.4					
A.12.5					
A.12.6					
A.12.7					

A.12.8					
A.12.9					
A.12.10					

Secondary Objective A.13: Increase the number of: ☐ Cities with improved public transportation options for accessing healthy food and beverage environments in the target community from 0 to **target**. ☐ Counties with improved public transportation options for accessing healthy food and beverage environments in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Cities estimated reach: ☐ Counties estimated reach:
Description of reach calculation	☐ Cities reach calculation: ☐ Counties reach calculation:

Secondary Objective A.13					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.13.1					
A.13.2					
A.13.3					
A.13.4					

A.13.5					
A.13.6					
A.13.7					
A.13.8					
A.13.9					
A.13.10					

Secondary Objective A.14: Increase the number of: ☐ Outside of school care providers that offer healthy food and beverage options in the target community from 0 to **target**. ☐ Group homes that offer healthy food and beverage options in the target community from 0 to **target**. ☐ Other—<**please specify**> that offer healthy food and beverage options in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Outside of school care providers estimated reach: ☐ Group homes estimated reach: ☐ Other--<**please specify**> estimated reach:
Description of reach calculation	☐ Outside of school care providers reach calculation: ☐ Group homes reach calculation: ☐ Other--<**please specify**> reach calculation:

Secondary Objective A.14					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.14.1					

A.14.2					
A.14.3					
A.14.4					
A.14.5					
A.14.6					
A.14.7					
A.14.8					
A.14.9					
A.14.10					

Secondary Objective A.15: Increase the number of: ☐ K-12 schools that increase SNAP enrollment from 0 to **target**. ☐ Other—<**please specify**> that offer healthy food and beverage options in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ K-12 schools estimated reach: ☐ Other--<**please specify**> estimated reach:
Description of reach calculation	☐ K-12 schools reach calculation: ☐ Other--<**please specify**> reach calculation:

Secondary Objective A.15

Activity Number	Activity Title	Description of Activity	Start Date	Completion Date	Outputs/Measures
A.15.1					
A.15.2					
A.15.3					
A.15.4					
A.15.5					
A.15.6					
A.15.7					
A.15.8					
A.15.9					
A.15.10					

Secondary Objective A.16: Increase the number of:

- K-12 schools that develop and implement a healthy cooking and/or nutrition curriculum from 0 to **target**.
- Outside of school care providers that develop and implement a healthy cooking and/or nutrition curriculum from 0 to **target**.
- Substance abuse facilities that develop and implement a healthy cooking and/or nutrition curriculum from 0 to **target**.
- Faith based organizations that develop and implement a healthy cooking and/or nutrition curriculum from 0 to **target**.

☐ Worksites that develop and implement a healthy cooking and/or nutrition curriculum from 0 to **target**. ☐ Prisons that develop and implement a healthy cooking and/or nutrition curriculum from 0 to **target**. ☐ Group homes that develop and implement a healthy cooking and/or nutrition curriculum from 0 to **target**. ☐ Government agencies that develop and implement a healthy cooking and/or nutrition curriculum from 0 to **target**. ☐ Military facilities that develop and implement a healthy cooking and/or nutrition curriculum from 0 to **target**. ☐ Veteran facilities that develop and implement a healthy cooking and/or nutrition curriculum from 0 to **target**. ☐ Other—<**please specify**>	
Estimated number of people reached by the intervention	☐ K-12 schools estimated reach: ☐ Outside of school care providers estimated reach: ☐ Substance abuse facilities estimated reach: ☐ Faith based organizations estimated reach: ☐ Worksites estimated reach: ☐ Prisons estimated reach: ☐ Group homes estimated reach: ☐ Government agencies estimated reach: ☐ Military facilities estimated reach: ☐ Veteran facilities estimated reach: ☐ Other—<**please specify**> estimated reach:
Description of reach calculation	☐ K-12 schools reach calculation: ☐ Outside of school care providers reach calculation: ☐ Substance abuse facilities reach calculation: ☐ Faith based organizations reach calculation: ☐ Worksites reach calculation: ☐ Prisons reach calculation: ☐ Group homes reach calculation: ☐ Government agencies reach calculation: ☐ Military facilities reach calculation: ☐ Veteran facilities reach calculation: ☐ Other—<**please specify**> reach calculation:

Secondary Objective A.16					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**

A.16.1					
A.16.2					
A.16.3					
A.16.4					
A.16.5					
A.16.6					
A.16.7					
A.16.8					
A.16.9					
A.16.10					

Primary Objective B: Increase the number of people in <**target community**> with improved access to opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from 0 to **target** by the end of the project period.

Secondary Objective B.1: Increase the number of new:

- Dental offices referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**.
- Hospitals referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**.

☐ Mental illness providers referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Pharmacies referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Primary care providers referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ K-12 schools referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Outside of school care providers referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Group homes referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Government agencies referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Military facilities referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Veteran facilities referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Faith based organizations referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Cities referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Counties referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Non-profit organizations referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Worksites referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Farmers' markets referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Grocery stores referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**. ☐ Other—<**please specify**> referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Dental offices estimated reach: ☐ Hospitals estimated reach: ☐ Mental illness providers estimated reach: ☐ Pharmacies estimated reach: ☐ Primary care providers estimated reach: ☐ K-12 schools estimated reach: ☐ Outside of school care providers estimated reach: ☐ Group homes estimated reach:

	☐ Government agencies estimated reach: ☐ Military facilities estimated reach: ☐ Veteran facilities estimated reach: ☐ Faith based organizations estimated reach: ☐ Cities estimated reach: ☐ Counties estimated reach: ☐ Non-profit organizations estimated reach: ☐ Worksites estimated reach: ☐ Farmers' markets estimated reach: ☐ Grocery stores estimated reach: ☐ Other—<**please specify**> estimated reach:
Description of reach calculation	☐ Dental offices reach calculation: ☐ Hospitals reach calculation: ☐ Mental illness providers reach calculation: ☐ Pharmacies reach calculation: ☐ Primary care providers reach calculation: ☐ K-12 schools reach calculation: ☐ Outside of school care providers reach calculation: ☐ Group homes reach calculation: ☐ Government agencies reach calculation: ☐ Military facilities reach calculation: ☐ Veteran facilities reach calculation: ☐ Faith based organizations reach calculation: ☐ Cities reach calculation: ☐ Counties reach calculation: ☐ Non-profit organizations reach calculation: ☐ Worksites reach calculation: ☐ Farmers' markets reach calculation: ☐ Grocery stores reach calculation: ☐ Other—<**please specify**> reach calculation:

Secondary Objective B.1

Activity Number	Activity Title	Description of Activity	Start Date	Completion Date	Outputs/Measures
B.1.1					
B.1.2					
B.1.3					
B.1.4					
B.1.5					
B.1.6					
B.1.7					
B.1.8					
B.1.9					
B.1.10					

Secondary Objective B.2: Increase the number of WIC agencies reimbursed by Medicaid and/or private insurance for (a) nutrition services provided by nutrition staff (including weight management, diabetes management, etc.), (b) breastfeeding services provided by WIC staff, and/or (c) new chronic disease prevention and management services that already have existing billing codes in the target community from 0 to **target**.

Estimated number of people reached by the intervention	
Description of reach calculation	

Secondary Objective B.2					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
B.2.1					
B.2.2					
B.2.3					
B.2.4					
B.2.5					
B.2.6					
B.2.7					
B.2.8					
B.2.9					
B.2.10					

Secondary Objective B.3: Increase the number of new: ☐ Dental offices that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Hospitals that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Mental illness providers that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Pharmacies that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Primary care providers that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ K-12 schools that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Outside of school care providers that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Group homes that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Government agencies that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Military facilities that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Veteran facilities that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Faith based organizations that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Cities that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Counties that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Non-profit organizations that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Worksites that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Farmers' markets that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Grocery stores that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ WIC agencies that are integrated into a strong referral network* in the target community from 0 to **target**. ☐ Other—<**please specify**> that are integrated into a strong referral network* in the target community from 0 to **target**. *Integrating into a strong referral network can include the following activities: Developing and disseminating new tools or resources designed to improve awareness of available chronic disease prevention and management services in the community; enhancing the WIC referral list with new community-based chronic disease prevention and management services; increasing the number of community partners that sign clients up for WIC; increasing the number of community partners that refer clients to WIC; increasing the number of community partners (including WIC) that refer and/or sign families up for healthcare; increasing the number of community partners that refer families to other chronic disease prevention and management services in the community; and increasing the number of community partners (including WIC) that offer new chronic disease prevention and management services.	
Estimated number of people reached by the intervention	☐ Dental offices estimated reach: ☐ Hospitals estimated reach: ☐ Mental illness providers estimated reach:

	☐ Pharmacies estimated reach: ☐ Primary care providers estimated reach: ☐ K-12 schools estimated reach: ☐ Outside of school care providers estimated reach: ☐ Group homes estimated reach: ☐ Government agencies estimated reach: ☐ Military facilities estimated reach: ☐ Veteran facilities estimated reach: ☐ Faith based organizations estimated reach: ☐ Cities estimated reach: ☐ Counties estimated reach: ☐ Non-profit organizations estimated reach: ☐ Worksites estimated reach: ☐ Farmers' markets estimated reach: ☐ Grocery stores estimated reach: ☐ WIC agencies estimated reach: ☐ Other—<**please specify**> estimated reach:
Description of reach calculation	☐ Dental offices reach calculation: ☐ Hospitals reach calculation: ☐ Mental illness providers reach calculation: ☐ Pharmacies reach calculation: ☐ Primary care providers reach calculation: ☐ K-12 schools reach calculation: ☐ Outside of school care providers reach calculation: ☐ Group homes reach calculation: ☐ Government agencies reach calculation: ☐ Military facilities reach calculation: ☐ Veteran facilities reach calculation: ☐ Faith based organizations reach calculation: ☐ Cities reach calculation: ☐ Counties reach calculation: ☐ Non-profit organizations reach calculation: ☐ Worksites reach calculation:

	☐ Farmers' markets reach calculation: ☐ Grocery stores reach calculation: ☐ WIC agencies reach calculation: ☐ Other—<please specify> reach calculation:

Secondary Objective B.3					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
B.3.1					
B.3.2					
B.3.3					
B.3.4					
B.3.5					
B.3.6					
B.3.7					
B.3.8					
B.3.9					
B.3.10					

Secondary Objective B.4: Increase the number of new: ☐ Dental offices that make "prescriptions" for non-pharmaceutical interventions like exercise and WIC in the target community from 0 to **target**. ☐ Hospitals that make "prescriptions" for non-pharmaceutical interventions like exercise and WIC in the target community from 0 to **target**. ☐ Mental illness providers that make "prescriptions" for non-pharmaceutical interventions like exercise and WIC in the target community from 0 to **target**. ☐ Pharmacies that make "prescriptions" for non-pharmaceutical interventions like exercise and WIC in the target community from 0 to **target**. ☐ Primary care providers that make "prescriptions" for non-pharmaceutical interventions like exercise and WIC in the target community from 0 to **target**. ☐ Other—<**please specify**> that make "prescriptions" for non-pharmaceutical interventions like exercise and WIC in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Dental offices estimated reach: ☐ Hospitals estimated reach: ☐ Mental illness providers estimated reach: ☐ Pharmacies estimated reach: ☐ Primary care providers estimated reach: ☐ Other—<**please specify**> estimated reach:
Description of reach calculation	☐ Dental offices reach calculation: ☐ Hospitals reach calculation: ☐ Mental illness providers reach calculation: ☐ Pharmacies reach calculation: ☐ Primary care providers reach calculation: ☐ Other—<**please specify**> reach calculation:

Secondary Objective B.4					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
B.4.1					
B.4.2					

B.4.3					
B.4.4					
B.4.5					
B.4.6					
B.4.7					
B.4.8					
B.4.9					
B.4.10					

Secondary Objective B.5: Increase the number of:

- Dental offices with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**.
- Hospitals with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**.
- Mental illness providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**.
- Pharmacies with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**.
- Primary care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**.

