Community Partnerships for Healthy Mothers and Children

Cohort 1 Evaluation Report

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ALTARUM INSTITUTE

SYSTEMS RESEARCH FOR BETTER HEALTH

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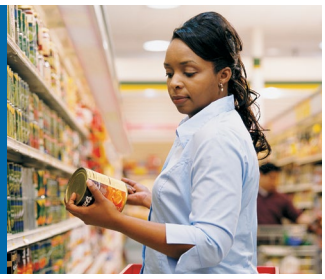


Executive Summary

Project Background and Overview

In 2014, the Center for Disease Control'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. In partnership with the American College of Obstetricians and Gynecologists (ACOG), NWA is supporting 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 Health Mothers and Children (CPHMC), the project is being implemented through two cohorts of local WIC agencies in 18 target states. The WIC agencies were selected via an application process to work with community partners to establish or enhance new 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 in 10 states conducted their projects during the period of January 1, 2015 through March 31, 2016. The majority of these local agencies (10) are government-run health departments, six are non-profit healthcare or community-based agencies, and one is an Indian Tribal Organization. The second cohort's projects will be conducted from February 15, 2016 through May 19, 2017.

Through the CPHMC projects, NWA seeks to achieve the following outcomes:

- Increased collaboration between national and community partners (e .g ., between NWA and ACOG and 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 and ACOG are providing 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, are spearheading these activities in their communities.

Using results of the needs assessment, each Cohort 1 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 of 1) increasing access to environments with healthy food or beverage options, 2) increasing opportunities for chronic disease prevention and care through community and clinical linkages, and 3) increasing the number of public and partner messages showcasing CPHMC project efforts and achievements related to improving access to environments with healthy food and beverage options and/or improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages.

The local projects could select one or more of the suggested secondary objectives for each primary objective or propose other secondary objectives in their CAPs. For each secondary objective included in the CAP, the local projects established targets for settings to be affected, e.g., grocery stores, schools, hospitals, and the estimated number of individuals who could be potentially reached if the objective was accomplished. Projects developed interventions with activities to accomplish each objective with consideration of community needs, resources, partners, and other factors.

Project Evaluation

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

- Whether and how local projects achieved increased collaboration across partners, increased community capacity to implement PSE change, and increased messaging on project activities and PSE changes;
- Whether and how local projects achieved objectives to increase access to environments with healthy food or beverage options and increase opportunities for chronic disease prevention and care; and
- How local projects pursuing common secondary objectives achieved their objectives, including identifying the activities and circumstances that lead to the most successful implementation.

The primary data sources used for the evaluation include local project CAPs and progress reports, early and late-implementation surveys, qualitative interviews of project leaders, and onsite visits with a subset of 8 local projects.

Select Evaluation Findings

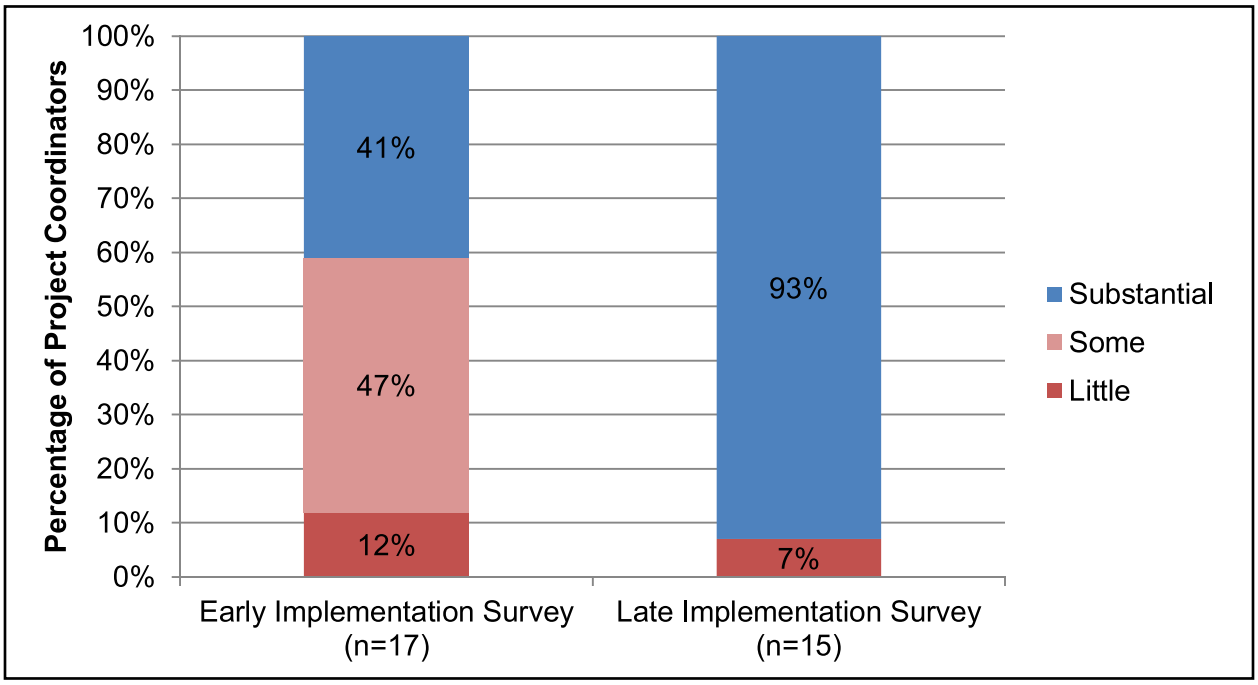
A. Coalition Building, Community Engagement, PSE Experience

Since the primary focus of WIC is to provide nutrition services directly to participants, such as nutrition education, breastfeeding support, and food benefits, working on community-based PSE activities is a relatively new endeavor for many local WIC agencies. For many of the WIC agencies 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, and engaging others in the community and building a coalition to support the project was a critical step in the development and implementation of the CAP.

To assess for change in perception of experience with community engagement, both the early and late-implementation surveys asked local project team members about their experience with community engagement. As shown in Exhibit 1, the percentage of project coordinators (or those in related roles) who responded that they have "substantial experience" more than doubled from the early project time period to the end. By the end of the project, all but one of the respondents indicated they have substantial experience.

Exhibit 1. Early and Late Implementation Survey: Experience with Community Engagement



Similarly, project coordinators reported a sizable increase in experience with PSE with 53% reporting "some" or "substantial" experience in the early-implementation survey and 93% reporting those levels of experience late in the project period.

The projects were asked on the early-implementation survey and interviews about the issues or challenges they faced when building their coalitions. About half said that they did not have any challenges. Of the other half, the major challenges that were noted included:

- Lack of existing, viable coalitions with which to work;
- Availability and time challenges for coalition members to participate and attend meetings;
- The fact that when starting a new coalition, building relationships takes time; and
- Administrative challenges associated with project contracts and approvals contributed to delays in building coalitions.

Responses from the late-implementation surveys showed that once the coalitions were in place, most (67%) of the project coordinators reported that there were few barriers or challenges related to continuing the coalitions. Nearly all projects (13 projects) reported on the late-implementation survey that the coalitions will continue to meet beyond the end of the project, and 12 of the projects said they will seek funds from other sources to continue project activities. Further, project coordinators unanimously responded "yes" to the question on the late-implementation survey, "Will you continue to engage some or all of your community partners beyond the end of the CPHMC Project?"

B. Project Implementation Successes and Challenges

Each Cohort 1 project set a goal for the number of settings they anticipated they could affect through each secondary objective included in their CAP and they also provided an estimate of the number of people who could be reached if the objective was accomplished. Projects then reported on the number of settings and people reached through implementation of project activities. Across all projects, about 40% of the targets for settings were achieved or exceeded and about half (48%) of the reach targets were met or exceeded by the end of the project period. For targets not achieved, there was significant progress towards meeting the goals.

Through surveys and interviews, project team members identified strategies and interventions that were successful. Examples include, but are not limited to:

- Increase in healthy food options in neighborhood corner stores;
- Promotion of the WIC program and enhanced WIC referral system;
- Development of tools and resources to increase awareness of healthy eating options and community-based preventive care services;
- Strengthened community, employer, and school partnerships to support breastfeeding mothers;
- Increase in healthy restaurant options and promotion of healthy menu offerings;
- Greater utilization of and improved access to farmers' markets;
- Donations of fresh produce by farmers to food banks/pantries; and
- Promotion of the project through 70 million media impressions through local newspapers, local television, radio, social/digital media, and other markets;

Project team members also identified a few interventions that were difficult to complete or even "get off the ground." Examples of these challenges are noted below.

- Working with school to increase community gardens and offerings of drinking water and healthier food options;
- Increasing the number of WIC-authorized retailers;
- Implementing "Green Prescriptions for Healthy Living" for Healthy Foods and Lifestyles; and
- Increasing the number of businesses that provide accommodations for breastfeeding mothers.

C. Next Steps and Lessons Learned

In late-implementation interviews and final project reports, 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 interventions that will continue, e.g., community or school gardens, maintenance of websites, sharing community resources. Others commented on their commitment to maintaining coalition engagement and sustaining project activities as well as pursuing additional funding sources to continue these efforts.

Through a combination of late-implementation surveys, interviews and, project reports, project staff shared lessons learned and gave recommendations for other WIC agencies relative to engaging in PSE change efforts in their communities . Success themes shared by respondents include the following:

- Importance of community buy-in and collaborative community coalitions and partners;
- Significance of ongoing communication and exchange of ideas among stakeholders;
- Leveraging of the expertise of coalition members, partners and WIC staff to implement activities and accomplish project objectives;
- Being realistic and focused on the quality and feasibility—not quantity—of project objectives;
- Thoughtful planning processes and recognition that time and resources can be limited;
- Understanding of the cultural issues and needs of the community; and
- Recognize successful efforts of other groups, and don't "reinvent the wheel".

Conclusions

The findings from the evaluation of CPHMC Cohort 1 projects support the conclusions described below.

1. **WIC can play an important role in creating partnerships to implement PSE changes for improving the food environment and promoting linkages for chronic disease prevention and treatment services.** The CPHMC project clearly demonstrates 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, farmer's 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. **Cohort 1 projects are an asset for Cohort 2 projects and other WIC agencies that are interested in community-based work.** The experiences, suggestions, and lessons learned by the first cohort should help increase project success for the second cohort and serve as an outline for others. Pairing Cohort 1 agencies as "mentors" for agencies participating in Cohort 2 may be particularly effective, especially if the agency pairs have similar project objectives and activities.
4. **Cohort 1 agencies should pursue opportunities to build upon their success by working 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.** Work with schools on policy changes or businesses on breastfeeding accommodation are two examples of efforts undertaken by Cohort 1 projects that were not realistic to accomplish in an implementation timeframe 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 assessment at the beginning of the project to determine what is feasible and over what time frame activities can be reasonably accomplished is an important planning step.
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.

I. Project Background and Overview

In 2014, the Center for Disease Control'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. In partnership with the American College of Obstetricians and Gynecologists (ACOG), NWA is supporting 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 Health Mothers and Children (CPHMC), the project is being implemented through two cohorts of local WIC agencies in 18 target 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's projects will be conducted from February 15, 2016 through May 19, 2017.

Altarum Institute's Center for Food and Nutrition was contracted to conduct an evaluation of Cohort 1 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 and presents findings from the evaluation activities.

CPHMC Outcomes and Objectives

Through the CPHMC projects, NWA seeks to achieve the following outcomes:

- Increased collaboration between national and community partners (e.g., between NWA and ACOG and 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 and ACOG are providing 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, are spearheading these activities in their communities.

Using results of the needs assessment, each Cohort 1 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 suggested secondary objectives for each of three outcomes or primary objectives of 1) increasing access to environments with healthy food or beverage options, 2) increasing opportunities for chronic disease prevention and care through community and clinical linkages, and 3) Increasing the number of public and partner messages showcasing CPHMC project efforts and achievements related to improving access to environments with healthy food and beverage options and/or improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages. Examples are shown in Exhibit 1.

Exhibit 1. Sample Project Objectives

Primary Objective: Increase 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
Primary Objective 2: Increase opportunities for chronic disease prevention and care through community and clinical linkages
• Increase the number of tools or resources to improve awareness of available chronic disease prevention and management services
• Increase the number of settings that offer new chronic disease prevention and management services
• Increase the number of healthcare staff and community partners that receive training on WIC services and//or breastfeeding
Primary Objective 3: Increase the number of public and partner messages showcasing CPHMC project efforts and achievements
• Increase the number of public messages around efforts and achievements to improve access to environments with healthy food and beverage options
• Increase the number of partner messages around efforts and achievements related to improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages

The local projects could select one or more of the suggested secondary objectives for each primary objective or propose other secondary objectives in their CAPs. For each secondary objective included in the CAP, the local projects established targets for settings to be affected, e.g., grocery stores, schools, hospitals, and the estimated number of individuals who could be potentially reached if the objective was accomplished. The number of individuals who could be reached represent the best estimates of the project staff with input from the NWA team. Projects developed interventions with activities to accomplish each objective with consideration of community needs, resources, partners, and other factors.

Throughout the project implementation period, Cohort 1 projects provided NWA with progress reports, project communications, and “implementation stories.” Along with other data collected from Cohort 1, these documents were used for an evaluation of Cohort 1 outcomes.

Organization of Report

This report includes five sections following this project overview along with several appendices. Section 2 provides a description of the evaluation methods and data collection activities. Section 3 presents a description of the Cohort 1 local WIC agencies and projects. Evaluation findings are included in Section 4, with sub-section discussions of Coalition Building and Community Engagement, Project Implementation Experience and Capacity Building, Sustainability and Lessons Learned. Conclusions are shared in Section 5. Appendices are referenced throughout the report.

II. Evaluation Methods

A mixed methods evaluation approach was used to explore:

a. Whether and how local projects achieved increased collaboration across partners, increased community capacity to implement PSE change, and increased messaging on project activities and PSE changes;

b. Whether and how local 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.

The focus of the evaluation was to understand the CPHMC project implementation experience and factors that facilitated or hindered implementation of the project activities and achievement of objectives. Key evaluation questions are shown in Exhibit 2.

Exhibit 2. 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 these 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?

Data Sources

The primary data sources used for the evaluation are shown in Table 1. Local project CAPs and progress reports were incorporated into the evaluation for all 17 Cohort 1 projects, and all were asked to complete pre and early-implementation web surveys and project leadership team interviews. A subset of eight local projects participated in additional onsite interviews with project staff and community partners and observation of project activities. Sixteen of the projects were asked to complete a late-implementation survey and interview. The Five Sandoval Indian Pueblos, Inc. project was continued as part of Cohort 2 and was not included in the late-implementation survey or interviews.

Table 1. Evaluation Data Sources

Data Source	Description	Projects Included*
Local project CAPs and progress reports	These documents provided data relevant for several evaluation questions. The target and estimated intervention reach for objectives in each project's CAP were compared to the actual target and reach numbers reported through progress reports. Qualitative information in progress reports informed evaluation questions associated with implementation success and challenges.	17 projects
Early-implementation survey of project leadership team	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 and partnerships and their readiness to implement the activities in the CAP.	17 projects 41 completed surveys
Early-implementation interviews with project leadership team	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 CAP development, early implementation, and successes and/or barriers.	17 projects 17 completed interviews
Onsite visits with interviews and observations	Onsite visits during the late-implementation period included interviews with project team members, project partners, and other staff in project organizations as well as observations of project activities.	8 projects 8 completed visits
Late-implementation survey of project leadership team	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 and success in achieving project objectives.	16 projects 39 completed surveys
Late-implementation interviews with project leadership team	Interviews with project coordinators and other members of the project leadership team were conducted during onsite visits or by phone near the end of the project implementation. These interviews focused on CAP implementation and key successes and/or barriers, project sustainability, capacity built, and lessons learned.	16 projects 16 completed interviews

* The Five Sandoval Indian Pueblos, Inc. project was continued as part of Cohort 2 and was not included in the late-implementation survey or interviews.

Analysis

Responses to web surveys were imported into SAS for tabulation of multiple choice and rating questions and compilation of qualitative responses. Interview responses were analyzed using QSR International NVivo, Version 10, 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 implementation partners.

III. Description of Cohort 1 Projects

The CPHMC Cohort 1 included 17 organizations that operate WIC programs in 10 states. The majority of the organizations (10) are government-run health departments, six are non-profit healthcare or community-based agencies, and one is an Indian Tribal Organization. Table 2 shows the organizations that participated in Cohort 1.

Table 2. Cohort 1 Organizations

Organization Name	Location	Organization Type
Angelina County and City Health Department	Lufkin, Texas	Government
CCI Health and Wellness Services	Silver Spring, Maryland	Non-profit
Crescent City WIC Services, Inc.	Gretna, Louisiana	Non-profit
Cumberland Plateau Health District	Tazewell, Virginia	Government
District Health Department #10	Cadillac, Michigan	Government
East Side Health District	East St. Louis, Illinois	Government
Eastern Shore Health District	Accomac, Virginia	Government
Edgerton Women's Health Center	Davenport, Iowa	Non-profit
Five Sandoval Indian Pueblos Inc.	Bernalillo, New Mexico	Indian Tribal Organization
Gateway Community Action Partnership	Bridgeton, New Jersey	Non-profit
Geary County Health Department	Junction City, Kansas	Government
Johns Hopkins University WIC Program	Baltimore, Maryland	Non-profit
Mount Rogers Health District	Marion, Virginia	Government
Richmond City Health District	Richmond, Virginia	Government
St Tammany Parish Hospital Community Wellness Center	Covington, Louisiana	Non-profit
Tarrant County Public Health Department	Fort Worth, Texas	Government
Wichita Falls-Wichita County Public Health District	Wichita Falls, Texas	Government

During the early implementation interviews, projects were asked to describe the staff members involved in the project. While many of the organizations identified existing staff members to serve as Project Coordinator, a small number hired individuals for that role. Of the Project Coordinators who were existing staff members of the organization, they were employed between 1 and 27 years. Some of the Cohort 1 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. Project staff had a variety of job titles and roles, e.g., Coalition Coordinator, Outreach Coordinator, Community Partnership Coordinator.

In addition to staff designated for project leadership roles, most of the projects had WIC program staff directly involved in project implementation activities. Examples of

WIC staff involved in project implementation include breastfeeding coordinator, peer counselor or Registered Dietitian.

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 the input of NWA and ACOG staff. For the third primary objective pertaining to messaging and communication, local projects were required to include four standard secondary objectives in their CAP.

All local projects selected one or more secondary objectives for primary objectives 1 and 2. As shown in Table 3, some secondary objectives were selected by multiple local projects while others were included in only one local project CAP.

Table 3. Secondary Objectives in Project CAPs

Secondary Objectives	Number of Projects That Selected Objective
Primary Objective 1: Increase access to environments with healthy food or beverage options	
Increase the number of [retail environments: grocery stores; convenience stores] that sell "healthy" foods in the target community from baseline to target.	3
Increase the number of [retail environments: grocery stores; convenience stores] that expand their inventory of "healthy" foods in the target community from baseline to target.	6
Increase the number of [retail environments: grocery stores; convenience stores] that accept WIC in the target community from baseline to target.	3
Increase the number of [retail environments: grocery stores; convenience stores] with new on-site and in-store placement and promotion strategies for healthy foods in the target community from baseline to target.	7
Increase the number of grocery stores with employees trained to assist shoppers to select healthy foods from baseline to target.	3
Increase the number of [retail environments: grocery stores; convenience stores] that offer cash or coupon incentives for purchase of healthy foods in the target community from baseline to target.	1
Increase the number of farmers' markets that offer cash or coupon incentives for the purchase of healthy foods in the target community from baseline to target.	2
Increase the number of farmers' markets available in the target community from baseline to target.	3
Increase the number of farmers markets that accept SNAP and/or WIC in the target community from baseline to target.	1
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; entertainment venues; faith based organizations; gardens; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; convenience stores; restaurants/bars; other—please specify] using new tools or resources to create awareness of how to access healthy food options in the community from baseline to target.	10
Increase the number of restaurants/bars using nutrition labeling to identify "healthy" menu options in the target community from baseline to target.	2
Increase the number of restaurants/bars with new "healthy" menu options in the target community from baseline to target.	2
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 baseline to target.	1
Increase the number of grocery stores participating in the Share Our Strength Cooking Matters at the Store program in the target community from baseline to target.	6

Secondary Objectives	Number of Projects That Selected Objective
Increase the number of [hotels/motels; entertainment venues; grocery stores; restaurants/bars; other—please specify] that publicly promote/welcome breastfeeding in the target community from baseline to target.	6
Increase the number of [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 from baseline to target.	2
Increase the number of [other—food banks] that offer healthy food and beverage options in the target community from baseline to target.	1
Increase the number of [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 improved access to health food and beverage options from baseline to target.	1
Increase the number of K-12 schools in the community that successfully implement a gardening curriculum from baseline to target.	1
Increase the number of gardens in the community from baseline to target.	1
Primary Objective 2: Increase opportunities for chronic disease prevention and care through community and clinical linkages	
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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] signing clients up for/referring to the WIC program from baseline to target.	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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] referring and/or signing patients up for healthcare from baseline to target.	3
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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] using new tools or resources to improve awareness of available chronic disease prevention and management services in the community from baseline to target.	7
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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] that use an enhanced WIC referral list with new community-based chronic disease prevention and management services added from baseline to target.	2
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] that refer to WIC in the target community from baseline to target.	3
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] that refer families to health care (a patient-centered medical home) in the target community from baseline to target.	1

Secondary Objectives	Number of Projects That Selected Objective
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] that refer families to other chronic disease prevention and management services in the community from baseline to target.	1
Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; other—please specify] that make "prescriptions" for non-pharmaceutical interventions like exercise in the target community from baseline to target.	2
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 basic training in breastfeeding in the target community from baseline to target.	5
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 basic training in community chronic disease prevention and management services referrals in the target community from baseline to target.	2
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 baseline to target.	4
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 basic training on WIC services and benefits in the target community from baseline to target.	8
Increase the number of [dental offices; health insurance companies; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; 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 baseline to target.	1
Increase the number of [other—WIC sites] that have the capacity to bill for preventive nutrition and breastfeeding services outside the scope of the WIC program in the target community from baseline to target.	1
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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] that offer new chronic disease prevention and management services in the target community from baseline to target.	3
Primary Objective 3: 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 related to improving access to environments with healthy food and beverage options from baseline to target by the end of the project period	17
Increase the number of public messages on CPHMC efforts and achievements related to improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from baseline to target by the end of the project period	17

Secondary Objectives	Number of Projects That Selected Objective
Increase the number of partner messages on CPHMC efforts and achievements related to improving access to environments with healthy food and beverage options from baseline to target by the end of the project period	17
Increase the number of partner messages on CPHMC efforts and achievements related to improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from baseline to target by the end of the project period	17

A table showing the secondary objectives selected by each of the Cohort 1 projects is included as Appendix B.

IV. Findings

Findings: Coalition Building and Community Engagement

Since the primary focus of WIC is to provide nutrition services directly to participants, such as nutrition education, breastfeeding support, and food benefits, working on community-based PSE activities is a relatively new endeavor for many local WIC agencies. Some WIC agencies have undertaken efforts to improve the retail food environment for WIC participants through policy and environmental activities with grocery stores, but these efforts are often led at the WIC State agency level rather than by local agencies. Others have worked on initiatives to expand farmer's 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; however, such activities are not the norm. For many of the WIC agencies 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, local projects were required to develop a project leadership team composed of local WIC agency staff, a healthcare provider, and a WIC client or patient representative. Next, it was necessary to either form a community coalition or join an existing coalition(s) that would work together on the project objectives. Finally, the projects were required to conduct a community needs assessment and develop a CAP with secondary objectives targeting specific settings and groups. Many of the secondary objectives selected by the projects required forming partnerships with community providers, organizations, and businesses with which they had not had much prior engagement. For example, projects selected objectives targeting:

- Restaurants to add healthy menu options and clearly identify healthier choices on menus;
- Local employers to provide support for breastfeeding employees or provide space within the business for customers to breastfeed;
- Small "corner" stores, many of which may not have been WIC vendors, to add produce and other healthy foods to their inventories;
- Hospitals and healthcare providers to improve breastfeeding support through changes in policies and practices; and
- Food banks and pantries to increase healthy food choices.