☐ K-12 schools with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**. ☐ Outside of school care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**. ☐ Group homes with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**. ☐ Government agencies with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**. ☐ Military facilities with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**. ☐ Veteran facilities with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**. ☐ Faith based organizations with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**. ☐ Non-profit organizations with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**. ☐ Worksites with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**. ☐ Other—<**please specify**> with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Dental offices estimated reach: ☐ Hospitals estimated reach: ☐ Mental illness providers estimated reach: ☐ Pharmacies estimated reach: ☐ Primary care providers estimated reach: ☐ K-12 schools estimated reach: ☐ Outside of school care providers estimated reach: ☐ Group homes estimated reach: ☐ Government agencies estimated reach: ☐ Military facilities estimated reach: ☐ Veteran facilities estimated reach: ☐ Faith based organizations estimated reach: ☐ Non-profit organizations estimated reach:

	☐ Worksites estimated reach: ☐ Other—<please specify> estimated reach:
Description of reach calculation	☐ Dental offices reach calculation: ☐ Hospitals reach calculation: ☐ Mental illness providers reach calculation: ☐ Pharmacies reach calculation: ☐ Primary care providers reach calculation: ☐ K-12 schools reach calculation: ☐ Outside of school care providers reach calculation: ☐ Group homes reach calculation: ☐ Government agencies reach calculation: ☐ Military facilities reach calculation: ☐ Veteran facilities reach calculation: ☐ Faith based organizations reach calculation: ☐ Non-profit organizations reach calculation: ☐ Worksites reach calculation: ☐ Other—<please specify> reach calculation:

Secondary Objective B.5					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
B.5.1					
B.5.2					
B.5.3					
B.5.4					
B.5.5					

B.5.6					
B.5.7					
B.5.8					
B.5.9					
B.5.10					

Secondary Objective B.6: Increase the number of:

- Dental offices with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Hospitals with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Mental illness providers with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Pharmacies with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Primary care providers with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- K-12 schools with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Outside of school care providers with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Group homes with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Government agencies with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Military facilities with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Veteran facilities with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Faith based organizations with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Non-profit organizations with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.
- Worksites with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.

☐ Other—<**please specify**> with providers and/or staff that receive cultural competency training in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Dental offices estimated reach: ☐ Hospitals estimated reach: ☐ Mental illness providers estimated reach: ☐ Pharmacies estimated reach: ☐ Primary care providers estimated reach: ☐ K-12 schools estimated reach: ☐ Outside of school care providers estimated reach: ☐ Group homes estimated reach: ☐ Government agencies estimated reach: ☐ Military facilities estimated reach: ☐ Veteran facilities estimated reach: ☐ Faith based organizations estimated reach: ☐ Non-profit organizations estimated reach: ☐ Worksites estimated reach: ☐ Other—<**please specify**> estimated reach:
Description of reach calculation	☐ Dental offices reach calculation: ☐ Hospitals reach calculation: ☐ Mental illness providers reach calculation: ☐ Pharmacies reach calculation: ☐ Primary care providers reach calculation: ☐ K-12 schools reach calculation: ☐ Outside of school care providers reach calculation: ☐ Group homes reach calculation: ☐ Government agencies reach calculation: ☐ Military facilities reach calculation: ☐ Veteran facilities reach calculation: ☐ Faith based organizations reach calculation: ☐ Non-profit organizations reach calculation: ☐ Worksites reach calculation: ☐ Other—<**please specify**> reach calculation:

Secondary Objective B.6					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
B.6.1					
B.6.2					
B.6.3					
B.6.4					
B.6.5					
B.6.6					
B.6.7					
B.6.8					
B.6.9					
B.6.10					

Secondary Objective B.7: Increase the number of new:

- Dental offices that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to **target**.

☐ Health insurance companies that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to **target**. ☐ Hospitals that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to **target**. ☐ Mental illness providers that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to **target**. ☐ Pharmacies that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to **target**. ☐ Primary care providers that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to **target**. ☐ Other—<**please specify**> that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Dental offices estimated reach: ☐ Health insurance companies estimated reach: ☐ Hospitals estimated reach: ☐ Mental illness providers estimated reach: ☐ Pharmacies estimated reach: ☐ Primary care providers estimated reach: ☐ Other—<**please specify**> estimated reach:
Description of reach calculation	☐ Dental offices reach calculation: ☐ Health insurance companies reach calculation: ☐ Hospitals reach calculation: ☐ Mental illness providers reach calculation: ☐ Pharmacies reach calculation: ☐ Primary care providers reach calculation: ☐ Other—<**please specify**> reach calculation:

Secondary Objective B.7					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
B.7.1					

B.7.2					
B.7.3					
B.7.4					
B.7.5					
B.7.6					
B.7.7					
B.7.8					
B.7.9					
B.7.10					

Secondary Objective B.8: Increase the number of: ☐ Cities with improved public transportation options for accessing chronic disease prevention and management services in the target community from 0 to **target**. ☐ Counties with improved public transportation options for accessing chronic disease prevention and management services in the target community from 0 to **target**.	
Estimated number of people reached by the intervention	☐ Cities estimated reach: ☐ Counties estimated reach:
Description of reach calculation	☐ Cities reach calculation: ☐ Counties reach calculation:

Secondary Objective B.8					
Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
B.8.1					
B.8.2					
B.8.3					
B.8.4					
B.8.5					
B.8.6					
B.8.7					
B.8.8					
B.8.9					
B.8.10					

Primary Objective C: Increase the number of **public** and **partner messages** showcasing CPHMC project efforts and achievements from 0 to 24 by the end of the project period.

Secondary Objective C.1: Increase the number of **public** messages on CPHMC efforts and achievements from 0 to 12 by the end of the project period.	
Write a short narrative about how the activities will result in achieving this secondary objective.	

Secondary Objective C.1						
Activity Number	**Communication Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Media Type (Television, Radio, Print, Social Media, Outdoor, Other)**	**Circulation/ Viewers/ Listeners/ Followers/ Subscribers**
C.1.1						
C.1.2						
C.1.3						
C.1.4						
C.1.5						
C.1.6						
C.1.7						
C.1.8						

C.1.9						
C.1.10						

Secondary Objective C.2: Increase the number of **partner** messages on CPHMC efforts and achievements from 0 to 12 by the end of the project period.	
Write a short narrative about how the activities will result in achieving this secondary objective.	

Secondary Objective C.2						
Activity Number	**Communication Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Partner Media Type (Email listserv/ newsletter, Blog, Social Media)**	**Circulation/ Followers/ Subscribers**
C.2.1						
C.2.2						
C.2.3						
C.2.4						
C.2.5						
C.2.6						

C.2.7						
C.2.8						
C.2.9						
C.2.10						

Appendix A: Secondary Objectives List

Secondary Objectives Related to Primary Objective A:

Secondary Objective A.1: Increase the number of [grocery stores; convenience stores; food banks; mobile grocers] that sell healthy foods and/or expand their inventory of healthy foods in the target community from 0 to target.

Secondary Objective A.2: Increase the number of [grocery stores; convenience stores; food banks] with new on-site and in-store placement and promotion strategies for healthy foods in the target community from 0 to target.

Secondary Objective A.3: Increase the number of new [grocery stores; convenience stores; farmers' markets; other—mobile grocers] that accept WIC in the target community from 0 to target.

Secondary Objective A.4: Increase the number of new [grocery stores; convenience stores; farmers' markets; other—mobile grocers] that accept SNAP in the target community from 0 to target.

Secondary Objective A.5: Increase the number of new [grocery stores; convenience stores; farmers' markets; other—mobile grocers] that offer cash or coupon incentives for purchase of healthy foods in the target community from 0 to target.

Secondary Objective A.6: Increase the number of new [farmers' markets; food banks; other—mobile grocers] in the target community from 0 to target.

Secondary Objective A.7: Increase the number of [restaurants/bars; hospitals; other—please specify] with new healthy menu options and/or using nutrition labeling to identify healthy menu options in the target community from 0 to target.

Secondary Objective A.8: Increase the number of new K-12 schools that implement healthy vending and concession practices in the target community from 0 to target.

Secondary Objective A.9: Increase the number of new K-12 schools that make plain drinking water available throughout the day at no cost to students in the target community from 0 to target.

Secondary Objective A.10: Increase the number of new [hotels/motels; entertainment venues; grocery stores; restaurants/bars; other—please specify] that publicly promote/welcome breastfeeding in the target community from 0 to target.

Secondary Objective A.11: Increase the number of new [K-12 schools; outside of school care providers; dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; faith based organizations; worksites; prisons; group homes; government agencies; military facilities; veteran facilities; other—please specify] that develop and/or implement policies to support breastfeeding in the target community from 0 to target.

Secondary Objective A.12: Increase the number of new community gardens and/or increase the number of existing community gardens that are strengthened in the target community from 0 to target.

Secondary Objective A.13: Increase the number of [cities; counties] with improved public transportation options for accessing healthy food and beverage environments in the target community from 0 to target.

Secondary Objective A.14: Increase the number of [outside of school care providers; group homes; other—please specify] that offer healthy food and beverage options in the target community from 0 to target.

Secondary Objective A.15: Increase the number of [K-12 schools; other—please specify] that increase SNAP enrollment from 0 to target.

Secondary Objectives Related to Primary Objective B:

Secondary Objective B.1: Increase the number of new [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; cities; counties; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to target.

Secondary Objective B.2: Increase the number of new [other—WIC agencies] reimbursed by Medicaid and/or private insurance for (a) nutrition services provided by nutrition staff (including weight management, diabetes management, etc.), (b) breastfeeding services provided by WIC staff, and/or (c) new chronic disease prevention and management services that already have existing billing codes in the target community from 0 to target.

Secondary Objective B.3: Increase the number of new [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; cities; counties; non-profit organizations; worksites; farmer's markets; grocery stores; WIC agencies; other—please specify] that are integrated into a strong referral network* in the target community from 0 to target.

*Integrating into a strong referral network can include the following activities: Developing and disseminating new tools or resources designed to improve awareness of available chronic disease prevention and management services in the community; enhancing the WIC referral list with new community-based chronic disease prevention and management services; increasing the number of community partners that sign clients up for WIC; increasing the number of community partners that refer clients to WIC; increasing the number of community partners (including WIC) that refer and/or sign families up for healthcare; increasing the number of community partners that refer families to other chronic disease prevention and management services in the community; and increasing the number of community partners (including WIC) that offer new chronic disease prevention and management services.

Secondary Objective B.4: Increase the number of new [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; other—please specify] that make "prescriptions" for non-pharmaceutical interventions like exercise and WIC in the target community from 0 to target.

Secondary Objective B.5: Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; non-profit organizations; worksites; other—please specify] with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to target.

Secondary Objective B.6: Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran

facilities; faith based organizations; non-profit organizations; worksites; other—please specify] with providers and/or staff that receive cultural competency training in the target community from 0 to target.

Secondary Objective B.7: Increase the number of new [dental offices; health insurance companies; hospitals; mental illness providers; pharmacies; primary care providers; other—please specify] that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to target.

Secondary Objective B.8: Increase the number of [cities; counties] with improved public transportation options for accessing chronic disease prevention and management services in the target community from 0 to target.

Secondary Objectives Related to Primary Objective C:

Secondary Objective C.1: Increase the number of public messages on CPHMC efforts and achievements from 0 to 12 by the end of the project period.

Secondary Objective C.2: Increase the number of partner messages on CPHMC efforts and achievements from 0 to 12 by the end of the project period.

Appendix B: CAP Terms and Definitions

Activities allow you to break your secondary objectives down into achievable, measurable tasks with specific deadlines throughout the project period.

Activity Titles are the names of the measureable tasks to be completed to reach your secondary objectives.

Activity Descriptions are the more detailed steps for completing the activities.

Baseline is the starting point for your measurement of change. If you're introducing a new intervention, the baseline will be zero. If you are continuing work, you may need to spend time thinking about how to capture a starting point that will help you articulate what you are adding through this project.

Circulation/ Viewers/ Listeners/ Followers/ Subscribers describes the number of people who are likely to view the TV PSA, hear the radio piece, read the newspaper article or PSA, open the social media post, view the billboard, etc.