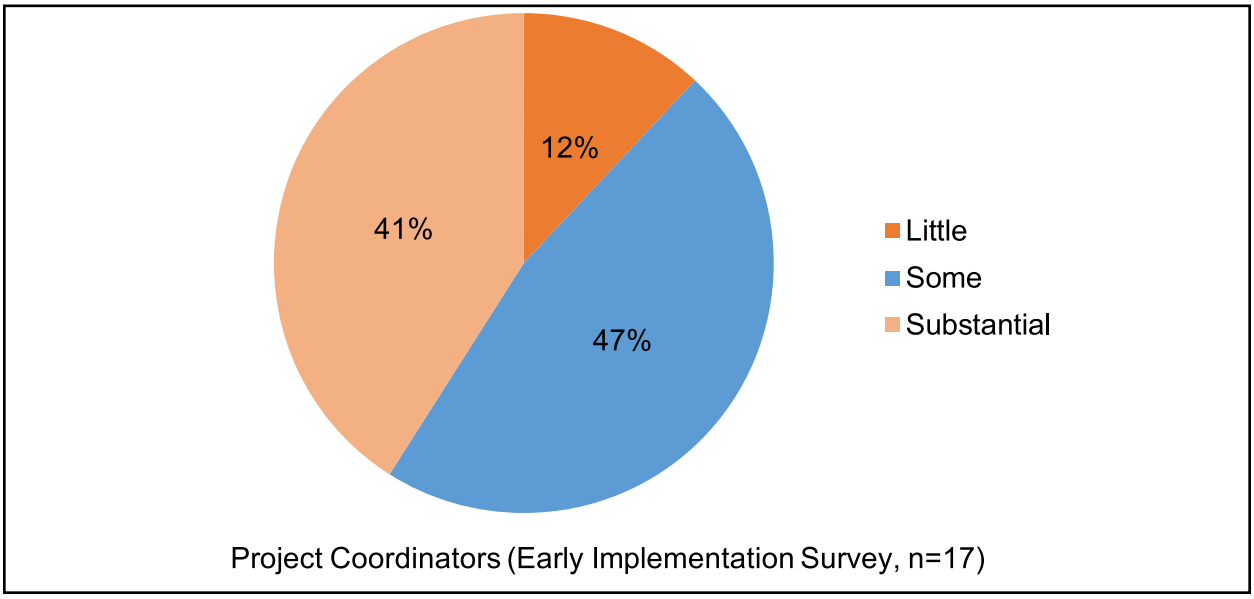
One aspect of the evaluation was to examine how well prepared the local project teams were to conduct these new PSE activities. Questions were included in both the early implementation survey and interviews to gather information from project leadership teams including:

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

A. Project Team Experience with Community Engagement and PSE

Engaging others in the community and building a coalition to support the project was a critical step in the development and implementation of the CAP. Local projects were encouraged to join existing coalitions if there were appropriate coalitions in existence or to establish a new coalition for the project. In the early implementation survey, project team members were asked about their prior experience working 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, about 59% of the respondents who indicated they were project coordinators or in a related role had little or some experience in this type of activity while 41% indicated that they had substantial experience.

Exhibit 3. Project Coordinator: Prior Experience with Community Engagement



Project Coordinators (Early Implementation Survey, n=17)

Healthcare providers on leadership teams who responded to the survey (n=9) had similar responses with 56% indicating they had little or some experience with community engagement and 44% indicating that they had substantial experience.

Examples of community engagement experience shared by survey respondents and during pre-implementation interviews included:

> ***"I am a member of two of the coalitions the CPHMC project is working with."***

"I'm our agency's community outreach coordinator. I attend community partner meetings and health fairs."

"I worked previously running community coalitions and also have worked on community non-profits building partnerships and collaboration for many years."

"I am active in the local American Academy of Pediatrics and our projects involve quite a bit of community engagement."

"I have worked with community agencies in trying to address the special needs of my patients affecting their well-being."

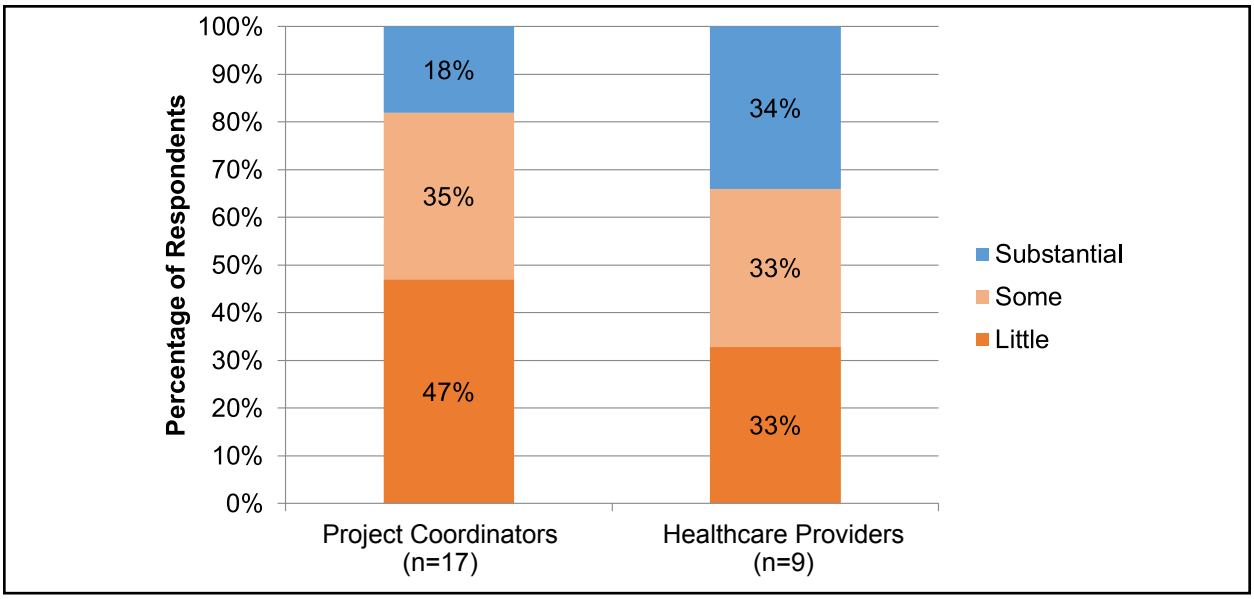
"I lead a health committee and organize health events in the community."

"I established a breastfeeding coalition and have collaborated with food pantries."

"I really enjoyed helping to start up the coalition. I've never done that before and I've never really had to look for people in the community to help with the project."

Prior to the CPHMC, the project leadership team members had limited experience in implementing projects focused on PSE changes as indicated in the early implementation survey. Respondents were asked about their experience in implementing PSE. As shown in Exhibit 4, most (82%) of the project coordinators reported that they had little or some experience implementing PSE activities while only 18% reported having substantial experience. For healthcare providers, the percentages were evenly split, with one-third having little or no experience, one-third with some experience, and one-third with substantial experience.

Exhibit 4. Project Coordinator and Healthcare Provider experience with Implementing PSE Changes



Comments related to experience with PSE from survey respondents include:

> ***"My focus is on programs, services and resources vs. PSE."***
>
> ***"There was little experience before this project."***
>
> ***"Working with some of the community groups enabled us to work with policy-level changes such as community/worksite breastfeeding policies."***
>
> ***"Lots of change management in organizations but not the social or community context of this project."***
>
> ***"I worked on development of an Active Living Policy for the county with multiple PSE strategies in 12 sectors, e.g. schools, businesses."***
>
> ***"Worked on food policy initiatives in a previous job."***

"We were working on projects that impacted policy, system, and environmental changes, but we did not call it that or recognize it as being that! We were just improving our community."

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. Three areas were examined, including how confident they were that:

- The right partners and stakeholders were identified;
- They had or would be able to build positive relationships with these partners/stakeholders; and
- The project had developed or could develop partnerships that would support the goals and objectives of the project.

A majority of the project coordinators reported on the pre-implementation survey that they were "very confident" that the right partners and stakeholders were engaged (52%), they had or would be able to build positive relationships (65%), and that partnerships would be supportive of the project goals and objectives (59%).

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 most 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 the 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 early-implementation interviews.

> ***"I am surprised at the overwhelming support and involvement of our local government, stakeholders and community. Our coalition members are highly engaged and are committed to our action plans."***

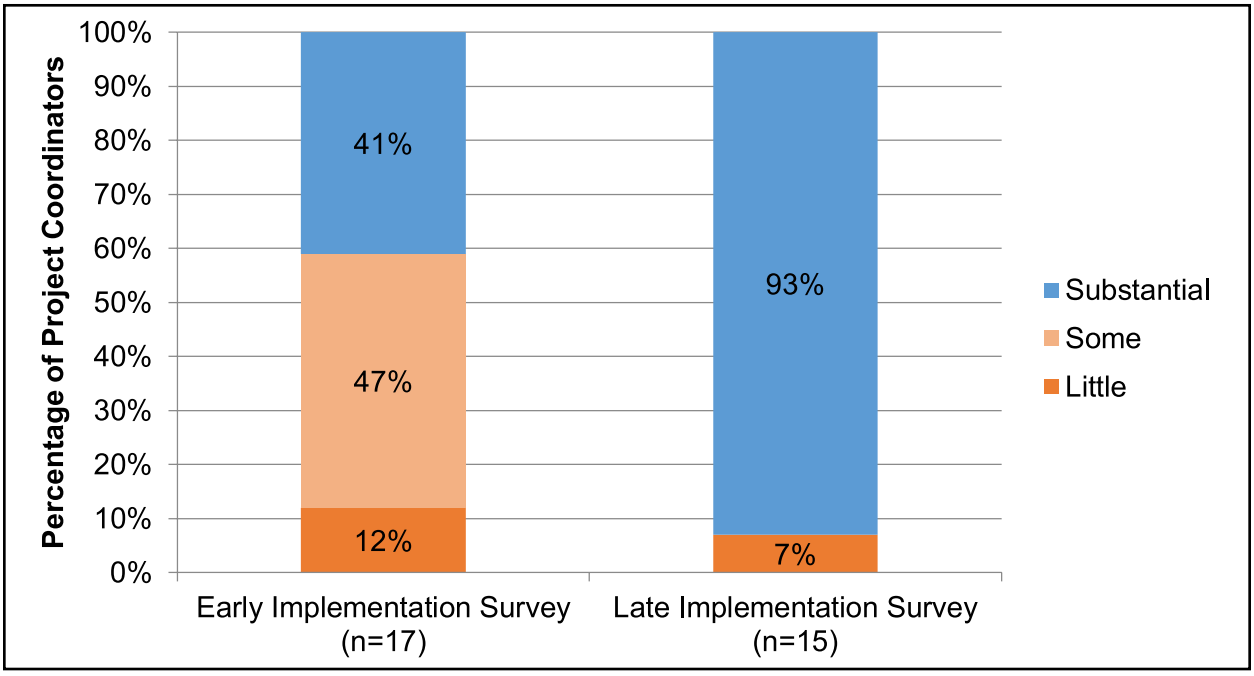
> ***"At first we thought there was a viable coalition working on the same types of issues within the community. When we learned the coalition leader stepped down from her professional role within the community the coalition dissolved. It took some work to reach out to those members and reorganize a new coalition. But right now we are functioning well and the members are all vested in the interest of this project and the work we are doing."***

C. Experience in Building Coalitions

As noted previously, key elements of these projects were the need for successful coalition building and the engagement of community partners in the coalition to implement the project activities to achieve objectives. Coalition members 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, health agencies or clinics, farmer's market sponsors, and others that joined with the WIC agency to plan and implement the project objectives and activities.

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, all but one of the project coordinators or respondents in related roles 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 projects could elect to use existing coalitions, if there were any that were a fit for the project, or build new ones. During interviews, project team members were asked about the strategies they used to build the coalitions. For about a third of the projects, the primary strategy was to share information about the project objectives and how others could help accomplish them with members of an existing coalition. Some of the existing coalitions that were identified included breastfeeding coalitions, health department coalitions, hunger coalitions, immunization coalitions, and groups involved in promoting farmer's markets. For the remaining two thirds, the process of building the coalitions most often started with individual meetings with potential partners, some of which they knew in advance would likely be interested, many telephone conversations, and brainstorming to identify others that were more "out of the box" or unusual. Several of the project team members noted that working with the SNAP-Ed providers in their community was a good way to start as these organizations were often tied into other groups that were working on efforts related to the project objectives. For example, in one project the SNAP-Ed program provided information to the WIC program about farmers who might be interested in promoting the expansion of farmer's markets as well as information about a high school advanced computer graphics teacher who could contribute to the coalition web design—both of which joined the coalition.

The projects were asked on the early-implementation survey and interviews about the issues or challenges they faced when building their coalitions. About half said that they did not have any challenges. Of the other half, the major challenges that were noted included:

- Lack of existing, viable coalitions with which to work;
- Availability and time challenges for coalition members to participate and attend meetings;
- The fact that when starting a new coalition, building relationships takes time; and
- Because of delays in contracts and funding, the projects were delayed in building coalitions.

Responses from the late-implementation surveys showed that once the coalitions were in place, most (67%) of the project coordinators reported that there were few barriers or challenges related to continuing the coalitions.

> ***"Right now, we are functioning well and the members are all vested in the interest of this project and the work we are doing."***

> ***"I feel pretty happy that with only five meetings we have done a lot, the people involved are proud of what we have accomplished."***

In late-implementation interviews conducted during site visits or by phone, project team members from each of the projects were asked about the extent to which they felt that their community coalition partners were engaged. Thirteen of the sixteen reported that they felt their partners were very engaged and enthusiastic about participation. Affirmative comments like the quote below were shared by project team members.

> ***"The partners have been there faithfully and will answer emails when I have questions, they are engaged and will want to be involved in projects like this in the future. We have a good core group."***

Coalitions involved in some of the projects existed prior to the CPHMC project, which may have helped with engaging coalition members, as described by project team members.

> ***"Our coalition partners were very receptive because we have that pre-existing relationship. It was fairly easy to engage our partners and basically trying to figure out solutions for our county because at the end of the day, that's all we want as a group."***

> ***"We already had the coalition in place. We already had representatives there that would have a vested interest in our program so it was just easy to do that than to make another program. We're a relatively small community so you start to find out that even in these three coalitions, you'll see some of the same people and their time is very valuable as it is so it didn't make sense forming a new coalition just to work on this when we already have people in place that were involved in similar work."***

> ***"To build the newly formed food coalition we used already existing relationships. Because this came out of our community health assessment, the health department, the hospital, and the whole district already had people invested in the work."***

Of the projects that felt their coalition members were not as engaged, one noted that a key member left their job and no one replaced the individual. This resulted in an agency that had committed to work with them not participating. A second project noted that people would attend coalition meetings but would say very little. They felt that some members were very engaged but several seemed to "be going through the motions." A third project reported that two of the five coalition partners dropped out because of delays in getting the project started due to contract and CAP approval logistics.

Also of interest was whether or not the coalitions would continue to work together once the project ended. In the late-implementation survey, nearly all project coordinators indicated their coalition will continue to meet after the project ends. They shared positive comments about the experience with the coalitions.

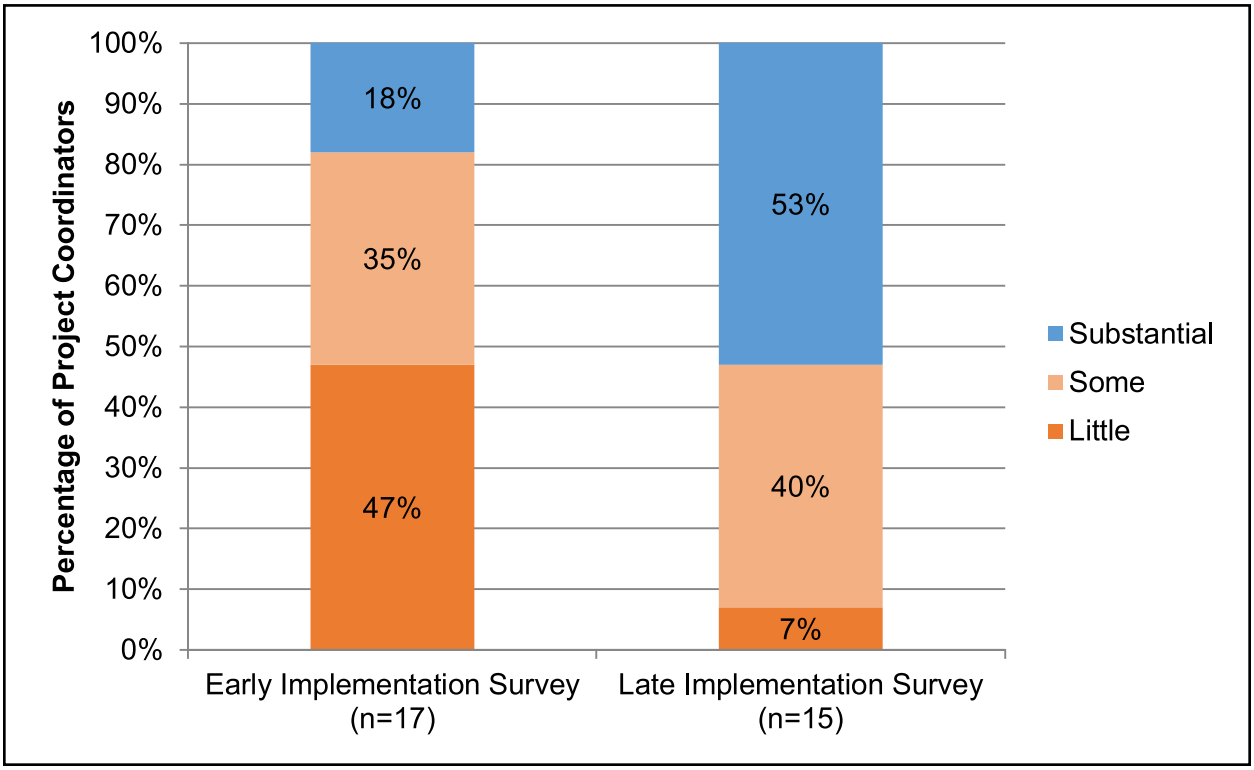
> ***"The biggest success is the relationship building, bringing people from the community together to talk about what our needs are and how we can move forward as a group."***

> ***"It's a bigger picture for the way we're serving clients…not just the WIC clients but the families, the community…we are more of a team."***

Finally, one the challenges that some project coordinators indicated they had overcome was lack of experience in implementing PSE changes. As was noted previously, 56% of the project directors indicated that they had little experience with implementing PSE. This was significant because project staff needed to be able to explain PSE to potential coalition members and partners. However, once the projects were underway, the confidence level of the project staff increased; near the end of the project, a majority of

staff reported that they felt they had substantial experience in implementing PSE (see Exhibit 6). This bodes well for WIC agencies to continue work on PSE change within the community.

Exhibit 6. Early and Late Implementation Survey: PSE Experience of Project Coordinators



D. Experience in Community Partner Engagement

In addition to coalition members, the projects needed to engage community partners. This is often more of a challenge because it is these partners that must be involved in making the desired PSE changes within their own settings for the projects to be successful. In other words, they often must change the way they do business. For example, when attempting to change the food environment to make healthy foods available in a community, one must engage businesses such as stores, farmer's markets or restaurants that are not in the nutrition business and are interested in profits. Another example is increasing breastfeeding support in the community where hospitals, health clinics, and healthcare providers may need to be engaged to change PSE factors related to how they promote and support breastfeeding. Other types of community partners may be schools, employers, and other community agencies with influence over food policy or chronic disease prevention.

In the late-implementation survey, the project coordinators were asked if they had identified the right partners in order to be successful. About three-quarters (11 of 15 projects) of them responded they were "very confident" that they had identified the important partners and stakeholders in their community, while others were "somewhat confident".

> ***"We were just not sure at first we had the right partners as we had not worked with some of these organizations before. As we moved forward, we narrowed down the partner list to those that were the best fit and were interested in working with us."***

Project team members were also asked in the surveys if they encountered barriers or challenges in trying to engage partners or stakeholders to assist with their project. The results were essentially the same for early and late-implementation surveys with 60% of project coordinators indicating that they were successful and 40% indicating that there were barriers.

Of those who indicated there were no barriers or challenges, several noted success in working with grocery stores and restaurants and others noted successful partnerships with hospitals and healthcare providers to improve breastfeeding support.

> ***"The other one I would say is with our hospital base, the breastfeeding training for hospital staff, I'm particularly proud of that partnership just because it moved so quickly. Through our partnership the project moved so quickly and our partners were really engaged, they were really enthusiastic about getting their staff better prepared to support breastfeeding in our community."***

One project team member noted that his/her organization's role in the community was helpful in recruiting partners.

> ***"I would like to add that the fact that being at a health department that's pretty connected in the community helps because we didn't have to make cozy new friends, we just had to build a relationship."***

Of those agencies identifying barriers to creating community partnerships, most indicated either 1) a lack of interest on the part of partners that would have been critical in implementing the change, 2) turnover in staff at partner organizations, or 3) a lack of willingness to participate because of time commitments. For example, one project noted that schools in the community would not participate in the community garden project because they were "too busy." Others noted that farmers were too busy to work with the coalition on farmer's market expansion or that community clinics were disinterested in making time available for the breastfeeding initiatives. One project coordinator summed up the challenge of engaging partners:

> ***"We tried to identify whatever challenges there may be with partners and potential partners and then we all try to work around it, but often we just move on if they're not engaged or clearly not willing to participate."***

While there were challenges with some community partners, the project coordinators unanimously responded "yes" to a question on the late-implementation survey that asked them, "Will you continue to engage some or all of your community partners beyond the end of the CPHMC Project?"

Findings: Project Implementation Experience

Evaluation of project success addressed five areas:

1. Achievement of project target and reach goals established in the CAP;
2. Perception of project staff regarding how well they achieved their secondary objectives;
3. Project successes;
4. Challenges projects faced, and if/how they overcame these; and
5. Extent to which projects felt satisfied with their project outcomes.

This section summarizes the collective findings across Cohort 1 projects. Individual project outcomes and success stories can be found on the Greater With WIC website at http://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 1 projects set a goal for the number of settings they anticipated they could affect through each secondary objective selected, and they also provided an estimate of the number of people who could be reached if the objective was accomplished. Projects then reported on the number of settings and an estimated number of people reached through implementation of project activities. Reporting on settings and reach was challenging due to CDC changes to reporting requirements during project implementation. Table 4 shows the overall success of the Cohort 1 projects in achieving target setting and reach goals for secondary objectives. For three objectives, setting and reach numbers achieved were not reported.

Across all projects, about 40% of the targets for settings were achieved or exceeded and about half (48%) of the reach targets were met or exceeded for objectives reported. As shown in Table 4, for targets not achieved, there was significant progress towards meeting the goals. Section B following this table presents project staff perspectives on achieving objectives and target goals.

Table 4: Target Setting and Reach Goals and Results

Secondary Objective	Target Settings	Target Reach	Settings Achieved	Reach Achieved	Target Settings Met?	Target Reach Met?
Increase the number of [retail environments: grocery stores; convenience stores] that sell "healthy" foods in the target community from baseline to target.	42	847,676	32	681,537	No	No
Increase the number of [retail environments: grocery stores; convenience stores] that expand their inventory of "healthy" foods in the target community from baseline to target.	43	546,236	31	459,193	No	No
Increase the number of [retail environments: grocery stores; convenience stores] that accept WIC in the target community from baseline to target.	13	90,525	NR	NR	NR	NR
Increase the number of [retail environments: grocery stores; convenience stores] with new on-site and in-store placement and promotion strategies for healthy foods in the target community from baseline to target.	70	517,623	25	255,814	No	No
Increase the number of grocery stores with employees trained to assist shoppers to select healthy foods from baseline to target.	8	75,322	4	752,468	No	Yes

Secondary Objective	Target Settings	Target Reach	Settings Achieved	Reach Achieved	Target Settings Met?	Target Reach Met?
Increase the number of [retail environments: grocery stores; convenience stores] that offer cash or coupon incentives for purchase of healthy foods in the target community from baseline to target.	4	8,000	2	4,400	No	No
Increase the number of farmers' markets that offer cash or coupon incentives for the purchase of healthy foods in the target community from baseline to target.	4	8,000	1	102,062	No	Yes
Increase the number of farmers' markets available in the target community from baseline to target.	7	52,172	10	140,197	Yes	Yes
Increase the number of farmers markets that accept SNAP and/or WIC in the target community from baseline to target.	8	7,884	5	3,078	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; entertainment venues; faith based organizations; gardens; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; convenience stores; restaurants/bars; other—please specify] using new tools or resources to create awareness of how to access healthy food options in the community from baseline to target.	168	1,229,719	114	940,513	No	No
Increase the number of restaurants/bars using nutrition labeling to identify "healthy" menu options in the target community from baseline to target.	14	80,376	22	146,204	No	No
Increase the number of restaurants/bars with new "healthy" menu options in the target community from baseline to target.	14	80,376	24	82,004	Yes	Yes
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 baseline to target.	3	11,432	1	11,432	No	Yes
Increase the number of grocery stores participating in the Share Our Strength Cooking Matters at the Store program in the target community from baseline to target.	51	191,394	33	298,943	No	Yes
Increase the number of [hotels/motels; entertainment venues; grocery stores; restaurants/bars; other—please specify] that publicly promote/ welcome breastfeeding in the target community from baseline to target.	47	71,139	46	160,875	No	Yes
Increase the number of [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 policies to support breastfeeding from baseline to target.	6	5,745	NR	NR	NR	NR
Increase the number of [other—food banks] that offer healthy food and beverage options in the target community from baseline to target.	3	16,500	3	16,500	Yes	Yes
Increase the number of [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 implement policies to support improved access to health food and beverage options from baseline to target.	1	741,206	1	741,206	Yes	Yes
Increase the number of K-12 schools in the community that successfully implement a gardening curriculum from baseline to target.	4	1,970	4	2,070	Yes	Yes
Increase the number of gardens in the community from baseline to target.	3	21,545	4	21,545	Yes	Yes

Secondary Objective	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; substance abuse facilities; K-12 schools; outside of school care providers; group homes; government agencies; military facilities; veteran facilities; faith based organizations; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] signing clients up for the WIC program from baseline to target.	206	493,771	138	456,319	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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] referring and/or signing patients up for healthcare from baseline to target.	20	17,071	21	16,838	Yes	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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] using new tools or resources to improve awareness of available chronic disease prevention and management services in the community from baseline to target.	52	370,499	35	155,198	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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] that use an enhanced WIC referral list with new community-based chronic disease prevention and management services added from baseline to target.	2	25,318	4	16,479	Yes	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] that refer families to health care (a patient-centered medical home) in the target community from baseline to target.	47	500,500	18	201,400	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] that refer families to other chronic disease prevention and management services in the community from baseline to target.	9	39,133	12	131,858	Yes	Yes
Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; other—please specify] that make "prescriptions" for non-pharmaceutical interventions like exercise in the target community from baseline to target.	13	21,184	7	14,500	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 basic training in breastfeeding in the target community from baseline to target.	162	243,451	154	182,951	No	No