Interventions are the actual actions you will be taking in your community to meet your Primary Objectives.

Media Type describes the type of media you will use to reach your local community (i.e. television, radio, print media, social media, outdoor communications, etc.).

Messages are unique stories and or perspectives showcasing your project. Please note that each unique message may include several activities. For example, one story may result in 3 separate activities—being shared as a blog post, on Facebook, and on Twitter.

Output/Measures are the products of all your work. Each task will lead to something—and that something is what we will count and evaluate. In some cases, task outputs are clear numbers or a definitive product. But, in many cases, you will produce a range of output types and spend time building systems and relationships that aren't easy to quantify—and that's okay. We want to understand your work; a more complete picture is a more realistic picture, even if it involves lots of different parts.

Partner is an audience type describing people who can be reached via partner communications networks such as email listservs.

Partner Media Type describes the type of media you will use to reach partners (this will almost always be a newsletter or email).

Primary Objectives describe the projected results of your three main strategies: Improving access to environments with healthy food and beverage options; improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages; and increasing the number of public and partner messages showcasing CPHMC project efforts and achievements related to the first two strategies. Primary objectives will determine total reach of project activities. Please keep in mind that each local agency should plan to reach at least 50% of their geographic population.

Public is an audience type describing your local community, which can be reached via television, radio, print media, social media (Facebook, Twitter, etc.), outdoor communications (such as billboards), and other media mechanisms.

Secondary Objectives describe the interventions that fall into these three categories of primary objectives; these interventions will help you achieve your primary objectives. The sum of the reach of the secondary objectives, accounting for overlap, should equal the total projected reach of each corresponding primary objective. You will regularly keep track of progress towards your secondary objectives to calculate your progress towards the primary objectives.

Reach is an estimate of the number of unique individuals you impact in a certain geographic region, in your case the "target community." All local agencies are working in the community setting and are defining reach by jurisdiction (county, city, municipality or neighborhood). Reach only counts one person one time. Reach will never be more than the total population of your settings. For this project, you are required to reach 50% of the target community.

Settings are where the work takes place. All projects have a designated geographic area and are working in the community at a jurisdiction level (county, city, municipality or neighborhoods). Settings could include more specific places (schools, worksites, hospitals, or childcare centers), depending on your particular project goals.

Start Date/Completion Date should be reported in terms of Quarter/Year. In other words**: Q3/2016**: April-June 2016; **Q4/2016**: July-Sept 2016; **Q1/2017**: Oct-Dec 2016; **Q2/2017**: Jan-Mar 2017; Q3/2017: Apr-June 2017.

Target is the ending point for your measurement of change and is meant to capture a realistic estimate of growth during the project period.

Target Community is the overall defined geographic area for the project.

Appendix B: Cohort 2 Secondary Objectives

OBJECTIVES	District 10 Health Department - Lake County	San Juan Basin Public Health	Five Sandoval Indian	Racine Kenosha Community Action Agency	Panhandle Health District-Bonner County	Dunklin County Health Department	Wood County Health Department	Clinton County Health Department	Westbay Community Action Agency	Truman Medical Center	Tri-County Health Department	Mid-Iowa Community Action Agency	Loudoun County Health Department	Southeast Health District - Tattnall County, GA	Thames Valley Community Action Agency	TOTAL
A.1: Increase the number of [setting] that sell healthy foods and/or expand their inventory of healthy foods in the target community from 0 to target.			x					x								2
A.2: Increase the number of [settings] with new on-site and in-store placement and promotion strategies for healthy foods in the target community from 0 to target.	x	x		x	x		x			x	x	x				8
A.3: Increase the number of new settings] that accept WIC in the target community from 0 to target.			x							x	x					3
A.4: Increase the number of new [settings] that accept SNAP in the target community from 0 to target.				x		x										2
A.5: Increase the number of new [settings] that offer cash or coupon incentives for purchase of healthy foods in the target community from 0 to target.					x			x								2
A.6: Increase the number of new [settings] in the target community from 0 to target.	x	x							x				x			4
A.7: Increase the number of [settings] with new healthy menu options and/or using nutrition labeling to identify healthy menu options in the target community from 0 to target.	x						x									2
A.8: Increase the number of new K-12 schools that implement healthy vending and concession practices in the target community from 0 to target.																0
A.9: Increase the number of new K-12 schools that make plain drinking water available throughout the day at no cost to students in the target community from 0 to target.													x			1
A.10: Increase the number of new [settings] that publicly promote/ welcome breastfeeding in the target community from 0 to target.						x		x				x		x	x	5

OBJECTIVES	District 10 Health Department - Lake County	San Juan Basin Public Health	Five Sandoval Indian	Racine Kenosha Community Action Agency	Panhandle Health District-Bonner County	Dunklin County Health Department	Wood County Health Department	Clinton County Health Department	Westbay Community Action Agency	Truman Medical Center	Tri-County Health Department	Mid-Iowa Community Action Agency	Loudoun County Health Department	Southeast Health District - Tattnall County, GA	Thames Valley Community Action Agency	TOTAL
A.11: Increase the number of new [settings] that develop and/ or implement policies to support breastfeeding in the target community from 0 to target.						x	x				x		x	x	x	6
A.12: Increase the number of new community gardens and/ or increase the number of existing community gardens that are strengthened in the target community from 0 to target.		x			x						x					3
A.13: Increase the number of [cities; counties] with improved public transportation options for accessing healthy food and beverage environments in the target community from 0 to target.																0
A.14: Increase the number of [settings] that offer healthy food and beverage options in the target community from 0 to target.						x			x				x			3
A.15: Increase the number of [K-12 schools; other—please specify] that increase SNAP enrollment from 0 to target.													x			1
A.16: Increase the number of [settings] that develop and implement a healthy cooking and/ or nutrition curriculum from 0 to target																0
B.1: Increase the number of new [settings] referring and/or signing patients up for Medicaid and/or private insurance in the target community from 0 to target.																0

OBJECTIVES	District 10 Health Department - Lake County	San Juan Basin Public Health	Five Sandoval Indian	Racine Kenosha Community Action Agency	Panhandle Health District-Bonner County	Dunklin County Health Department	Wood County Health Department	Clinton County Health Department	Westbay Community Action Agency	Truman Medical Center	Tri-County Health Department	Mid-Iowa Community Action Agency	Loudoun County Health Department	Southeast Health District - Tattnall County, GA	Thames Valley Community Action Agency	TOTAL
B.2: Increase the number of new [other—WIC agencies] reimbursed by Medicaid and/or private insurance for (a) nutrition services provided by nutrition staff (including weight management, diabetes management, etc.), (b) breastfeeding services provided by WIC staff, and/or (c) new chronic disease prevention and management services that already have existing billing codes in the target community from 0 to target.			x								x					2
B.3: Increase the number of new [settings] that are integrated into a strong referral network* in the target community from 0 to target.	x	x			x	x							x	x	x	7
B.4: Increase the number of new [settings] that make “prescriptions” for non-pharmaceutical interventions like exercise and WIC in the target community from 0 to target.				x	x		x	x		x	x			x		7
B.5: Increase the number of [settings] with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to target.	x	x					x	x	x	x	x	x	x		x	10
B.6: Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; non-profit organizations; worksites; other—please specify] with providers and/or staff that receive cultural competency training in the target community from 0 to target.											x					1

OBJECTIVES	District 10 Health Department - Lake County	San Juan Basin Public Health	Five Sandoval Indian	Racine Kenosha Community Action Agency	Panhandle Health District-Bonner County	Dunklin County Health Department	Wood County Health Department	Clinton County Health Department	Westbay Community Action Agency	Truman Medical Center	Tri-County Health Department	Mid-Iowa Community Action Agency	Loudoun County Health Department	Southeast Health District - Tattnall County, GA	Thames Valley Community Action Agency	TOTAL
B.7: Increase the number of new [settings] that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to target.										x						1
B.8: Increase the number of [cities; counties] with improved public transportation options for accessing chronic disease prevention and management services in the target community from 0 to target.																0

Appendix C: Project Profiles

Clinton County Health Department
Agency Profile

Clinton County, NY
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Clinton County, NY
Population Total		308,745,538	81,685
Population Density (# people per square mile)	Average	88.23	78.71
	Range	Varies	Under 51 – 5,000
Racial and Ethnic Make-Up	White	74.02%	91.47%
	Black	12.57%	4.29%
	Asian	4.89%	1.34%
	Native American/ Alaska Native	0.82%	0.31%
	Native Hawaiian/ Pacific Islander	0.17%	0.01%
	Other Race	4.73%	1.17%
	Multiple Races	2.80%	1.41%
	Hispanic	16.00%	2.72%
Income	Per Capita	$28,154	$24,940
	% Living in Poverty	15.37%	16.48%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.44

*Community characteristics data were extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Clinton County, NY
% Adults Overweight	35.78%	37.90%
% Adults Obese	27.14%	30.00%
% Adults with Heart Disease	4.40%	5.80%
% Adults with Diagnosed Diabetes	9.11%	9.00%
% Adults with High Cholesterol	38.52%	27.77%
% Adults with Hypertension	28.16%	28.40%
% Babies Born with Low Birth Weight	8.20%	7.30%
Infant Mortality Rate (per 1,000 births)	6.52	6.50
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	8.10%
% of Insured Population Receiving Medicaid	20.21%	23.72%
% Adults Without Any Regular Doctor	22.07%	16.23%
% of Population Living in a Health Professional Shortage Area**	34.07%	0.00%
Food Insecurity Rate	15.94%	12.82%
% Population with Low Food Access***	23.61%	25.17%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	75.30%

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

Clinton County Health Department (CCHD) helped improve healthy food options and encourage healthy choices in their community's food pantries. It performed a baseline nutrition inventory in 13 pantries, trained 18 staff on "nudges," which are subtle environmental changes in the pantry intended to increase demand for healthier items. It implemented these "nudges" in 3 pantries with plans to do so in all 13 with additional funding that the agency has secured. It also partnered with 5 organizations to help encourage healthier donations to the pantries.

CCHD also recruited 5 farm stands and 3 farmers markets to participate in a nutrition incentive program. And, it created a stronger referral system to WIC with 20 pharmacies and 13 daycare providers. Finally, it worked with colleagues to include breastfeeding guidelines for the Clinton County Better Choice Eatery (BCE) Program to incentivize local restaurants to welcome breastfeeding as part of the award program.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Clinton County Health Department
Agency Profile

Starting Capacity and Coalition Partners:

For this project, Clinton County Health Department enhanced an existing coalition, which was established approximately 10 years before. Coalition members engaged in this project represented the following entities, among others: Resident/WIC Peer Counselor; Clinton County Public Transportation; Interfaith Food Shelf; Recreation Director, Town of Plattsburgh; Clinton County Health Department; JCEO; Adirondack Health Institute; Cornell Cooperative Extension; Adirondack Health Institute; Hannaford's Supermarket – Management; Elected Officials; Healthy Neighborhoods Program.