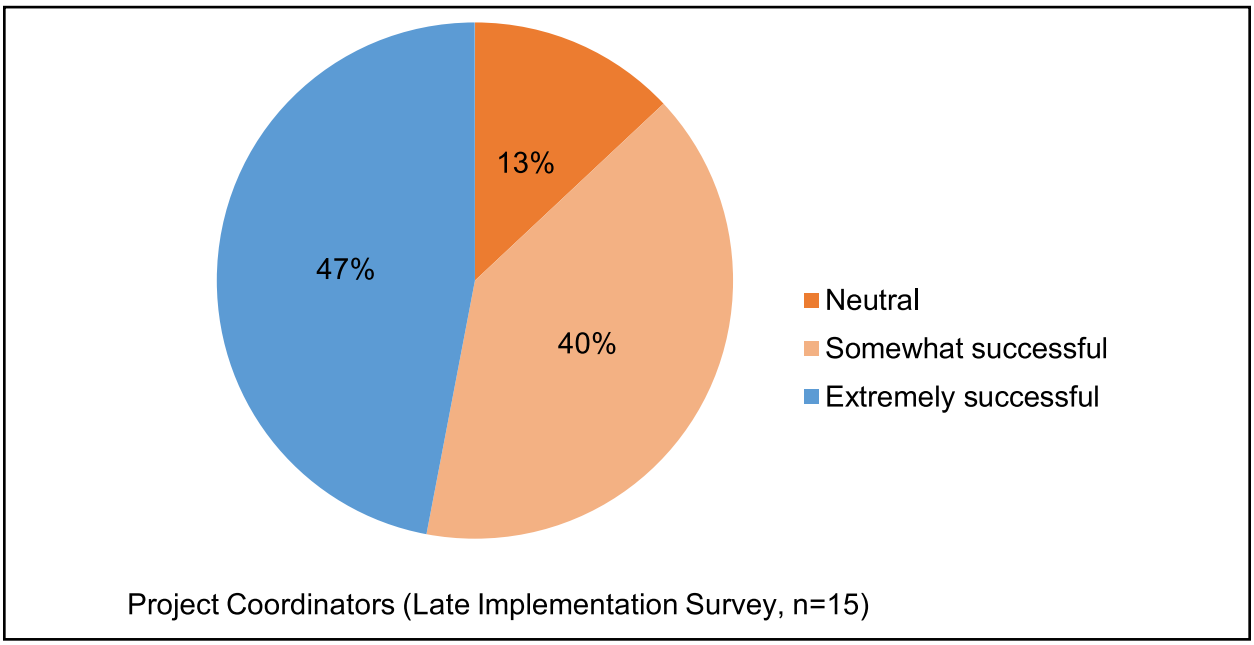
Secondary Objective	Target Settings	Target Reach	Settings Achieved	Reach Achieved	Target Settings Met?	Target Reach Met?
Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; K-12 schools; outside of school care providers; 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 basic training in community chronic disease prevention and management services referrals in the target community from baseline to target.	14	16,598	23	16,598	Yes	Yes
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 baseline to target.	23	164,466	26	109,550	Yes	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 basic training on WIC services and benefits in the target community from baseline to target.	239	455,205	111	613,818	No	Yes
Increase the number of [dental offices; health insurance companies; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; 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 baseline to target.	11	6,600	9	26,809	No	Yes
Increase the number of [other—WIC sites] that have the capacity to bill for preventive nutrition and breastfeeding services outside the scope of the WIC program in the target community from baseline to target.	3	7,597	NR	NR	NR	NR
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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] that offer new chronic disease prevention and management services in the target community from baseline to target.	28	168,304	13	140,683	No	No

NR = Not Reported

B. Project Staff Perceptions

Project team members were asked on the late-implementation survey how successful they felt their projects were in implementing the interventions for secondary objectives and achieving successful project outcomes. As can be seen in Exhibit 7, 47% of project coordinators or those in similar roles indicated that they felt they were extremely successful while 40% felt that they were somewhat successful and 13% were neutral.

Exhibit 7. Success in Implementing Projects



Across all projects there were key themes regarding factors that contributed to project success identified through late-implementation surveys and interviews.

1. **Teamwork among the coalition members.** Many projects identified the support they received from the coalition members as a primary factor for success in accomplishing their objectives. The key elements of this support included active participation in meetings and planning sessions, assistance with planning activities to implement project strategies, help with brokering contacts within the community, sharing the workload, participating in implementation activities, and providing expertise that was unavailable within the project organization.

   "These people are very passionate about what they're doing and they say it. They have known what they wanted to do in the community. This grant allows everybody to get together and put their dreams together and actually implement it. "

   "Both the local hospital, the Diabetes Center, they've all been engaged. Our extension office has been very involved. All the food banks have been involved and been involved in discussion either through a work group or one-one-one with our team. Children organizations, daycares, and our WIC Department I think has been a wealth of information, and all have worked with the staff."

"Having people who are willing and able to contribute especially when needed and without being asked. Everyone in our team brings something very different to the table. It really creates a unique dynamic within us and we also really enjoy working alongside each other and seeing the result and how it benefits the community that we serve"

2. **Cooperation and interest from program partners.** Much of the success was attributed to the willingness of community partners to participate. Partners that were identified as being very cooperative included hospitals, farmer's markets, grocery stores, and food banks. Project team members noted that it was helpful having these partners be involved and enthusiastic about their participation.

"The key to our success was teamwork. We all worked together so well because we knew the community had this great need, and we were better together than individually."

"We will have exceeded the number of businesses that they signed up for the breastfeeding initiative. The most difficult part was finding times to meet with business owners that would work for their schedule and also fall within the workday of the staff. Several meetings were held on weekends and evening to accommodate business schedules. In addition, convincing business that they should care about breastfeeding was a challenge, but once the business case was presented, things went well and they were really supportive."

"We were fortunate to have several strong existing relationships and partnerships so having the engagement of our community partners was not a challenge for us."

"Another thing that we did at our initial meeting was to ask our partners to go tell three other partners about what we're doing and let them know, 'We're trying to increase access to healthy food. Would you like to be a part of this? Do you have a passion for this?' I can honestly say that every partner honestly has a passion for increasing access to healthy food because they know the need in this community."

3. **Support from their organization leadership.** Several of the project teams cited the support within their organization as important in their success. The organizations provided

both staff and financial support for project activities. One example mentioned often was that staff from departments or divisions outside of WIC helped with coalition meetings and assisted with planning activities where joint resources could be applied.

"The leadership in the county health department was all for this project, and they have been supportive all along. When we needed help from other organizations within the health department, the director always approved staff time in other departments to work with us. They were great in supporting our efforts."

"I often called on support from the chronic disease prevention staff. Their leadership was very positive about our efforts and was always available to help."

While project team members identified key factors that contributed to success, there were a number of factors that presented challenges in meeting their project objectives. Some of the key factors described below as challenges are the converse of what other projects identified as contributing to success.

1. **Lack of interest or participation on the part of coalition members.** Some of the projects noted that their coalitions started out larger than they ended because some coalition members became disinterested or did not participate. It was noted that some coalition partners attended all of the meetings and were very involved, while others did not attend meetings, had turnover in the person representing the partner agency, did not meet their commitments, or were unable or unwilling to follow through on their commitments.

   "We could not get the representative from the health center to show up for the meeting, or be involved in the planning. As a result, we had to drop them from the coalition and revise our plan to exclude them."

   "When we asked the agency about things they had committed to, they then backed out and they were unable to work with us. It was unfortunate because they were working in the community already on a similar initiative, and we just wanted to partner to share resources."

2. **Difficulty in recruiting community partners to participate.** Some of the projects noted that the organizations or businesses they had targeted for partnerships ended up not being interested or having the time to participate. Among the local partners that were difficult to work with were schools, primary care centers, and physicians.

   "While the school started out being helpful, they eventually told us that they could no longer participate. They were just too busy with other things."

   "Some of the people we thought would be helpful have been more of a thorn in my side. One agency had offered to contact some of the school personnel. We didn't have any connections to the superintendent, teachers, etc. They offered to do a bunch of things and none of it got done. Fast forward a month and a half later and I haven't heard anything. It was just a mess."

3. **Selecting too many secondary objectives.** Some of the projects identified that they had selected too many secondary objectives for the project and did not have the time or the resources to work on all of these objectives. These project team members noted that the needs assessment process identified several needs within their community and, as a result, there was great interest in trying to address them. However, project timelines, budget and staffing resources, and lack of contributing partners resulted in little progress on some objectives.

   "We just picked too many secondary objectives. Once we got started we realized that we needed to focus on one or two of the objectives, we could not do them all within our budget."

   "I think we tried to do too much at first. We decided later to drop some of the secondary objectives because we just did not have time to work on them."

4. **Administrative challenges.** During early and late-implementation interviews, project team members described administrative challenges they felt impacted their projects. In some cases, contracts were delayed due to CDC review and approval processes, and for other projects there were prolonged negotiations on contract terms and conditions between the local agency and NWA. Some projects had to make significant revisions to CAPs to ensure the planned activities were appropriate, consistent with the project objectives, and focused on PSE efforts as required by the CDC grant. When administrative challenges caused delays in receiving funds, projects had two options—either move forward using local funding in hopes that their projects would be approved or not start project activities until approval and funding were assured. Some opted for the latter choice and projects were delayed. Coupled with the short time period for implementation, delays led to frustration on the part of the project staff and their organizations as expressed below.

   "I hope the second cohort will have better luck getting their contract and funding. That was our largest frustration and look at the project period we're in now. We didn't receive our funding until two weeks ago, so we have gone six months without funding."

   "The on and off funding process, combined with the amount of time it took to receive funds, resulted in a lack of ongoing continuity in program activities. This would just start and then they would have to stop because the budget was not approved or there were delays in getting the funds. The county health department would not fund the project without an approved contract in place, so the delays resulted in fewer meetings being able to be held and delays in getting activities moving forward."

C. Project Implementation Successes

When discussing objectives that were implemented successfully, project team members identified a number of strategies and interventions that were successful. Examples are described below with many more included in the project profiles (Appendix C).

Strategies for Healthy Food in Corner Stores

Several projects reported success in working with corner stores in their community to increase access to healthy foods. Some of these projects partnered with other organizations in their communities that were already working on this effort. WIC seemed like a natural addition to the community efforts since the WIC program could offer experience working with small stores; in addition, WIC's involvement could provide the incentive that the store might be able to obtain WIC authorization, which could potentially increase business. One project noted that working with an existing corner store initiative within their community significantly increased their success in achieving the target number of stores offering healthy options. Another project noted that working with their SNAP-Ed program's healthy corner store initiative brought together the two food assistance programs in a combined effort to improve the healthy eating options of low-income families in their community.

> ***"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."***

> ***"Cooperative extension already had a great corner store project going, and adding WIC helped provide both additional resources and leverage. Small WIC stores became targets for our project."***

An interesting finding noted from two of the projects was that working on a healthy corner store initiative was a new experience for both the WIC program and the stores with which they worked. Many of the store owners assumed that the WIC program was involved because of compliance or monitoring issues (its more traditional role), not to help improve healthy eating options. One of the two projects also noted that store owners were skeptical about their involvement because the WIC representatives were from a local health department; the owners assumed that the visit related to health inspections.

Comprehensive Referral Systems for WIC

Several of the projects reported success in working with community groups, healthcare organization, and local doctor's offices to increase referrals to the WIC program. Through developing improved systems of referral, the projects were able to accomplish two goals—increase awareness of the WIC program in their communities and increase their WIC caseload. Projects used a number of techniques for outreach to providers including one-on-one meetings with doctors and other primary care providers, making presentations at meetings, offering WIC "tours", and working with other community organizations to add WIC to existing referral networks.

> ***"One of our goals was to increase the number of providers and community partners that refer to WIC which would then also increase the number of participants enrolled in the WIC program. Basically what we did is go around the community and do WIC benefits presentations at doctors' offices, health fairs, and doing presentation at universities and community events. Really just talking to people, letting them know 'Oh this is what WIC is' because among other things that we found, especially amongst providers, is that providers they didn't know what WIC was. They just thought, 'Oh that's the formula place. If you need formula, you should go there'.***

New Tools for Identifying Community Food and Healthcare Resources

Developing tools and resources to increase awareness of healthy eating options and preventive care services within communities was another example of project success shared by team members. Project staff worked with other community organizations to create tools, both written material and web-based options, to help people in the community know about and understand how to find healthy food options in stores, restaurants, farmer's markets, and food pantries/banks, and to locate preventive care services. Once developed, these resources were introduced into the community in a variety of ways, e.g., personal visits to organizations, presentations at meetings, health fairs, community events.

> ***"One of our successes was to increase the number of dental offices, hospitals, mental health providers, primary care providers, K-12 schools, childcare providers, entertainment venues, non-profit worksites, farmer's markets, and grocery stores to use new tools or resources to increase the awareness of accessing healthy foods in the community."***

Strengthening Partnerships for Breastfeeding Support

WIC has long been providing breastfeeding promotion and support, but much of the effort has been focused on working with individual mothers. Several projects reported success in working with community partners to change policies and practices to help support breastfeeding mothers. One type of initiative involved working with hospitals to train staff who provide care to new mothers to help them more effectively support the mothers' decision to breastfeed. In addition to providing training and materials to hospital staff, they assisted hospitals in modifying their policies relative to infant formula and provided breastfeeding expertise to support and mentor staff.

> ***"We are most proud of our breastfeeding initiative. We have been working with two local hospitals to provide training and support to their staff, and work with hospital administrators to create policies that will support breastfeeding moms while they are in the hospital. The progress has been great, and we will continue with this effort after the grant is finished."***

> ***"Our breastfeeding counselor, who is part of our leadership team, actually was able to engage a WIC mother to be on the coalition as well to give us the on the ground information about what's going on and reactions to what we are proposing."***

Some projects worked with employers and businesses to provide appropriate facilities and time for breastfeeding employees to express milk and/or space for customers to breastfeed their babies. There were successes, especially with schools and government agencies, and some projects were successful in working with local businesses as reflected in this comment from a business owner in one of the project areas.

> ***"After talking with the WIC folks it just made sense to add a breastfeeding room. They convinced me it was good for customers and good for business."***

Other projects reported challenges in working with local employers and businesses on breastfeeding accommodation efforts as discussed in the implementation challenges section below.

Increasing Healthy Options in Restaurants

One objective that was a new venture for project staff was to increase healthy options offered by restaurants in their community. Projects that chose this as a secondary objective reported success in persuading local restaurants that not only was offering healthy options good for the customers, it was good for business and something that they could promote in their advertising. The project activities involved convincing the restaurant owners and chefs to offer healthy options, assisting them with modifying recipes or adding new healthy offerings to the menu, and helping promote the healthier options and the restaurants that offer them.

"Now we have more restaurants that are primed to commit to being a part of our effort and to try new menu options, healthier options. When we started this, the restaurants were only required to have one adult and one child menu item. Well, over time, they realized that not everybody is going to come in here and get that one item and we have a few restaurants to about 6, 8, 10, 12 items now to their menu and they really jumped on. Before, it was - they agreed that they needed to provide something healthy- now it's becoming part of their restaurant mission to have more healthy items and promote health."

Increasing Utilization of Farmer's Markets and Helping Food Banks/Pantries Access Produce Donations from Farmers

Some of the projects worked with local farmers and farm organizations to increase access to farmer's markets and some also helped food banks access fresh produce that was not being sold by the farmers. These projects worked with the farmers and farm organizations to add more market locations (e.g., near the WIC clinic) and set up information booths at the farmer's markets to help low-income SNAP and WIC participants use their benefits and understand the value of purchasing fruits and vegetables. They offered recipes and did cooking demonstrations to help people understand how to prepare the produce. Some then worked with the farmers to transport unsold produce to the local food bank as donations made available to people using the food banks/pantries.

"People think that fruits and vegetables are expensive, but they often do not use their SNAP and WIC benefits to the fullest when shopping for produce. We help them understand that farmer's markets are a good option, and we help them learn how to prepare the many fruits and vegetables available so their families can try these."

"Now the produce that used to be wasted is going to the food pantry. People are very happy to see fresh fruits and vegetables in the pantry. We are helping them learn how to cook these vegetables so they now go to good use."

Messaging on Project Efforts

All projects were required to implement secondary objectives pertaining to messaging and communication regarding project activities. The projects in Cohort 1 were very successful in accomplishing these objectives with over 70 million media impressions throughout the course of their projects. These media impressions were achieved through 1,237 individual media placements in local newspapers and on local television, radio, social/digital media, and other outlets.

D. Project Implementation Challenges

Project team members identified a few interventions that were difficult to complete or even "get off the ground." Examples of these are described below.

Working with Schools

Working with schools was noted to be a challenge by some projects that hoped to increase community gardens in school settings or offer drinking water or healthier food options in schools. Project staff reported difficulty in getting the schools to even engage in these activities, with school staff often indicating that they did not have time to work on the project, were not interested in the project, or that they did not have the resources to devote to the project.

> ***"We just could not get them interested. After we had our first meeting they seemed interested, but then they did not show up for other meetings or meet their commitments. Often they told us they were just too busy, and we were not a priority."***

While some projects reported challenges working with schools to implement project activities, as noted above, others were successful in expanding schools' efforts to support breastfeeding employees.

Increasing the Number of WIC Vendors

A few projects wanted to increase access to WIC foods by increasing the number of WIC-authorized vendors in their community. However, coordination with the WIC State agency vendor staff was complex, and one project coordinator reported that this objective was ultimately abandoned at the request of the state.

> ***"The state vendor manager called us and asked us not to continue. They told us that they were not accepting more applications right now, and that the process was complicated enough that we should not continue."***

Implementing "Green Prescriptions for Healthy Living" for Healthy Foods and Lifestyles

Some projects chose to work with healthcare providers to issue "green prescriptions for healthy living" to their patients. Green prescriptions are recommendations for healthy foods, physical activity, referrals to WIC, and other healthy lifestyle changes. Healthcare providers give these green prescriptions to patients who are overweight or have chronic conditions, such as diabetes, and to other patients who might benefit from lifestyle changes or resources such as WIC. Project team members reported that some doctors

did not like the use of the term “prescription” as they felt it confused the patients and they had to spend too much time trying to explain it.

> ***“The feedback we got on green prescriptions was, ‘I don’t like this. I’m not using it’, although they felt the concept was very constructive. We’re actually turning that into something else in another program. We obtained some provider feedback and then we asked the physician’s group, ‘What do you think of this?’ For our diabetes program, we’re going to change it into a My Plan of Action so that we’re not handing something in prescription-like form.”***

> ***“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.”***

Increasing Businesses that Provide Accommodations for Breastfeeding Mothers

As noted in the findings pertaining to project implementation successes, some of the projects worked to increase the number of organizations and businesses that provide appropriate facilities and time for breastfeeding employees to express milk and/or space for customers to breastfeed their babies. While there were successes, notably with government offices and schools, project staff indicated that working with businesses on this initiative requires a significant amount of time and effort, in some cases exceeding what was realistic during the project period.

> ***“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.”***

> ***“We had both success and challenges with this objective. On the one hand, some businesses were very open to making the workplace more breastfeeding friendly. Others were not sure what the advantage would be to them, and had to be convinced to participate. It took a lot of time, especially when we started to do “cold calls” to businesses we know serve low-income families. The first question they asked was “what would this cost me?”***

Findings: Capacity Building, Sustainability, Lessons Learned

A. Staff and Organizational Capacity

One of the goals of the CPHMC project is to increase community capacity to implement PSE improvements. For many of the staff involved in the 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. As described above, local project staff 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.

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

"The PSE change thing was huge….going from individualized care to community engagement and policy change has been a big learning experience."

> ***"I definitely learned to become a good persuader in terms of trying to engage stakeholders in the community… and to be flexible."***

> ***"The coalition building and working with local businesses on breastfeeding has provided an opportunity for me to expand beyond WIC."***

> ***"This project has helped me develop a deeper understanding of how to bring community members together to make a bigger change."***

> ***"The experience helped us in expanding our traditional roles because we have skills and experience to offer to the community."***

The WIC agencies that participated as part of Cohort 1 also benefited from increased organizational capacity for community-based efforts. Project coordinators and managers in several of these organizations identified ways the project enhanced their capabilities, making it possible to continue to work on project strategies or continue working with coalitions.

> ***"We're really excited because the health department picked up two assets [two project staff] through the project…the efforts will continue."***

> ***"She [project coordinator] will be moving into a new role that will allow her to continue to oversee some of the work that was started…some of it might look a little different after the project, but it will continue."***

"The coalition started by the project will continue under co-leadership from the health department and extension office."

"We learned a lot about food insecurity and food deserts and had the opportunity to have two great staff members to dig into a subject deeply and was very refreshing because now we have staff members who I can go to and talk about food and food insecurity and how we're doing with our food banks."

Project coalition and community partners who were interviewed also commented on increased knowledge and other benefits they attribute to the CPHMC project. Themes of the partner comments included greater awareness of community needs related to food access, increased understanding of the WIC program, and enhanced relationships and understanding of other community partners.

"Knowledge is probably the biggest thing that I gained, and the fact is there's an awareness…the whole food security thing, it was a huge eye opener, a huge revelation to us."

"Well, definitely I was familiar with WIC beforehand, but I definitely gained more information about how WIC works and the scope of the program and so forth."

"There were opportunities to get a little deeper knowledge of what each different partner representative was doing. So again, it may not result immediately in initiatives, but it's like the collective knowledge of who's doing what."

"WIC grew and sees that there's a bigger world out there than just who comes in… it's a bigger vision for the community….not just keep it in the clinic but bring it out to the people."

"I really think it's very much helped elevate our - I won't say agenda - but our plans for the Council on Healthy Lifestyles. It's had us look at more of, I would say community-wide needs and opportunities."

"I really believed in, and I've seen before, but even more now I know that organizations that work in silos aren't going to accomplish any community-wide health improvement, so you really, really have to work together to get the job done and so everyone's on the same page."

B. Sustainability of Project Outcomes

In addition to increased capacity to implement PSE improvements, Cohort 1 projects were charged with planning and implementing improvements that could 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?" Respondents from all 15 projects that completed the survey responded "yes." Examples provided via the survey included:

"We are just getting started and the community is fully engaged and excited. We want to continue to grow."

"Cultural competency and WIC training for providers will continue."

"We will always promote, support and educate the public on breastfeeding."

"The garden project in the school will continue next school year."

"We will continue to work with the stores. The healthy corner stores and virtual supermarkets will continue."

"Really the relationship that I think will extend beyond the project. I think going forward, that our communication [will be] just more open. If we have ideas as a hospital or they have ideas, I feel like we'll be so much more approachable…. kind of moving forward at probably a little more rapid rate."

"We will continue to implement most of the project activities beyond the grant period."

Questions regarding sustainability asked during late-implementation interviews yielded similar responses. Project staff shared new approaches and systems that will continue beyond the end of the project, including outreach and referral systems, food distribution systems, breastfeeding support networks, ongoing staff training, and other examples.

"One of the biggest systems we've implemented…. and we expanded through all of our counties is the prescription pad project…the project is outreach for WIC and referrals using the prescription pad and it's working."

"We've now included cultural competency training for all staff, and not only do we provide this training annually but we've also incorporated it into onboarding as well."

"We have a clear channel of communication for providers and the WIC nutritionists to communicate constantly and do referrals seamlessly."

"The breastfeeding initiative that we took on basically changed policy. We have several schools and offices that are breastfeeding-friendly, for instance."

"Work we've done on this project is integrated into the healthy corner store initiative which strengthened it for the better."

"This partnership with the corner stores resulted in store modifications including stocking the shelves with more fresh fruits and vegetables, whole grains, low-fat milk, eggs, beans, water, and more."

"Something that will continue...we've partnered with the food bank to have donations of produce come in and we give those to patients, and WIC clients. We get 20-30 boxes of produce--a variety of everything--and patients and clients pick what they want and take what they need"

"We've changed the delivery of fresh produce to food pantries in communities in rural areas with increased access to fruits and vegetables for people in these communities."

C. Sustaining Coalitions

Nearly all projects (13 projects) reported on the late-implementation survey that the coalitions will continue to meet beyond the end of the project, and 12 of the projects said they will seek funds from other sources to continue the activities started by the project.

"We are scheduled to meet monthly as our project continues to grow."

"Healthy food access and chronic disease are among the topics the coalition will continue to address as part of ongoing efforts for a healthy community."

"The coalition developed is thriving, and extension has offered staff to help run the coalition beyond the grant period. The coalition will continue to engage the community regarding food, access, and policies."

"We applied for a WIC infrastructure grant…..an Aetna Cultivating Healthy Communities grant to increase capacity of the food access app and our collaboration with Healthy Corner Store Initiative and we applied for a CDC fellow to take on some of the work that continues to bridge the gap between the WIC and Chronic Disease Department."

"The coalition partnered with the local YMCA and received partial funding from the anti-hunger grant to support the healthy corner store initiative."

"We will continue to work with our existing Breastfeeding Coalition and Perinatal Coalition to offer an annual Breastfeeding Summit through grants. Additionally, the project coalition has explored additional grant funding to continue with and expand the food access objectives."

"The coalition will continue to meet monthly to work on future initiatives and partnerships that address improving public health and wellness. The lack of a community coalition in itself was a major gap and added to the barriers the community faces."

Project team members who participated in late-implementation interviews voiced intent to continue engaging coalitions in healthy food access and chronic disease prevention beyond the end of the project.

"It's going to change a little bit to where it's focused on policy and systems. It's really going to be a quarterly meeting and it's going to be focused on convening stakeholders to provide feedback on WIC policy and systems that influence the service delivery particularly, with some focus on breastfeeding as well."