Project Reach:

Overall, Clinton County Health Department reached **95 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **80,287 people.**

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.1	Increase the number of Food banks that sell healthy foods and/or expand their inventory of healthy foods in the target community from 0 to 13 by September 2017.	13
A.5	Increase the number of farmers markets that offer cash or coupon incentives for purchase of healthy foods in the target community from 0 to 4 by September 2017.	8
A.10	Increase the number of restaurants/bars that publicly promote/welcome breastfeeding in the target community from 0 to 5 by September 2017.	8
B.4	Increase the number of pharmacies that that make "prescriptions" for non-pharmaceutical interventions in the target community from 0 to 20 by September 2017.	20
B.4	Increase the number of outside of school providers that that make "prescriptions" for non-pharmaceutical interventions in the target community from 0 to 18 by September 2017.	13
B.5	Increase the number of pharmacies with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 20 by September 2017.	20
B.5	Increase the number of outside of school care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 18 by September 2017.	13

Dunklin County Health Department
Agency Profile

Dunklin County, MO
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Dunklin County, MO
Population Total		308,745,538	31,562
Population Density (# people per square mile)	Average	88.23	58.33
	Range	Varies	Under 51 - 1000
Racial and Ethnic Make-Up	White	74.02%	85.71%
	Black	12.57%	9.76%
	Asian	4.89%	0.42%
	Native American/ Alaska Native	0.82%	0.45%
	Native Hawaiian/ Pacific Islander	0.17%	0%
	Other Race	4.73%	1.87%
	Multiple Races	2.80%	1.79%
	Hispanic	16.00%	6.11%
Income	Per Capita	$28,154	$18,008
	% Living in Poverty	15.37%	27.74%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.47

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Dunklin County, MO
% Adults Overweight	35.78%	40.70%
% Adults Obese	27.14%	31.90%
% Adults with Heart Disease	4.40%	9.30%
% Adults with Diagnosed Diabetes	9.11%	9.60%
% Adults with High Cholesterol	38.52%	41.08%
% Adults with Hypertension	28.16%	45.10%
% Babies Born with Low Birth Weight	8.20%	11.40%
Infant Mortality Rate (per 1,000 births)	6.52	8.70%
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	18.94%
% of Insured Population Receiving Medicaid	20.21%	38.36%
% Adults Without Any Regular Doctor	22.07%	13.30%
% of Population Living in a Health Professional Shortage Area**	34.07%	100%
Food Insecurity Rate	15.94%	20.36%
% Population with Low Food Access***	23.61%	22.13%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	81.7%

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

Dunklin County Health Department established a coalition and worked with local businesses to help them become breastfeeding friendly workplaces. By the end of the project period, it helped 3 businesses achieve the designation and 3 more were in progress. It also provided supporting materials like signs, banners and handouts.

Additionally, the coalition certified 2 nurses as CLCs and created a referral system between providers, the hospital, schools, mental health, and the health department by implementing non-pharmaceutical prescription pads for referrals, creating brochures, and developing a WIC training for other organizations.

Finally, it helped 5 daycare centers offer healthier options and become Eat Smart certified. At the end of the funded project period, it is still working with the local market to try to implement an EBT system, and it is still working with the hospital to implement a skin to skin policy to support breastfeeding.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Dunklin County Health Department
Agency Profile

Starting Capacity and Coalition Partners:

For this project, Dunklin County Health Department started a new coalition in their community. Coalition members engaged in this project represented the following entities, among others; Building Blocks; Health Director; Church; Project Outreach/University Missouri Extension; OBGYN; Head Start/Arbyrd; Kennett Head Start; Early Head Start; Family Counseling Center; DAEOC; Twin Rivers Regional Medical Center, CNO; University of Missouri; Kids R Us; WIC Coordinator; WIC Breastfeeding Peer Counselor.

Project Reach:

Overall, Dunklin County Health Department reached **3 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **8,875 people.**

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.4	Increase the number of farmers markets that accept SNAP in the community from 0 to 1 by September 2017.	0
A.10	Increase the number of mental illness providers that publicly promote/welcome breastfeeding in the target community from 0 to 1 by September 2017.	1
A.10	Increase the number of grocery stores that publicly promote/welcome breastfeeding in the target community from 0 to 2 by September 2017.	2
A.11	Increase the number of hospitals that develop and/or implement policies to support breastfeeding in the target community from 0 to 1 by September 2017.	0
A.14	Increase the number of daycares that offer healthy food and beverage options in the target community from 0 to 19 by September 2017.	0
B.3	Increase the number of mental illness providers that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	0
B.3	Increase the number of outside of school providers that are integrated into a strong referral network in the target community from 0 to 3 by September 2017.	0
B.3	Increase the number of primary care providers that are integrated into a strong referral network in the target community from 0 to 3 by September 2017.	0

Five Sandoval Indian Pueblos, Inc.
Agency Profile

Sandoval County, NM
March 1, 2015 – September 1, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Sandoval County, NM
Population Total		308,745,538	136,638
Population Density (# people per square mile)	Average	88.23	36.82
	Range	Varies	Under 51 - 5000
Racial and Ethnic Make-Up	White	74.02%	69.97%
	Black	12.57%	2.66%
	Asian	4.89%	1.38%
	Native American/ Alaska Native	0.82%	12.30%
	Native Hawaiian/ Pacific Islander	0.17%	0.04%
	Other Race	4.73%	9.73%
	Multiple Races	2.80%	3.91%
	Hispanic	16.00%	36.85%
Income	Per Capita	$28,154	$26,742
	% Living in Poverty	15.37%	14.24%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.43

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Sandoval County, NM
% Adults Overweight	35.78%	38%
% Adults Obese	27.14%	23.8%
% Adults with Heart Disease	4.40%	3.50%
% Adults with Diagnosed Diabetes	9.11%	7.10%
% Adults with High Cholesterol	38.52%	30.46%
% Adults with Hypertension	28.16%	25.50%
% Babies Born with Low Birth Weight	8.20%	8.50%
Infant Mortality Rate (per 1,000 births)	6.52	4.3
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	13.57%
% of Insured Population Receiving Medicaid	20.21%	23.12%
% Adults Without Any Regular Doctor	22.07%	25.08%
% of Population Living in a Health Professional Shortage Area**	34.07%	13.53%
Food Insecurity Rate	15.94%	15.14%
% Population with Low Food Access***	23.61%	43.96%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	77.77%

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

The Five Sandoval Indian Pueblos, Inc. (FSIP) spent time establishing a coalition with members of the 5 tribes that it serves. In an extremely rural area with very low healthy food access, FSIP worked to establish relationships with local food retailers and distributors and explored the option of a mobile market to bring healthier food to the tribes. While FSIP did not establish a new onsite store or mobile market for any of the tribes during the project period, it was able to build important relationships to pave the way for future work related to healthy eating. FSIP secured additional funding beyond the project period for a project focused on reducing consumption of sugar-sweetened beverages.

In addition, FSIP developed a culturally sensitive breastfeeding curriculum that was well-received by tribal women. FSIP plans to extend the curriculum to non-FSIP tribes through school and parenting-based education programs.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Five Sandoval Indian Pueblos, Inc.
Agency Profile

Starting Capacity and Coalition Partners:

Five Sandoval Indian Pueblos, Inc. (FSIP) started a new coalition for this project. Coalition members engaged in this project represented the following entities, among others: MoGro Mobile Grocery; Santa Fe Community Foundation; Jemez Pueblo; Sandia Pueblo; Albuquerque Health Partners Women's Services; Santa Ana Pueblo; Kids Cook! (SNAP-Ed); Five Sandoval Indian Pueblos; FSIP; Santa Ana Pueblo; WIC Mom.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description
A.1	Increase the number of convenience stores that sell healthy foods and/or expand their inventory of healthy foods in the target community from 0 to 2 by September 2017.
A.5	Increase the number of convenience stores that accept WIC in the target community from 1 to 2 by September 2017.
A.10	Increase the number of tribal administration officers and staff who receive basic training in breastfeeding in the target community from 0 to 5 by September 2017. This training is newly developed and culturally sensitive, utilizing tools and activities honoring tribal tradition, values, norms and behaviors to educate tribal leaders in the value of breastfeeding for family and community health and social cohesiveness.

A Note on Five Sandoval Indian Pueblos, Inc.

In contrast to other agencies funded through this project, FSIP provides a range of services to five sovereign Pueblo tribes-Cochiti, Jemez, Sandia, Santa Ana, and Zia-in Sandoval County, NM. Each tribe has its own customs and traditions. All five Pueblos appoint new leaders to tribal government each year, which made it difficult to obtain buy-in from tribal leadership for project objectives given the shifting tribal priorities each year. Additionally, Sandoval County covers 3,716 square miles, making it larger than the states of Rhode Island and Delaware. The rural, remote and sparsely populated nature of several of the Pueblos also contributed to challenges recruiting a healthcare provider for their leadership team, maintaining stable food distribution and supply services, regularly convening a coalition, and fulfilling the communications requirements for the project. While the project structure posed challenges, FSIP made several notable community health achievements outlined on the previous page.

District Health Department #10
Agency Profile

Lake County, MI
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Lake County, MI
Population Total		308,745,538	11,426
Population Density (# people per square mile)	Average	88.23	20.13
	Range	Varies	Under 51
Racial and Ethnic Make-Up	White	74.02%	87.46%
	Black	12.57%	7.89%
	Asian	4.89%	0.10%
	Native American/ Alaska Native	0.82%	0.49%
	Native Hawaiian/ Pacific Islander	0.17%	0.04%
	Other Race	4.73%	0.38%
	Multiple Races	2.80%	3.64%
	Hispanic	16.00%	2.45%
Income	Per Capita	$28,154	$16,679
	% Living in Poverty	15.37%	28.74%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.44

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Lake County, MI
% Adults Overweight	35.78%	No data
% Adults Obese	27.14%	31.30%
% Adults with Heart Disease	4.40%	No data
% Adults with Diagnosed Diabetes	9.11%	9.20%
% Adults with High Cholesterol	38.52%	No data
% Adults with Hypertension	28.16%	No data
% Babies Born with Low Birth Weight	8.20%	8.30%
Infant Mortality Rate (per 1,000 births)	6.52	7.60
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	10.41%
% of Insured Population Receiving Medicaid	20.21%	26.79%
% Adults Without Any Regular Doctor	22.07%	No data
% of Population Living in a Health Professional Shortage Area**	34.07%	0%
Food Insecurity Rate	15.94%	18.98%
% Population with Low Food Access***	23.61%	16.03%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	No data

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

District Health Department #10 created the Choosing Health in Lake County (CHIL) coalition, which sought to make the healthy choice the easy choice. It established a new farmers market onsite at the local WIC clinic. It implemented healthy item labelling at 3 local grocery stores. And, it launched Eat Fit NW Michigan, a healthy menu labeling initiative with an accompanying app that had 2 participating restaurants and 4 pending restaurants at the end of the funded project period.

After the project period, CHIL became part of a working group of the Lake County Community Food Council, secured additional funding for community nutrition projects, and planned to continue to implement Eat Fit NW Michigan with additional restaurants.

*Extracted from submitted success stories, posters, and one-page project fact sheets

District Health Department #10
Agency Profile

Starting Capacity and Coalition Partners:

For this project, District Health Department #10 started a new coalition in their community. Coalition members engaged in this project represented the following entities, among others: Edgettes Wesleyan Church; County Commissioner; WIC Participant; Food Security Advocate; Great Start Collaborative; Natural Choices; Houseman's Foods Center; Save-A-Lot; Circle R Farms; Tiki Hut; Five-Cap; Irons Community Service Center SDA; Local School Board Superintendent.

Project Reach:

Overall, District Health Department #10 reached **14 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **20,837 people.**

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.2	Increase the number of grocery stores with new onsite and in-store placement and promotion strategies for healthy goods in the target community from 0 to 2 by September 2017.	3
A.6	Increase the number of farmers markets in the target community from 0 to 1 by September 2017.	1
A.7	Increase the number of restaurants using nutrition labeling to identify healthy menu options in the target community from 0 to 4 by September 2017.	4
B.3	Increase the number of faith based organizations that are integrated into a strong referral network in the target community from 0 to 2 by September 2017.	4
B.5	Increase the number of worksites with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 5 by September 2017.	2

Loudoun County Health Department
Agency Profile

Loudoun County, VA
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Loudoun County, VA
Population Total		308,745,538	351,129
Population Density (# people per square mile)	Average	88.23	680.80
	Range	Varies	51-5,000
Racial and Ethnic Make-Up	White	74.02%	67.77%
	Black	12.57%	7.43%
	Asian	4.89%	16.20%
	Native American/ Alaska Native	0.82%	0.23%
	Native Hawaiian/ Pacific Islander	0.17%	0.06%
	Other Race	4.73%	3.63%
	Multiple Races	2.80%	4.67%
	Hispanic	16.00%	13.18%
Income	Per Capita	$28,154	$47,495
	% Living in Poverty	15.37%	4.02%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.37

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Loudoun County, VA
% Adults Overweight	35.78%	39.60%
% Adults Obese	27.14%	21.3%
% Adults with Heart Disease	4.40%	2.00%
% Adults with Diagnosed Diabetes	9.11%	7.4%
% Adults with High Cholesterol	38.52%	26.15%
% Adults with Hypertension	28.16%	26.7%
% Babies Born with Low Birth Weight	8.20%	6.8%
Infant Mortality Rate (per 1,000 births)	6.52	4.2
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	8.37%
% of Insured Population Receiving Medicaid	20.21%	4.85%
% Adults Without Any Regular Doctor	22.07%	20.37%
% of Population Living in a Health Professional Shortage Area**	34.07%	0%
Food Insecurity Rate	15.94%	4.25%
% Population with Low Food Access***	23.61%	17.76%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	73.60%

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

The Loudoun County Pediatric Obesity Coalition focused on creating an equitable environment for breastfeeding in their community. It hosted a CLC training with 65 participants, including 20 from WIC agencies across the state. It distributed a toolkit on best practices for breastfeeding support to all local OB-GYNs, pediatricians and family medicine practices. It implemented a lactation support program at the local government. It also developed and distributed a toolkit on breastfeeding friendly workplaces and incorporated breastfeeding criteria into the chamber of commerce's "Healthy Business Challenge."