"Yes, because like I said, some of them [coalition ideas] are just blossoming right now. We're not going to stop that. If what we're doing is effective, we want to keep it going."

"We continue to meet….then as our new projects come to tie in with what we're currently doing, we are able to still engage with a lot of our members.

"Well, the same people that have been involved are going to continue to be involved, but they're going to take over the leadership office rather than the community planner that we've had for the grant."

"I will continue to work with the food policy council….will continue to be involved...especially on things that we already have moving."

"Ongoing coalition meetings are occurring and initial paperwork has been submitted for the non-profit status of the coalition."

D. Next Steps

In late-implementation interviews and final project reports, 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 interventions that will continue, e.g., community or school gardens, maintenance of websites, sharing community resources. Others commented on future directions for the coalitions that were engaged in the CPHMC project.

> ***"The outreach manager will continue reaching out to organizations to talk to them about WIC."***

> ***"We'll continue to work with the coalition and will have a food summit."***

> ***"The nutrition and physical activity program in schools will continue….it started before this project with support from United Way and it fit in well with this project. We're working with a nursing program to have nursing students facilitate the program activities as part of their required studies."***

> ***"The training team has begun to educate new trainers to be able to accommodate future breastfeeding trainings and consider expanding the training opportunity to staff from other local hospitals."***

> ***"A work group has been created to sustain the results of the food summit. The workgroup within the coalition will continue to find and sustain solutions to food insecurity."***

> ***"Funding for additional initiatives and projects is actively being pursued and members are working out these logistics."***

E. Lessons Learned and Recommendations for Others

Through a combination of late-implementation surveys and interviews and project reports, project staff shared lessons learned and gave recommendations for other WIC agencies regarding engaging in efforts to change policies, systems and environments in their communities. A clear theme shared by all projects is the importance of coalitions and partners.

> ***"Community engagement…having those community partners, the collaborative efforts are much more successful than one individual trying to make a difference."***

> ***"We found that if you find the right people that have the same vision as you, that any kind of project can be successful."***

"We learned we have some unusual partners…you never know how relationships will evolve and people have a lot of resources that go beyond the organization they are working with."

"Utilize existing partnerships and establish shared goals."

"Developing partnerships and the community engagement has been the best thing for us…our community partners have been great!"

Suggestions for working with coalitions and partners include:

"Communication with coalition members to keep them active and engaged….frequent emails, agendas, minutes from meetings and ongoing communications."

"It's really important to communicate with everybody regularly…if you've got a plan, then you've got to focus on specific items in order to accomplish them."

"I think being able to focus on something that is already in progress and then reach for the bigger picture, but really focus on a couple of areas or you get spread too thin."

"Tap into to the partners for resources and contacts."

"Duplication of efforts is greatly reduced when WIC partners with other organizations."

Project team members shared many "how to" suggestions for conducting community projects, with several commenting on replicating successful efforts and others emphasizing the importance of working effectively with partners.

"Be realistic. If there is something successful in another community that to pull from, do it versus trying to develop something new."

"Don't reinvent the wheel and take advantage of what other groups have done. Also, have a driver on your team."

"We were supposed to visit and spend time with [another project]…there never was time. I really wanted to go see them because I felt if we could have had more 1:1 interaction, we could have built off each other."

"Understand the cultural issues and be sensitive to those and doing what needs to be done to work with those."

"Understanding community needs is a lesson…. you really need to know what the needs are in the community."

"Leverage the expertise of your coalition, leadership team, and WIC staff to ensure your time with providers is relevant and impactful."

"Establishing a strong community buy-in early on with local businesses, community members, and community organizations proves beneficial in spreading the mission of the project and filling voids where funds are limited."

"Listen to partners' needs and ideas and work together to meet goals."

"Share successes and lessons learned with partners to avoid duplicating efforts."

Lastly, project team members shared comments and thoughts regarding the experience with the CPHMC project in the late-implementation surveys and interviews. Comments reflected both the rewards and the challenges of taking part in the project.

"This was a great grant which provided exceptional training and support! Thank you"

"Overall it was a very rewarding experience. The National WIC Association staff were great partners and a tremendously helpful resource in helping us navigate the complexities of the project. The only issue was with funding. We would have been able to accomplish so much more if funding was predictable, available and provided in a realistic time frame."

"This project has been a positive experience giving us an opportunity to work outside of the silo. Although we started 5 months behind schedule, the partnerships we developed are still in place and we anticipate achieving the initiatives we set out to accomplish. Additionally, we are working to replicate these efforts in the other counties that [the organization] serves."

"The CPHMC project was successful because of the valued partnerships established early on in the process. I appreciate the education opportunities that were available to the CPHMC leadership team and staff. Working with the NWA staff has been a joy and I appreciate their willingness to provide ongoing assistance to ensure every funded project succeeded!"

"We appreciated the opportunity to begin and continue our important work in our community. The unfortunate reality is that without funding, we now struggle to move forward to keep up the momentum that was begun.".

"We got our funds late and there wasn't much time to spend them and that makes it difficult to carry out a project. When you go to a coalition and you list out things you want to do and you have goals you want to accomplish, but you don't have the resources, it is a problem."

"The project took a lot more time than we anticipated....it's for the reporting and changes in the plan....the administration of the project."

"When the mission changed from the time we applied to when we got selected and had the money, that was a problem…I had the wrong people around the table the first time and you don't want to lose credibility with the people you're working with."

V. Conclusions

The findings from the evaluation of CPHMC Cohort 1 projects support the conclusions described below.

1. **WIC can play an important role in creating partnerships to implement PSE changes for improving the food environment and promoting linkages for chronic disease prevention and treatment services.** The CPHMC project clearly demonstrates 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, farmer's 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. **Cohort 1 projects are an asset for Cohort 2 projects and other WIC agencies that are interested in community-based work.** The experiences, suggestions, and lessons learned by the first cohort should help increase project success for the second cohort and serve as an outline for others. Pairing Cohort 1 agencies as "mentors" for agencies participating in Cohort 2 may be particularly effective, especially if the agency pairs have similar project objectives and activities.
4. **Cohort 1 agencies should pursue opportunities to build upon their success by working 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.** Work with schools on policy changes or businesses on breastfeeding accommodation are two examples of efforts undertaken by Cohort 1 projects that were not realistic to accomplish in an implementation timeframe 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 assessment at the beginning of the project to determine what is feasible and over what time frame activities can be reasonably accomplished is an important planning step.

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.

Appendices

Appendix A: CAP Template for Cohort 1

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 related to improving access to environments with healthy food and beverage options and/or improving 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.

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.5: Increase the number of stores in <**target community**> that accept WIC from 7 to 9.	
Estimated number of people reached by the intervention	500
Description of **reach** calculation	Estimated # of WIC clients living near new store #1 + Estimated # of WIC clients living near new store #2 - # of clients that live near 2 new stores = 400 +200 – 100 = 500

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 2-4 secondary objectives related to primary objective C in your CAPs, depending on whether or not your interventions are focused on improving access to healthy foods, improving access to chronic disease prevention, risk reduction or management opportunities, or both. If you are focusing on both strategies, you are required to include all 4 secondary objectives related to communications. All 4 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.

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.

COMMUNITY ACTION PLAN

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.X*: Increase the number of <select **setting**> with <Enter **intervention**> from <**baseline**> to <**target**> by the end of the project period.	
Estimated number of people reached by the intervention	
Description of **reach** calculation	

*Please consult Appendix A for the appropriate numbering for your secondary objectives. If you do not see your objective listed, please contact NWA for a number assignment for the objective. Consistent objective numbers across all agencies helps to streamline reporting to CDC.

Secondary Objective A.X*

Activity Number	**Activity Title**	**Description of Activity**	**Start Date**	**Completion Date**	**Outputs/Measures**
A.X.1					
A.X.2					
A.X.3					

Activity Number	Activity Title	Description of Activity	Start Date	Completion Date	Outputs/Measures
A.X.4					
A.X.5					
A.X.6					
A.X.7					
A.X.8					
A.X.9					
A.X.10					

Repeat the above format for each chosen intervention related to Primary Objective A.

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.X**: Increase the number of <select setting> with <enter intervention> from <baseline> to <target> by the end of the project period.	
Estimated number of people reached	
Description of reach calculation	

**Please consult Appendix A for the appropriate numbering for your secondary objectives. If you do not see your objective listed, please contact NWA for a number assignment for the objective. Consistent objective numbers across all agencies helps to streamline reporting to CDC.

Secondary Objective B.X

Activity Number	Activity Title	Description of Activity	Start Date	Completion Date	Outputs/Measures
B.X.1					
B.X.2					
B.X.3					
B.X.4					
B.X.5					
B.X.6					
B.X.7					
B.X.8					
B.X.9					
B.X.10					

Repeat the above format for each chosen intervention related to Primary Objective B.

Primary Objective C: Increase the number of **public** and **partner messages** showcasing CPHMC project efforts and achievements related to improving access to environments with healthy food and beverage options and improving 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 C.1: Increase the number of **public** messages on CPHMC efforts and achievements related to improving access to environments with healthy food and beverage options from <baseline> to <target> 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						

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.1.9						
C.1.10						

Secondary Objective C.2: Increase the number of **public** messages on CPHMC efforts and achievements related to improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from <baseline> to <target> 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	Media Type (Television, Radio, Print, Social Media, Outdoor, Other)	Circulation/ Viewers/ Listeners/ Followers/ Subscribers
C.2.1						
C.2.2						
C.2.3						
C.2.4						

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.2.5						
C.2.6						
C.2.7						
C.2.8						
C.2.9						
C.2.10						

Secondary Objective C.3: Increase the number of **partner** messages on CPHMC efforts and achievements related to improving access to environments with healthy food and beverage options from <baseline> to <target> 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.3

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.3.1						
C.3.2						
C.3.3						
C.3.4						
C.3.5						
C.3.6						
C.3.7						
C.3.8						
C.3.9						
C.3.10						

Secondary Objective C.4: Increase the number of **partner** messages on CPHMC efforts and achievements related to improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from <baseline> to <target> 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.4

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.4.1						
C.4.2						
C.4.3						
C.4.4						
C.4.5						
C.4.6						
C.4.7						

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.4.8						
C.4.9						
C.4.10						

Appendix B: Secondary Objectives List

Secondary Objectives Related to Primary Objective A:

Secondary Objective A.1: Increase the number of grocery stores located in the target community from baseline to target.

Secondary Objective A.2: Increase the number of [retail environments: grocery stores; convenience stores] that sell "healthy" foods in the target community from baseline to target.

- Note: For this objective, focus on stores that are already existing.

Secondary Objective A.3: Increase the number of [retail environments: grocery stores; convenience stores] that expand their inventory of "healthy" foods in the target community from baseline to target.

- Note: For this objective, focus on stores that are already existing.

Secondary Objective A.5: Increase the number of [retail environments: grocery stores; convenience stores] that accept WIC in the target community from baseline to target.

Secondary Objective A.6: Increase the number of [retail environments: grocery stores; convenience stores] that accept SNAP in the target community from baseline to target.

Secondary Objective A.7: Increase the number of [retail environments: grocery stores; convenience stores] with new on-site and in-store placement and promotion strategies for healthy foods in the target community from baseline to target.

Secondary Objective A.8: Increase the number of grocery stores with employees trained to assist shoppers to select healthy foods from baseline to target.

Secondary Objective A.9: Increase the number of [retail environments: grocery stores; convenience stores] that offer cash or coupon incentives for purchase of healthy foods in the target community from baseline to target.

Secondary Objective A.10: Increase the number of farmers' markets that offer cash or coupon incentives for the purchase of healthy foods in the target community from baseline to target.

Secondary Objective A.11: Increase the number of farmers' markets available in the target community from baseline to target.

Secondary Objective A.12: Increase the number of farmers markets that accept SNAP and/or WIC in the target community from baseline to target.

Secondary Objective A.13: 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; entertainment venues; faith based organizations; gardens; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; convenience stores; restaurants/bars; other—please specify] using new tools or resources to create awareness of how to access healthy food options in the community from baseline to target.

Secondary Objective A.14: Increase the number of restaurants/bars using nutrition labeling to identify "healthy" menu options in the target community from baseline to target.

Secondary Objective A.15: Increase the number of restaurants/bars with new "healthy" menu options in the target community from baseline to target.

Secondary Objective A.16: Increase the number of [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] in the community that develop healthy food and beverage procurement policies from baseline to target.

Secondary Objective A.17: Increase the number of [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] in the community that successfully implement healthy food and beverage procurement practices outlined in policies from baseline to target.

Secondary Objective A.18: Increase the number of K-12 schools that implement "healthy" vending and concession practices in the target community from baseline to target.

Secondary Objective A.19: 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 baseline to target.

Secondary Objective A.20: Increase the number of grocery stores participating in the Share Our Strength Cooking Matters at the Store program in the target community from baseline to target.

Secondary Objective A.21: Increase the number of [hotels/motels; entertainment venues; grocery stores; restaurants/bars; other—please specify] that publicly promote/welcome breastfeeding in the target community from baseline to target.