This coalition was also successful in its work to improve access to drinking water at schools by rewriting the school district's wellness policy; to strengthen the existing referral system between WIC, providers, and community organizations with a resource guide; and to establish two new farmers market sites.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Loudoun County Health Department
Agency Profile

Starting Capacity and Coalition Partners:

The Loudoun County Health Department lead this project from the existing Loudoun Pediatric Obesity Coalition, which was established in 2013. Coalition members engaged in this project represented the following entities, among others: Girls Running Group; Girl Scouts; Connect Northern Virginia Media; Girls on the Run; HealthWorks for Northern Virginia; Community Clinic; INTotal Health Medicaid Services; Junior League of Northern Virginia; MHSADS Mental & Behavioral Health; Loudoun County Health Department; Town of Leesburg; Parks and Recreation; Loudoun County Public Schools; Head Start; School PE; Health and Transportation; Loudoun County Public Schools, Food Service; Local WIC Agency; Loudoun Extension Office Cooperative Extension; Loudoun Family Services Family Services; Loudoun Free Clinic Community Clinic; Loudoun Health Council Health Council; Loudoun Valley; Homegrown Markets; MD; LPOC Founder & Chair; National League of Cities; Northern Virginia Family Service Early Head Start; Community Member; YMCA; Springhouse Green Nutrition, Gardening,& Wellness Experts; Loudoun Veg; Loudoun Interfaith Relief Food Pantry; Feed Loudoun; UMC Faith Organization; Real Food 4 Kids; George Mason University; Loudoun Times; Whole Foods Grocery Store.

Project Reach:

Overall, Loudoun County Health Department reached **442 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **882,650 people.**

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.6	Increase the number of farmers markets in the target community from 0 to 1 by September 2017.	2
A.9	Increase the number of K-12 Schools that make plain drinking water available throughout the day at no cost to students in the target community from 0 to 80 by September 2017.	91
A.9	Increase the number of preschool programs that make plain drinking water available throughout the day at no cost to students in the target community from 0 to 1 by September 2017.	0
A.11	Increase the number of k-12 schools that develop and/or implement policies to support breastfeeding in the target community from 0 to 80 by September 2017.	89
A.11	Increase the number of government agencies that develop and/or implement policies to support breastfeeding in the target community from 0 to 28 by September 2017.	3
A.14	Increase the number of worksites that offer healthy food and beverage options in the target community from 0 to 1 by September 2017.	12
A.15	Increase the number of k-12 schools that increase SNAP enrollment in the target community from 0 to 80 by September 2017.	1
B.3	Increase the number of hospitals that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	1
B.3	Increase the number of primary care providers that are integrated into a strong referral network in the target community from 0 to 50 by September 2017.	47

Loudoun County Health Department
Agency Profile

Objective #	Objective Description	# Settings Reached
B.3	Increase the number of K-12 schools that are integrated into a strong referral network in the target community from 0 to 80 by September 2017.	90
B.3	Increase the number of non-profit organizations that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	2
B.3	Increase the number of farmer's markets that are integrated into a strong referral network in the target community from 0 to 5 by September 2017.	5
B.3	Increase the number of WIC Agencies that are integrated into a strong referral network in the target community from 0 to 2 by September 2017.	0
B.5	Increase the number of primary care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 50 by September 2017.	80
B.5	Increase the number of government agencies with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 15 by September 2017.	15
B.5	Increase the number of hospitals with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 4 by September 2017.	4

Mid-Iowa Community Action Agency Profile

Marshal County and Tama County, IA
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Marshall County, IA	Tama County, IA
Population Total		308,745,538	40,962	17,479
Population Density (# people per square mile)	Average	88.23	71.55	24.24
	Range	Varies	Under 51 – 5,000	Under 51 - 500
Racial and Ethnic Make-Up	White	74.02%	84.41%	88.68%
	Black	12.57%	1.73%	0.51%
	Asian	4.89%	2.89%	0.26%
	Native American/ Alaska Native	0.82%	0.35%	7.28%
	Native Hawaiian/ Pacific Islander	0.17%	0%	0.03%
	Other Race	4.73%	8.95%	1.29%
	Multiple Races	2.80%	1.67%	1.95%
	Hispanic	16.00%	19.28%	8.02%
Income	Per Capita	$28,154	$24,648	$26,431
	% Living in Poverty	15.37%	11.14%	11.27%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.39	0.40

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Marshall County, IA	Tama County, IA
% Adults Overweight	35.78%	31.80%	32.2%
% Adults Obese	27.14%	34.50%	30.8%
% Adults with Heart Disease	4.40%	6.6%	4.2%
% Adults with Diagnosed Diabetes	9.11%	9.1%	7.9%
% Adults with High Cholesterol	38.52%	41.06%	38.18%
% Adults with Hypertension	28.16%	21.2%	22.10%
% Babies Born with Low Birth Weight	8.20%	6.6%	8.7%
Infant Mortality Rate (per 1,000 births)	6.52	2.0	2.8
% of Mothers with Late or No Prenatal Care	17.25%	No data	No data
Adult Uninsured Rate	20.76%	10.53%	9.2%
% of Insured Population Receiving Medicaid	20.21%	23.43%	16.71%
% Adults Without Any Regular Doctor	22.07%	19.59%	17.65%
% of Population Living in a Health Professional Shortage Area**	34.07%	100%	100%
Food Insecurity Rate	15.94%	11.73%	11.73%
% Population with Low Food Access***	23.61%	22.10%	22.10%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	83.6%	83.6%

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

Mid-Iowa Community Action formed a coalition and focused on a community breastfeeding initiative and strengthening the WIC referral system. It developed and implemented a "Breastfeeding Friendly Environment" training packet and developed an online map of breastfeeding friendly environments in the community, which shows the over 20 businesses and organizations in the area that have been designated as having a breastfeeding friendly environment. It trained health care professionals on breastfeeding in a training developed by the Iowa Breastfeeding Coalition. It also designed and implemented a WIC services training and established a universal referral system. It successfully worked with two local food retail outlets to highlight and promote healthy food in their stores.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Mid-Iowa Community Action Agency Profile

Project Reach:

Overall, Mid-Iowa Community Action reached **21 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **103,288 people.**

Starting Capacity and Coalition Partners:

Mid-Iowa Community Action started a new coalition. Coalition members engaged in this project represented the following entities, among others: Medical Center; Iowa State Extension; Mid-Iowa Community Action; Participant/ family member; Tama Public Health Hy-Vee grocery store; Public Health Director of Marshall County; Tama Food Pantry; Breastfeeding Peer Counselor; WIC Coordinator of Story County.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.2	Increase the number of grocery stores with new onsite and in-store placement and promotion strategies for healthy goods in the target community from 0 to 1 by September 2017.	1
A.2	Increase the number of Convenience stores with new onsite and in-store placement and promotion strategies for healthy goods in the target community from 0 to 1 by September 2017.	1
A.10	Increase the number of faith based organizations that publicly promote/welcome breastfeeding in the target community from 0 to 1 by September 2017.	1
A.10	Increase the number of grocery stores that publicly promote/welcome breastfeeding in the target community from 0 to 2 by September 2017.	1
A.10	Increase the number of restaurants/bars that publicly promote/welcome breastfeeding in the target community from 0 to 5 by September 2017.	8
A.10	Increase the number of non-profit organizations that publicly promote/welcome breastfeeding in the target community from 0 to 2 by September 2017.	4
A.10	Increase the number of outside of school care providers that publicly promote/welcome breastfeeding in the target community from 0 to 1 by September 2017.	2
B.5	Increase the number of hospitals with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 1 by September 2017.	1
B.5	Increase the number of primary care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 2 by September 2017.	0
B.5	Increase the number of non-profit organizations with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 1 by September 2017.	2

Panhandle Health District
Agency Profile

Bonner County, ID
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Bonner County, IA
Population Total		308,745,538	41,066
Population Density (# people per square mile)	Average	88.23	23.67
	Range	Varies	Under 51 – 5,000
Racial and Ethnic Make-Up	White	74.02%	95.52%
	Black	12.57%	0.18%
	Asian	4.89%	0.49%
	Native American/ Alaska Native	0.82%	0.56%
	Native Hawaiian/ Pacific Islander	0.17%	0.16%
	Other Race	4.73%	0.44%
	Multiple Races	2.80%	2.67%
	Hispanic	16.00%	2.68%
Income	Per Capita	$28,154	$23,981
	% Living in Poverty	15.37%	15.26%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.46

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Bonner County, IA
% Adults Overweight	35.78%	33.80%
% Adults Obese	27.14%	24.00%
% Adults with Heart Disease	4.40%	4.70%
% Adults with Diagnosed Diabetes	9.11%	5.80%
% Adults with High Cholesterol	38.52%	40.53%
% Adults with Hypertension	28.16%	29.80%
% Babies Born with Low Birth Weight	8.20%	6.10%
Infant Mortality Rate (per 1,000 births)	6.52	6.2
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	15.66%
% of Insured Population Receiving Medicaid	20.21%	18.98%
% Adults Without Any Regular Doctor	22.07%	25.79%
% of Population Living in a Health Professional Shortage Area**	34.07%	100%
Food Insecurity Rate	15.94%	16.87%
% Population with Low Food Access***	23.61%	16.69%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	74.7%

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

The Panhandle Health District developed the coalition Bonner County Coalition for Health, which has almost 100 members separated into four distinct work groups. The "Change for Change" group has worked to establish a coupon incentive program for healthy foods with a local grocer with supportive recipes and store signage. The program has been popular with customers and the grocer is seeing a return on its healthy food coupon investment. The "Bonner County Resources for Health and Wellness" group focused creating a stronger referral network that systematically encouraged healthy behaviors through a healthy lifestyle prescription pad and access to an online resource guide. The "Harvesting for Health" group worked to establish 10 new community gardens. And, the "Bonner County Communications Group" focused on creating and maintaining the coalition website.

The City of Sandpoint secured additional funding to continue community health efforts, and the Bonner County Coalition for Health will serve as the advisory board for the new projects.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Panhandle Health District
Agency Profile

Project Reach:

Overall, Panhandle Health District reached **36 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **153,316 people.**

Starting Capacity and Coalition Partners:

Panhandle Health created a new coalition. Coalition members engaged in this project represented the following entities, among others: Panhandle Health District; Family Health Center; Heart Clinics; Sandpoint Women's Health; Sandpoint Pediatrics; North Idaho College; Caribou orthopedics and sports; Bonner General Health; LPO High School; Kaniksu Land Trust; Lake Pend Orielle School District; Bonner County Commissioner; Panhandle Health District.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.2	Increase the number of grocery stores with new onsite and in-store placement and promotion strategies for healthy goods in the target community from 0 to 1 by September 2017.	1
A.5	Increase the number of grocery stores that offer cash or coupon incentives for purchase of healthy foods in the target community from 0 to 1 by September 2017.	1
A.12	Increase the number of community gardens in the target community from 0 to 1 by September 2017.	10
B.3	Increase the number of primary care providers that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	4
B.3	Increase the number of K-12 schools that are integrated into a strong referral network in the target community from 0 to 7 by September 2017.	1
B.3	Increase the number of non-profit organizations that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	5
B.3	Increase the number of farmers markets that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	1
B.3	Increase the number of grocery stores that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	1
B.3	Increase the number of WIC Agencies, Ob-Gyn's that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	2
B.4	Increase the number of primary care providers that that make "prescriptions" for non-pharmaceutical interventions in the target community from 0 to 1 by September 2017.	5
B.4	Increase the number of specialty clinics that that make "prescriptions" for non-pharmaceutical interventions in the target community from 0 to 1 by September 2017.	5

Racine-Kenosha Community Action Agency Profile

Kenosha County, WI
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Kenosha County, WI
Population Total		308,745,538	167,738
Population Density (# people per square mile)	Average	88.23	616.67
	Range	Varies	Under 51 – Over 5,000
Racial and Ethnic Make-Up	White	74.02%	87.48%
	Black	12.57%	7.38%
	Asian	4.89%	1.39%
	Native American/ Alaska Native	0.82%	0.35%
	Native Hawaiian/ Pacific Islander	0.17%	0.02%
	Other Race	4.73%	1.28%
	Multiple Races	2.80%	2.11%
	Hispanic	16.00%	12.42%
Income	Per Capita	$28,154	$26,514
	% Living in Poverty	15.37%	22.48%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.43

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Kenosha County, WI
% Adults Overweight	35.78%	34.40%
% Adults Obese	27.14%	32.50%
% Adults with Heart Disease	4.40%	1.80%
% Adults with Diagnosed Diabetes	9.11%	8.30%
% Adults with High Cholesterol	38.52%	38.30%
% Adults with Hypertension	28.16%	20.60%
% Babies Born with Low Birth Weight	8.20%	7.80%
Infant Mortality Rate (per 1,000 births)	6.52	5.50%
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	8.56%
% of Insured Population Receiving Medicaid	20.21%	21.90%
% Adults Without Any Regular Doctor	22.07%	16.62%
% of Population Living in a Health Professional Shortage Area**	34.07%	100%
Food Insecurity Rate	15.94%	11.83%
% Population with Low Food Access***	23.61%	21.99%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	77.40%

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS

Notable Project Successes*:

Racine-Kenosha Community Action's Coalition focused on increasing access to healthy food. It worked with 4 local grocery stores on health food promotion and placement. It also collaborated with physician offices, the health department, cooperative extension, and the YMCA on its "Eat. Move. Thrive." prescription pad initiative that involves doctors prescribing healthy food and exercise. It also partnered with Cooperative Extension, which facilitated monthly Cooking Matters at the Store tours. In addition, the coalition was successful in getting SNAP EBT accepted at a local farmers market.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Racine-Kenosha Community Action Agency Profile

Project Reach:

Overall, Racine-Kenosha Community Action reached **20 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **836,340 people.**

Starting Capacity and Coalition Partners:

Racine-Kenosha Community Action built their coalition with members from a coalition established in 2013 with similar core goals. Coalition members engaged in this project represented the following entities, among others: Racine Kenosha Community Action Agency; UW-Extension; United Way of Kenosha; Kenosha Achievement Center Early Head Start; Green Acres Farm; Kenosha Human Development Services-KHDS; CUSH; Women and Children's Horizons; Shalom Center Food Pantry; Kenosha Unified School District-KUSD Head Start; ELCA Outreach Center; Racine/Kenosha Nutrition Education Program; Community member; Gateway Technical College; Kenosha County Division of Health; Kenosha Unified School District- Environmental Science Teacher; Kenosha Community Health Center; Kenosha Lifecourse; Initiative for Healthy Families Partnership Project; State Senator; Aging & Disabilities Resource Center of Kenosha; County Government; Kenosha Area Family & Aging Services; Kenosha Harbor Market; Sharing Center Pantry.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.2	Increase the number of grocery stores with new onsite and in-store placement and promotion strategies for healthy goods in the target community from 0 to 3 by September 2017.	4
A.4	Increase the number of farmers markets that accept SNAP in the community from 0 to 1 by September 2017.	1
B.4	Increase the number of non-profits that that make "prescriptions" for non-pharmaceutical interventions in the target community from 0 to 1 by September 2017.	8
B.4	Increase the number of primary care providers that that make "prescriptions" for non-pharmaceutical interventions in the target community from 0 to 15 by September 2017.	5
B.4	Increase the number of mental illness providers that that make "prescriptions" for non-pharmaceutical interventions in the target community from 0 to 1 by September 2017.	2

San Juan Basin Health Department
Agency Profile

La Plata County and Archuleta County, CO
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	La Plata County, CO	Archuleta County, CO
Population Total		308,745,538	53,182	12,174
Population Density (# people per square mile)	Average	88.23	31.47	9.02
	Range	Varies	Under 51 – 5,000	Under 51 - 500
Racial and Ethnic Make-Up	White	74.02%	88.58%	87.37%
	Black	12.57%	0.38%	0.90%
	Asian	4.89%	0.72%	0.75%
	Native American/ Alaska Native	0.82%	5.50%	2.3%
	Native Hawaiian/ Pacific Islander	0.17%	0.12%	0%
	Other Race	4.73%	2.37%	7.55%
	Multiple Races	2.80%	2.34%	1.13%
	Hispanic	16.00%	12.46%	18.49%
Income	Per Capita	$28,154	$31,822	$28,884
	% Living in Poverty	15.37%	10.59%	11.69%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.43	0.45

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	La Plata County, CO	Archuleta County, CO
% Adults Overweight	35.78%	31.60%	25.40%
% Adults Obese	27.14%	16.10%	16.00%
% Adults with Heart Disease	4.40%	3.80%	4.50%
% Adults with Diagnosed Diabetes	9.11%	4.50%	4.40%
% Adults with High Cholesterol	38.52%	28.54%	29.59%
% Adults with Hypertension	28.16%	19.90%	20.80%
% Babies Born with Low Birth Weight	8.20%	7.50%	9.00%
Infant Mortality Rate (per 1,000 births)	6.52	2.4	8.10%
% of Mothers with Late or No Prenatal Care	17.25%	No data	No data
Adult Uninsured Rate	20.76%	11.55%	14.55%
% of Insured Population Receiving Medicaid	20.21%	13.52%	27.17%
% Adults Without Any Regular Doctor	22.07%	30.02%	19.78%
% of Population Living in a Health Professional Shortage Area**	34.07%	0%	100%
Food Insecurity Rate	15.94%	12.79%	18.26%
% Population with Low Food Access***	23.61%	15.86%	13.10%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	73.70%	No data

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

San Juan Basin Health Department's (SJBHD) Healthy Living Task Force improved access to healthy food through the implementation of several successful strategies. It created two new farm stand sites; one located at the local soup kitchen and the other at a local Head Start site. It also trained teachers on and implemented the CATCH (Coordinated Approach to Child Health) curriculum at local Head Start locations. This curriculum is intended to teach preschool-aged children about physical activity, gardening, nutrition and healthy eating. It also provided 12 laminated "food of the month" lessons to each site intended to complement and help facilitate the CATCH curriculum. Another complementary effort involved creating 3 preschool gardens for hands-on garden learning.

SJBHD also updated and strengthened their internal referral system and hosted WIC 101 trainings for community partners, OB-GYNs, and pediatricians as part of that process.

*Extracted from submitted success stories, posters, and one-page project fact sheets

San Juan Basin Health Department
Agency Profile

Project Reach:

Overall, San Juan Basin Health Department reached **20 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **2,622 people.**

Starting Capacity and Coalition Partners:

For this project, San Juan Basin Health Department created a new task force under the umbrella of a larger existing coalition. Coalition members engaged in this project represented the following entities, among others: Cooking Matters (SNAP-Ed); Growing Partners of SW Colorado; Local Food Policy Council; Local Rancher; CSU Extension; La Plata Family Center/Pine River Shares; Department of Human Services (La Plata County); Department of Human Services (Archuleta County); The Garden Project of SW Colorado; Manna Soup Kitchen

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.2	Increase the number of non-profit agencies with new onsite and in-store placement and promotion strategies for healthy goods in the target community from 0 to 12 by September 2017.	3
A.6	Increase the number of mobile grocers in the target community from 3 to 6 by September 2017.	1
A.12	Increase the number of community gardens in the target community from 4 to 7 by September 2017.	1
B.3	Increase the number of primary care providers that are integrated into a strong referral network in the target community from 0 to 4 by September 2017.	1
B.3	Increase the number of government agencies that are integrated into a strong referral network in the target community from 0 to 2 by September 2017.	1
B.3	Increase the number of non-profit organizations that are integrated into a strong referral network in the target community from 0 to 4 by September 2017.	0
B.3	Increase the number of farmers markets that are integrated into a strong referral network in the target community from 0 to 2 by September 2017.	0
B.5	Increase the number of hospitals with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 1 by September 2017.	0
B.5	Increase the number of primary care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 2 by September 2017.	2
B.5	Increase the number of government agencies with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 4 by September 2017.	1
B.5	Increase the number of non-profit organizations with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 4 by September 2017.	1

Southeast Health District
Agency Profile

Tattnall County, GA
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Tattnall County, GA
Population Total		308,745,538	25, 302
Population Density (# people per square mile)	Average	88.23	52.77
	Range	Varies	Under 51 - 500
Racial and Ethnic Make-Up	White	74.02%	61.04%
	Black	12.57%	28.99%
	Asian	4.89%	0.34%
	Native American/ Alaska Native	0.82%	0.26%
	Native Hawaiian/ Pacific Islander	0.17%	0%
	Other Race	4.73%	6.62%
	Multiple Races	2.80%	2.75%
	Hispanic	16.00%	10.69%
Income	Per Capita	$28,154	$14,956
	% Living in Poverty	15.37%	29.21%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.46

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Tattnall County, GA
% Adults Overweight	35.78%	35.30%
% Adults Obese	27.14%	32.9%
% Adults with Heart Disease	4.40%	4.80%
% Adults with Diagnosed Diabetes	9.11%	10.20%
% Adults with High Cholesterol	38.52%	47.95%
% Adults with Hypertension	28.16%	52.20%
% Babies Born with Low Birth Weight	8.20%	9.4%
Infant Mortality Rate (per 1,000 births)	6.52	10.7
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	24.31%
% of Insured Population Receiving Medicaid	20.21%	27.96%
% Adults Without Any Regular Doctor	22.07%	46.00%
% of Population Living in a Health Professional Shortage Area**	34.07%	100%
Food Insecurity Rate	15.94%	18.26%
% Population with Low Food Access***	23.61%	13.1%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	No data

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

Southeast Health District and their coalition, Mommy & Me, Healthy As Can Be, worked to create a breastfeeding friendly community in their rural county. They established a strong partnership with Meadows Regional Medical Center, which had a shared vision. They specifically focused their efforts on local businesses. Attending community events and visiting each business individually, they built relationships with local businesses, provided education and materials about breastfeeding, encouraged them to welcome breastfeeding, and encouraged them to create lactation rooms. At the end of the project period, over 4 businesses had pledged to become breastfeeding friendly.

This coalition also worked with their local library system to establish two new community gardens.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Southeast Health District
Agency Profile

Project Reach:

Overall, Southeast Health District reached **18 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **51,095 people.**

Starting Capacity and Coalition Partners:

Southeast Health District created a new coalition for this project. Coalition members engaged in this project represented the following entities, among others: Tattnall County Family Connection; Optim Medical Center; Meadows Regional Medical Center; Tattnall County Health Department; Tattnall County Board of Education; Tattnall County School/Community Member; Southside Mobile Healthcare.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.10	Increase the number of grocery stores that publicly promote/welcome breastfeeding in the target community from 0 to 2 by September 2017.	2
A.10	Increase the number of restaurants/bars that publicly promote/welcome breastfeeding in the target community from 0 to 3 by September 2017.	1
A.10	Increase the number of faith based organizations that publicly promote/welcome breastfeeding in the target community from 0 to 2 by September 2017.	0
A.10	Increase the number of government agencies that publicly promote/welcome breastfeeding in the target community from 0 to 2 by September 2017.	1
A.10	Increase the number of hair salons that publicly promote/welcome breastfeeding in the target community from 0 to 1 by September 2017.	1
A.10	Increase the number of worksites that publicly promote/welcome breastfeeding in the target community from 0 to 2 by September 2017.	6
A.10	Increase the number of farm stands that publicly promote/welcome breastfeeding in the target community from 0 to 1 by September 2017.	0
A.10	Increase the number of Libraries that publicly promote/welcome breastfeeding in the target community from 0 to 2 by September 2017.	1
A.10	Increase the number of Health Insurance Companies that publicly promote/welcome breastfeeding in the target community from 0 to 1 by September 2017.	0
A.10	Increase the number of primary care providers that publicly promote/welcome breastfeeding in the target community from 0 to 1 by September 2017.	2
A.10	Increase the number of dental offices that publicly promote/welcome breastfeeding in the target community from 0 to 1 by September 2017.	1
A.11	Increase the number of hospitals, primary care providers, and libraries that develop and/or implement policies to support breastfeeding in the target community from 0 to 3 by September 2017.	0
A.12	Increase the number of gardens in the target community from 0 to 1 by September 2017.	2
B.3	Increase the number of settings that are integrated into a strong referral network in the target community from 0 to 6 by September 2017.	0
B.4	Increase the number of dental offices that that make “prescriptions” for non-pharmaceutical interventions in the target community from 0 to 1 by September 2017.	0
B.4	Increase the number of hospitals that that make “prescriptions” for non-pharmaceutical interventions in the target community from 0 to 1 by September 2017.	1
B.4	Increase the number of primary care providers that that make “prescriptions” for non-pharmaceutical interventions in the target community from 0 to 1 by September 2017.	0

Thames Valley Community Action Agency Profile

New London County, CT
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	New London County, CT
Population Total		308,745,538	273,185
Population Density (# people per square mile)	Average	88.23	410.73
	Range	Varies	51 – Over 5,000
Racial and Ethnic Make-Up	White	74.02%	81.47%
	Black	12.57%	5.62%
	Asian	4.89%	4.16%
	Native American/ Alaska Native	0.82%	0.59%
	Native Hawaiian/ Pacific Islander	0.17%	0.04%
	Other Race	4.73%	3.19%
	Multiple Races	2.80%	4.94%
	Hispanic	16.00%	9.58%
Income	Per Capita	$28,154	$34,2017
	% Living in Poverty	15.37%	9.87%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.43

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	New London County, CT
% Adults Overweight	35.78%	32.60%
% Adults Obese	27.14%	27.30%
% Adults with Heart Disease	4.40%	3.90%
% Adults with Diagnosed Diabetes	9.11%	8.10%
% Adults with High Cholesterol	38.52%	35.58%
% Adults with Hypertension	28.16%	26.90%
% Babies Born with Low Birth Weight	8.20%	7.30%
Infant Mortality Rate (per 1,000 births)	6.52	5.6
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	6.48%
% of Insured Population Receiving Medicaid	20.21%	19.8%
% Adults Without Any Regular Doctor	22.07%	13.24%
% of Population Living in a Health Professional Shortage Area**	34.07%	28.27%
Food Insecurity Rate	15.94%	12.70%
% Population with Low Food Access***	23.61%	41.75%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	71.90%

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

Thames Valley Community Action focused on making New London County breastfeeding friendly. It trained 68 Certified Lactation Consultants (CLCs) within the county's pediatric offices, OB-GYN offices and home visiting agencies. It opened a BabyCafe, which is a facilitated drop-in support meeting for breastfeeding moms. It also worked with local businesses to work toward a Breastfeeding Friendly Worksite award; hosted community forums about how businesses can support breastfeeding; started a community breastfeeding social media campaign; opened a breast milk bank deposit depot; created a nursing station for use at local events; and developed a Breastfeeding 101 training for WIC staff.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Thames Valley Community Action Agency Profile

Starting Capacity and Coalition Partners:

Thames Valley Community Action created a work group under the existing New London County ACHIEVE Coalition. Coalition members engaged in this project represented the following entities, among others: Navy's New Parent Support Home Visiting Program; Lawrence + Memorial; Hospital's Nurturing Family Network; Ledge Light Health District; Pediatrician, United Community & Family Services; Nurse Manager, United Community & Family Services; Nutritionist, Norwich Public Schools; TVCCA; TVCCA Family Advocate; Head Start; Reliance House; Nurse Manager, Community Health Center; Director of Health, Uncas Health District; Pawcatuck Neighborhood Center; Director of Human Services, City of New London; Madonna Place, Director; Riverfront Children's Center; Planned Parenthood; IBCLC, Backus Hospital; Director of Groton Parks & Rec; IBCLC, L+ M Hospital; UConn Center for Public Health & Health Policy.

Project Reach:

Overall, Thames Valley Community Action reached **31 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **391,142 people.**

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.10	Increase the number of farmers markets that publicly promote/welcome breastfeeding in the target community from 0 to 1 by September 2017.	1
A.10	Increase the number of grocery stores that publicly promote/welcome breastfeeding in the target community from 0 to 1 by September 2017.	1
A.10	Increase the number of restaurants/bars that publicly promote/welcome breastfeeding in the target community from 0 to 16 by September 2017.	5
A.10	Increase the number of primary care providers that publicly promote/welcome breastfeeding in the target community from 0 to 10 by September 2017.	1
A.10	Increase the number of other settings that publicly promote/welcome breastfeeding in the target community from 0 to 6 by September 2017.	7
A.11	Increase the number of outside of school care providers that develop and/or implement policies to support breastfeeding in the target community from 0 to 1 by September 2017.	0
A.11	Increase the number of k-12 schools that develop and/or implement policies to support breastfeeding in the target community from 0 to 2 by September 2017.	0
A.11	Increase the number of worksites that develop and/or implement policies to support breastfeeding in the target community from 0 to 1 by September 2017.	5
A.11	Increase the number of government agencies that develop and/or implement policies to support breastfeeding in the target community from 0 to 1 by September 2017.	4
A.11	Increase the number of hospitals that develop and/or implement policies to support breastfeeding in the target community from 0 to 1 by September 2017	0
A.11	Increase the number of primary care providers that develop and/or implement policies to support breastfeeding in the target community from 0 to 2 by September 2017.	2
A.11	Increase the number of military facilities that develop and/or implement policies to support breastfeeding in the target community from 0 to 1 by September 2017.	0
A.11	Increase the number of non-profit organizations that develop and/or implement policies to support breastfeeding in the target community from 0 to 4 by September 2017.	0
B.3	Increase the number of primary care providers that are integrated into a strong referral network in the target community from 0 to 2 by September 2017.	1
B.3	Increase the number of k-12 schools that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	0
B.3	Increase the number of outside school providers that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	0
B.3	Increase the number of non-profit organizations that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	3
B.3	Increase the number of WIC agencies that are integrated into a strong referral network in the target community from 0 to 1 by September 2017.	1
B.5	Increase the number of primary care providers, outside of school care providers, and non-profit organizations with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 299 by September 2017.	0

Tri-County Health District
Agency Profile

Thornton, CO
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Thornton, CO
Population Total		308,745,538	127,688
Population Density (# people per square mile)	Average	88.23	3,577.38
	Range	Varies	501 – Over 5,000
Racial and Ethnic Make-Up	White	74.02%	85.30%
	Black	12.57%	1.62%
	Asian	4.89%	5.01%
	Native American/ Alaska Native	0.82%	0.93%
	Native Hawaiian/ Pacific Islander	0.17%	0.07%
	Other Race	4.73%	3.91%
	Multiple Races	2.80%	3.17%
	Hispanic	16.00%	32.17%
Income	Per Capita	$28,154	$27,617
	% Living in Poverty	15.37%	8.87%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	No data

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Thornton, CO
% Adults Overweight	35.78%	37.20%
% Adults Obese	27.14%	26.20%
% Adults with Heart Disease	4.40%	No data
% Adults with Diagnosed Diabetes	9.11%	No data
% Adults with High Cholesterol	38.52%	No data
% Adults with Hypertension	28.16%	No data
% Babies Born with Low Birth Weight	8.20%	No data
Infant Mortality Rate (per 1,000 births)	6.52	6.6
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	15.65%
% of Insured Population Receiving Medicaid	20.21%	17.20%
% Adults Without Any Regular Doctor	22.07%	No data
% of Population Living in a Health Professional Shortage Area**	34.07%	No data
Food Insecurity Rate	15.94%	10.74%
% Population with Low Food Access***	23.61%	27.37%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	No data

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

Tri-County Health District developed the Bringing Health 2 U coalition, which worked on a variety of community health projects to improve access to healthy foods and to services. The coalition helped local food pantries stock and promote healthy food by developing a toolkit on how to do so. It worked to create new farm stands and have identified a farmer willing to do so who also accepts WIC and SNAP. It strengthened the community referral system by training community partners about WIC and working with care providers to give more referrals to WIC with the use of a prescription pad tool. It also established a Breastfeeding Friendly Worksite award program. There is one certified business, and there are plans for further outreach through the Chamber of Commerce.

This coalition is also working on creating better linkages between WIC and healthcare. It co-located a WIC site with a health care provider office, offering WIC benefits onsite. It is currently working on the legal logistics to be able to offer and bill for breastfeeding services.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Tri-County Health District
Agency Profile

Project Reach:

Overall, Tri-County Health District reached **38 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **141,005 people.**

Starting Capacity and Coalition Partners:

Tri-County Health District created a new coalition for this project. Coalition members engaged in this project represented the following entities, among others: Adams County Housing Authority; SNAP/TANF; Early Childhood Partnership of Adams County; Rocky Mountain Youth Clinic; Head Start; Adams 12 school district; Women's Health Group; North Suburban Medical Center; Birthing Boutique; City of Thornton; Rocky Mountain Youth Clinic; Community Enterprise; Tri-County Health Department; Salud clinics, Brighton; Immaculate Heart of Mary Church; City of Thornton; Tri-County Health Department; Rocky Mountain Youth Clinics.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.2	Increase the number of food banks with new onsite and in-store placement and promotion strategies for healthy goods in the target community from 0 to 2 by September 2017.	0
A.2	Increase the number of government agencies with new onsite and in-store placement and promotion strategies for healthy goods in the target community from 0 to 1 by September 2017.	1
A.3	Increase the number of farm stands that accept WIC in the target community from 0 to 2 by September 2017.	1
A.11	Increase the number of primary care providers that develop and/or implement policies to support breastfeeding in the target community from 0 to 2 by September 2017.	4
A.11	Increase the number of k-12 schools that develop and/or implement policies to support breastfeeding in the target community from 0 to 1 by September 2017.	1
A.11	Increase the number of government agencies that develop and/or implement policies to support breastfeeding in the target community from 0 to 1 by September 2017.	1
A.11	Increase the number of colleges/universities that develop and/or implement policies to support breastfeeding in the target community from 0 to 1 by September 2017.	1
A.11	Increase the number of worksites that develop and/or implement policies to support breastfeeding in the target community from 0 to 5 by September 2017.	3
A.12	Increase the number of community gardens in the target community from 0 to 3 by September 2017.	3
B.2	Increase the number of WIC Agencies reimbursed by Medicaid and/or private insurance for (a) nutrition services provided by nutrition staff, (b) breastfeeding services provided by WIC staff, and/or (c) new chronic disease prevention and management services from 0 to 1 by September 2017.	0
B.4	Increase the number of primary care providers that that make "prescriptions" for non-pharmaceutical interventions in the target community from 0 to 2 by September 2017.	3
B.5	Increase the number of hospitals with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 2 by September 2017.	2
B.5	Increase the number of primary care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 5 by September 2017.	5
B.5	Increase the number of outside of school care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 4 by September 2017.	0
B.5	Increase the number of government agencies with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 2 by September 2017.	1
B.6	Increase the number of hospitals that receive cultural competency training in the target community from 0 to 1 by September 2017.	1
B.6	Increase the number of primary care providers that receive cultural competency training in the target community from 0 to 2 by September 2017.	3
B.6	Increase the number of outside of school care providers that receive cultural competency training in the target community from 0 to 2 by September 2017.	4
B.6	Increase the number of government agencies that receive cultural competency training in the target community from 0 to 2 by September 2017.	3
B.6	Increase the number of faith based organizations that receive cultural competency training in the target community from 0 to 2 by September 2017.	0
B.6	Increase the number of non-profit organizations that receive cultural competency training in the target community from 0 to 1 by September 2017.	1

Truman Medical Centers
Agency Profile

Kansas City, MO
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Kansas City, MO
Population Total		308,745,538	467,990
Population Density (# people per square mile)	Average	88.23	1,485.81
	Range	Varies	51 – Over 5,000
Racial and Ethnic Make-Up	White	74.02%	59.75%
	Black	12.57%	28.90%
	Asian	4.89%	2.62%
	Native American/ Alaska Native	0.82%	0.43%
	Native Hawaiian/ Pacific Islander	0.17%	0.20%
	Other Race	4.73%	2.02%
	Multiple Races	2.80%	1.94%
	Hispanic	16.00%	4.89%
Income	Per Capita	$28,154	$35,157
	% Living in Poverty	15.37%	7.01%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	No data

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Kansas City, MO
% Adults Overweight	35.78%	No data
% Adults Obese	27.14%	No data
% Adults with Heart Disease	4.40%	No data
% Adults with Diagnosed Diabetes	9.11%	No data
% Adults with High Cholesterol	38.52%	No data
% Adults with Hypertension	28.16%	No data
% Babies Born with Low Birth Weight	8.20%	No data
Infant Mortality Rate (per 1,000 births)	6.52	No data
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	19.16%
% of Insured Population Receiving Medicaid	20.21%	19.64%
% Adults Without Any Regular Doctor	22.07%	No data
% of Population Living in a Health Professional Shortage Area**	34.07%	No data
Food Insecurity Rate	15.94%	16.94%
% Population with Low Food Access***	23.61%	26.18%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	No data

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

Truman Medical Centers and its coalition focused efforts on creating mobile markers to improve food access in a community that is otherwise a food desert. Working with the state WIC office, it is planning a pilot of one of the mobile grocers as a WIC-authorized vendor. To encourage shopping at the mobile markets, the coalition has developed a prescription pad for healthy food. It plans to test to see if this system, which also includes a $5 coupon for the mobile market, works to get community members to shop for healthy food at the local market.

The coalition has also worked on educating care providers about WIC and on strengthening the WIC referral system and between other local support organizations and opportunities.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Truman Medical Centers
Agency Profile

Project Reach:

Overall, Truman Medical Centers reached **26 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **762,485 people.**

Starting Capacity and Coalition Partners:

No data.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.2	Increase the number of grocery stores with new onsite and in-store placement and promotion strategies for healthy goods in the target community from 0 to 2 by September 2017.	9
A.3	Increase the number of mobile grocers that accept WIC in the target community from 0 to 1 by September 2017.	0
B.4	Increase the number of primary care providers that that make "prescriptions" for non-pharmaceutical interventions in the target community from 0 to 1 by September 2017.	0
B.4	Increase the number of WIC Clinics that that make "prescriptions" for non-pharmaceutical interventions in the target community from 0 to 1 by September 2017.	2
B.5	Increase the number of primary care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 1 by September 2017.	1
B.5	Increase the number of other settings with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 2 by September 2017.	0
B.5	Increase the number of non-profit organizations with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 5 by September 2017.	3
B.5	Increase the number of grocery stores with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 5 by September 2017.	9
B.7	Increase the number of primary care providers that create and implement policies to assess for healthy behaviors, including access to fruits and vegetables and neighborhood walkability, during the medical history intake with patients, in the target community from 0 to 1 by September 2017.	2

Westbay Community Action Agency Profile

Warwick and West Warwick, RI
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Warwick, RI
Population Total		308,745,538	81,855
Population Density (# people per square mile)	Average	88.23	2,336.06
	Range	Varies	500-5,000
Racial and Ethnic Make-Up	White	74.02%	91.91%
	Black	12.57%	1.40%
	Asian	4.89%	2.58%
	Native American/ Alaska Native	0.82%	0.16%
	Native Hawaiian/ Pacific Islander	0.17%	0%
	Other Race	4.73%	2.02%
	Multiple Races	2.80%	1.94%
	Hispanic	16.00%	4.89%
Income	Per Capita	$28,154	$35,157
	% Living in Poverty	15.37%	7.01%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	No data

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Warwick, RI
% Adults Overweight	35.78%	No data
% Adults Obese	27.14%	No data
% Adults with Heart Disease	4.40%	No data
% Adults with Diagnosed Diabetes	9.11%	No data
% Adults with High Cholesterol	38.52%	No data
% Adults with Hypertension	28.16%	No data
% Babies Born with Low Birth Weight	8.20%	No data
Infant Mortality Rate (per 1,000 births)	6.52	No data
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	12.02%
% of Insured Population Receiving Medicaid	20.21%	14.59%
% Adults Without Any Regular Doctor	22.07%	No data
% of Population Living in a Health Professional Shortage Area**	34.07%	No data
Food Insecurity Rate	15.94%	12.11%
% Population with Low Food Access***	23.61%	31.85%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	No data

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

Westbay Community Action and their coalition created a pop-up farmers market on 2 dates that accepted WIC, SNAP, and senior vouchers. Also as part of the pop-up markets, they implemented a Bonus Bucks program, meaning for every $5 spent at the market, qualifying patrons would receive an additional $2 token to spend at the market. With 598 people served at the markets and $3,124 in sales, the markets were deemed successful and plans were made for 4 dates in the 2017 market season.

Additionally, the coalition created a resource guide of food assistance locations; partnered with the library to serve summer meals with reading before and after the meals, tripling the number of meals served compared with the prior year; and created a more efficient and user-friendly local food delivery system for elders and protectives. Finally, they strengthened their referral system to WIC by developing stronger community partnerships, including WIC in the dropdown menu of community referral options for the Thundermist Health Center, and by providing WIC 101 trainings to health professionals.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Westbay Community Action Agency Profile

Project Reach:

Overall, Westbay Community Action reached **11 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **260,273 people.**

Starting Capacity and Coalition Partners:

Westbay Community Action created a coalition for this project. Coalition members engaged in this project represented the following entities, among others: West Bay Community Action Agency; South Country YMCA; Thunder Mist Health Center; West Warwick School Department; Farm Fresh RI; Sodexo; South Point Church; Brown University Food on the move; West Warwick Library; Echo Valley Property Manager; West Warwick Senior Center.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.6	Increase the number of farmers markets in the target community from 0 to 2 by September 2017.	3
A.14	Increase the number of outside of school care providers that offer healthy food and beverage options in the target community from 1 to 2 by September 2017.	2
A.17	Increase the number of non-profit organizations that establish a new healthy food delivery program from 0 to 1 by September 2017.	1
B.5	Increase the number of dental offices with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 19 by September 2017.	0
B.5	Increase the number of hospitals with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 1 by September 2017.	1
B.5	Increase the number of pharmacies with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 9 by September 2017.	0
B.5	Increase the number of primary care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 23 by September 2017.	2
B.5	Increase the number of k-12 schools with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 23 by September 2017.	0
B.5	Increase the number of outside of school care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 13 by September 2017.	0
B.5	Increase the number of government agencies with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 1 by September 2017.	0
B.5	Increase the number of veteran facilities with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 1 by September 2017.	0
B.5	Increase the number of faith based organizations with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 20 by September 2017.	2

Wood County Health Department
Agency Profile

Wood County, WI
February 15, 2016 – May 19, 2017

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Wood County, WI
Population Total		308,745,538	74,012
Population Density (# people per square mile)	Average	88.23	93.34
	Range	Varies	Under 51 – 5,000
Racial and Ethnic Make-Up	White	74.02%	95.00%
	Black	12.57%	0.53%
	Asian	4.89%	1.99%
	Native American/ Alaska Native	0.82%	0.70%
	Native Hawaiian/ Pacific Islander	0.17%	0.01%
	Other Race	4.73%	0.61%
	Multiple Races	2.80%	1.15%
	Hispanic	16.00%	2.63%
Income	Per Capita	$28,154	$26,515
	% Living in Poverty	15.37%	10.96%
	GINI Index, Income Inequality (0=Perfect Equality; 1=Perfect Inequality)	0.48	0.42

*Community characteristics data was extracted from the agency's Community Health Need Assessment, which was informed by data from the U.S. Census.

Community Health Indicators:

HEALTH INDICATORS*	United States	Wood County, WI
% Adults Overweight	35.78%	37.30%
% Adults Obese	27.14%	31.80%
% Adults with Heart Disease	4.40%	6.60%
% Adults with Diagnosed Diabetes	9.11%	6.50%
% Adults with High Cholesterol	38.52%	43.94%
% Adults with Hypertension	28.16%	23.00%
% Babies Born with Low Birth Weight	8.20%	5.90%
Infant Mortality Rate (per 1,000 births)	6.52	4.3
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	6.83%
% of Insured Population Receiving Medicaid	20.21%	21.80%
% Adults Without Any Regular Doctor	22.07%	22.13%
% of Population Living in a Health Professional Shortage Area**	34.07%	0%
Food Insecurity Rate	15.94%	11.15%
% Population with Low Food Access***	23.61%	24.55%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	77%

*Health indicators data was extracted from the agency's Community Health Needs Assessment, which was informed by data from the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), HHS Health Indicators Warehouse, CDC National Vital Statistics System, Feeding America, USDA-Food Access Research Atlas, and HHS Area Health; **Health Professional Shortage Area= area having a shortage of primary care, dental or mental health professionals; ***Low Food Access = living in census tracts designated as food deserts

Notable Project Successes*:

Wood County Health Department and its community partners have focused on promoting healthy food and existing services. They implemented a "Go, Slow, Whoa" grocery store labeling system in 4 grocery stores, which includes healthy checkout lanes, shelf tags, promoting a fruit or vegetable each month, and education materials about the system. They also created a website for local farmers markets, noting dates/times and which ones accept EBT or WIC, among other information. They have also helped over 15 local restaurants implement the Smart Meal™ menu labelling system to encourage healthy choices.

Finally, they built a strong referral system between WIC, local primary care and mental health providers, and the YMCA and have educated over 25 local providers about WIC services.

*Extracted from submitted success stories, posters, and one-page project fact sheets

Wood County Health Department
Agency Profile

Project Reach:

Overall, Wood County Health Department reached **38 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching **286,720 people.**

Starting Capacity and Coalition Partners:

The Wood County Health Department used the framework of an existing coalition for this project as the coalitions goals aligned well with the project. Coalition members engaged in this project represented the following entities, among others: Mid-State Technical College; Aging Disability and Resource Center; YMCA; Marshfield Clinic, Ministry Health ; Farmshed; Wood County Health Department & Wood County WIC; School Districts (Nekoosa, Pittsville, Wisconsin Rapids); UW-Extension; Wisconsin Rapids Police Department; Security Health; Incourage Community Foundation; Wood County Head Start; The Wellness Barn Studio.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.2	Increase the number of grocery stores with new onsite and in-store placement and promotion strategies for healthy goods in the target community from 0 to 4 by September 2017.	4
A.2	Increase the number of farmers markets with new onsite and in-store placement and promotion strategies for healthy goods in the target community from 0 to 4 by September 2017.	6
A.7	Increase the number of restaurants/bars using nutrition labeling to identify healthy menu options in the target community from 5 to 15 by September 2017.	14
A.11	Increase the number of primary care providers that develop and/or implement policies to support breastfeeding in the target community from 0 to 8 by September 2017.	3
A.11	Increase the number of pharmacies that develop and/or implement policies to support breastfeeding in the target community from 0 to 1 by September 2017.	4
B.4	Increase the number of mental illness facilities that that make “prescriptions” for non-pharmaceutical interventions in the target community from 0 to 3 by September 2017.	1
B.4	Increase the number of primary care providers that that make “prescriptions” for non-pharmaceutical interventions in the target community from 0 to 5 by September 2017.	1
B.5	Increase the number of primary care providers with providers and/or staff that receive basic training in (a) WIC services and benefits, (b) community chronic disease prevention and management services referrals, and/or (c) breastfeeding in the target community from 0 to 20 by September 2017.	2