Secondary Objective A.22: Increase the number of [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 policies to support breastfeeding from baseline to target.

Secondary Objective A.23: Increase the number of [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 implement policies that support breastfeeding in the target community from baseline to target.

Secondary Objective A.24: Increase the number of [other—food banks] that offer healthy food and beverage options in the target community from baseline to target.

Secondary Objective A.26: Increase the number of [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 implement policies to support improved access to health food and beverage options from baseline to target.

Secondary Objective A.28: Increase the number of K-12 schools in the community that successfully implement a gardening curriculum from baseline to target.

Secondary Objective A.29: Increase the number of gardens in the community from baseline to target.

Secondary Objectives Related to Primary Objective B:
Chronic disease prevention, risk reduction, and management opportunities include but are not limited to: WIC services, grocery store tours, lifestyle modification programs, tobacco cessation support groups, hotlines, National Diabetes Prevention Program, Chronic Disease Self-Management Program, other breastfeeding services, other services.

Secondary Objective B.1: 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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] signing clients up for the WIC program from baseline to target.

Secondary Objective B.2: 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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] referring and/or signing patients up for healthcare from baseline to target.

Secondary Objective B.4: Increase the number of worksites with comprehensive worksite wellness programs that include assessment of health risks with feedback and health education in the target community from baseline to target.

Secondary Objective B.5: Increase the number of health insurance companies who reimburse for nutrition services provided by WIC staff in the target community from baseline to target.

Secondary Objective B.6: Increase the number of health insurance companies who reimburse for breastfeeding services provided by WIC staff in the target community from baseline to target.

Secondary Objective B.7: Increase the number of health insurance companies who cover cash value fruit and vegetable prescriptions, based on the WIC CVB guidelines, in the target community from baseline to target.

Secondary Objective B.8: Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; other—please specify] that offer chronic disease prevention or treatment programs that are covered by Medicaid in the target community from baseline to target.

Secondary Objective B.9: 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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] using new tools or resources to improve awareness of available chronic disease prevention and management services in the community from baseline to target.

Secondary Objective B.10: 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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] that use an enhanced WIC referral list with new community-based chronic disease prevention and management services added from baseline to target.

Secondary Objective B.11: 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] that refer to WIC in the target community from baseline to target.

Secondary Objective B.12: 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] that refer families to health care (a patient-centered medical home) in the target community from baseline to target.

Secondary Objective B.13: 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] that refer families to other chronic disease prevention and management services in the community from baseline to target.

Secondary Objective B.14: Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; other—please specify] that make "prescriptions" for non-pharmaceutical interventions like exercise in the target community from baseline to target.

Secondary Objective B.15: 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 basic training in breastfeeding in the target community from baseline to target.

Secondary Objective B.16: 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 basic training in community chronic disease prevention and management services referrals in the target community from baseline to target.

Secondary Objective B.17: 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 baseline to target.

Secondary Objective B.18: 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 basic training on WIC services and benefits in the target community from baseline to target.

Secondary Objective B.19: Increase the number of [dental offices; health insurance companies; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; 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 baseline to target.

Secondary Objective B.20: Increase the number of [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] using new tools and resources to sustain training on breastfeeding, WIC services and benefits, referrals, and cultural competency in the future in the target community from baseline to target.

Secondary Objective B. 21: Increase the number of [other—WIC sites] that have the capacity to bill for preventive nutrition and breastfeeding services outside the scope of the WIC program in the target community from baseline to target.

Secondary Objective B.22: 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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] that offer new chronic disease prevention and management services in the target community from baseline to target.

- Note: This objective includes expanding service offerings at WIC clinics and health centers, performing WIC services in local doctor's offices, developing a mobile WIC/other services van or bus, etc.

Secondary Objective B.23: Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; other—please specify] that bill insurance for new chronic disease prevention and management services that already have existing billing codes in the target community from baseline to target.

Secondary Objectives Related to Primary Objective C:

Secondary Objective C.1: Increase the number of public messages on CPHMC efforts and achievements related to improving access to environments with healthy food and beverage options from 0 to target by the end of the project period.

Secondary Objective C.2: Increase the number of public messages on CPHMC efforts and achievements related to improving 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 C.3: Increase the number of partner messages on CPHMC efforts and achievements related to improving access to environments with healthy food and beverage options from 0 to target by the end of the project period.

Secondary Objective C.4: Increase the number of partner messages on CPHMC efforts and achievements related to improving 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.

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**: Q3/2015**: April-June 2015; **Q4/2015**: July-Sept 2015; **Q1/2016**: Oct-Dec 2015; **Q2/2016**: Jan-Mar 2016.

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: Secondary Objectives Selected by Each Cohort 1 Agency

	AGENCY																	
OBJECTIVES	1. Crescent City WIC (LA)	2. St. Tammany Parish Hospital (LA)	3. Cumberland Plateau Health District (VA)	4. Angelina County & Cities Health Department (TX)	5. Wichita Falls-Wichita County Public Health District (TX)	6. Geary County Health Department (KS)	7. Tarrant County WIC (TX)	8. Johns Hopkins University WIC (MD)	9. Eastern Shore Health District (VA)	10. Mt. Rogers Health District (VA)	11. Community Clinic, Inc. (MD)	12. East Side Health District (IL)	13. District Health Department #10 (MI)	14. Scott County WIC (IA)	15. Richmond City Health District (VA)	16. Gateway CAP (NJ)	17. Five Sandoval Indian Pueblos, Inc. (NM)	**Total**
A.2: Increase the number of [retail environments: grocery stores; convenience stores] that expand their inventory of "healthy" foods in the target community from baseline to target.								X						X	X			3
A.3: Increase the number of [retail environments: grocery stores; convenience stores] that expand their inventory of "healthy" foods in the target community from baseline to target.								X		X		X			X	X	X	6
A.5: Increase the number of [retail environments: grocery stores; convenience stores] that accept WIC in the target community from baseline to target.						X									X		X	3
A.6: Increase the number of [retail environments: grocery stores; convenience stores] that accept SNAP in the target community from baseline to target.																		0
A.7: Increase the number of [retail environments: grocery stores; convenience stores] with new on-site and in-store placement and promotion strategies for healthy foods in the target community from baseline to target.					X		X	X				X	X	X	X			7
A.8: Increase the number of grocery stores with employees trained to assist shoppers to select healthy foods from baseline to target.	X	X					X											3
A.9: Increase the number of [retail environments: grocery stores; convenience stores] that offer cash or coupon incentives for purchase of healthy foods in the target community from baseline to target.												X						1

OBJECTIVES	1. Crescent City WIC (LA)	2. St. Tammany Parish Hospital (LA)	3. Cumberland Plateau Health District (VA)	4. Angelina County & Cities Health Department (TX)	5. Wichita Falls-Wichita County Public Health District (TX)	6. Geary County Health Department (KS)	7. Tarrant County WIC (TX)	8. Johns Hopkins University WIC (MD)	9. Eastern Shore Health District (VA)	10. Mt. Rogers Health District (VA)	11. Community Clinic, Inc. (MD)	12. East Side Health District (IL)	13. District Health Department #10 (MI)	14. Scott County WIC (IA)	15. Richmond City Health District (VA)	16. Gateway CAP (NJ)	17. Five Sandoval Indian Pueblos, Inc. (NM)	Total
A.10: Increase the number of farmers' markets that offer cash or coupon incentives for the purchase of healthy foods in the target community from baseline to target.					X							X						2
A.11: Increase the number of farmers' markets available in the target community from baseline to target.		X			X					X								3
A.12: Increase the number of farmers markets that accept SNAP and/or WIC in the target community from baseline to target.	X																	1
A.13: 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; entertainment venues; faith based organizations; gardens; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; convenience stores; restaurants/bars; other—please specify] using new tools or resources to create awareness of how to access healthy food options in the community from baseline to target.			X	X	X		X	X	X		X	X	X	X				10
A.14: Increase the number of restaurants/bars using nutrition labeling to identify "healthy" menu options in the target community from baseline to target.					X								X					2
A.15: Increase the number of restaurants/bars with new "healthy" menu options in the target community from baseline to target.		X							X									2
A.19: 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 baseline to target.					X													1
A.20: Increase the number of grocery stores participating in the Share Our Strength Cooking Matters at the Store program in the target community from baseline to target.	X	X		X		X				X				X				6
A.21: Increase the number of [hotels/motels; entertainment venues; grocery stores; restaurants/bars; other—please specify] that publicly promote/welcome breastfeeding in the target community from baseline to target.	X					X			X	X				X		X		6

OBJECTIVES	1. Crescent City WIC (LA)	2. St. Tammany Parish Hospital (LA)	3. Cumberland Plateau Health District (VA)	4. Angelina County & Cities Health Department (TX)	5. Wichita Falls-Wichita County Public Health District (TX)	6. Geary County Health Department (KS)	7. Tarrant County WIC (TX)	8. Johns Hopkins University WIC (MD)	9. Eastern Shore Health District (VA)	10. Mt. Rogers Health District (VA)	11. Community Clinic, Inc. (MD)	12. East Side Health District (IL)	13. District Health Department #10 (MI)	14. Scott County WIC (IA)	15. Richmond City Health District (VA)	16. Gateway CAP (NJ)	17. Five Sandoval Indian Pueblos, Inc. (NM)	Total
A.22: Increase the number of [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 from baseline to target.									X							X		2
A.24: Increase the number of [other—food banks] that offer healthy food and beverage options in the target community from baseline to target.				X														1
A.26: Increase the number of [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 improved access to health food and beverage options from baseline to target.							X											1
A.28: Increase the number of K-12 schools in the community that successfully implement a gardening curriculum from baseline to target.			X															1
A.29: Increase the number of gardens in the community from baseline to target.		X																1
B.1: 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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] signing clients up for/referring to the WIC program from baseline to target.				X		X			X		X			X	X			6

OBJECTIVES	1. Crescent City WIC (LA)	2. St. Tammany Parish Hospital (LA)	3. Cumberland Plateau Health District (VA)	4. Angelina County & Cities Health Department (TX)	5. Wichita Falls-Wichita County Public Health District (TX)	6. Geary County Health Department (KS)	7. Tarrant County WIC (TX)	8. Johns Hopkins University WIC (MD)	9. Eastern Shore Health District (VA)	10. Mt. Rogers Health District (VA)	11. Community Clinic, Inc. (MD)	12. East Side Health District (IL)	13. District Health Department #10 (MI)	14. Scott County WIC (IA)	15. Richmond City Health District (VA)	16. Gateway CAP (NJ)	17. Five Sandoval Indian Pueblos, Inc. (NM)	Total
B.2: 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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] referring and/or signing patients up for healthcare from baseline to target.									X				X			X		3
B.9: 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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] using new tools or resources to improve awareness of available chronic disease prevention and management services in the community from baseline to target.	X			X	X	X	X	X					X					7
B.10: 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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] that use an enhanced WIC referral list with new community-based chronic disease prevention and management services added from baseline to target.							X									X		2
B.11: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] that refer to WIC in the target community from baseline to target.						X						X	X					3

OBJECTIVES	1. Crescent City WIC (LA)	2. St. Tammany Parish Hospital (LA)	3. Cumberland Plateau Health District (VA)	4. Angelina County & Cities Health Department (TX)	5. Wichita Falls-Wichita County Public Health District (TX)	6. Geary County Health Department (KS)	7. Tarrant County WIC (TX)	8. Johns Hopkins University WIC (MD)	9. Eastern Shore Health District (VA)	10. Mt. Rogers Health District (VA)	11. Community Clinic, Inc. (MD)	12. East Side Health District (IL)	13. District Health Department #10 (MI)	14. Scott County WIC (IA)	15. Richmond City Health District (VA)	16. Gateway CAP (NJ)	17. Five Sandoval Indian Pueblos, Inc. (NM)	Total
B.12: 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] that refer families to health care (a patient-centered medical home) in the target community from baseline to target.											X							1
B.13: 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] that refer families to other chronic disease prevention and management services in the community from baseline to target.					X													1
B.14: Increase the number of [dental offices; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; other—please specify] that make "prescriptions" for non-pharmaceutical interventions like exercise in the target community from baseline to target.				X	X													2
B.15: 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 basic training in breastfeeding in the target community from baseline to target.		X			X	X	X									X		5

OBJECTIVES	1. Crescent City WIC (LA)	2. St. Tammany Parish Hospital (LA)	3. Cumberland Plateau Health District (VA)	4. Angelina County & Cities Health Department (TX)	5. Wichita Falls-Wichita County Public Health District (TX)	6. Geary County Health Department (KS)	7. Tarrant County WIC (TX)	8. Johns Hopkins University WIC (MD)	9. Eastern Shore Health District (VA)	10. Mt. Rogers Health District (VA)	11. Community Clinic, Inc. (MD)	12. East Side Health District (IL)	13. District Health Department #10 (MI)	14. Scott County WIC (IA)	15. Richmond City Health District (VA)	16. Gateway CAP (NJ)	17. Five Sandoval Indian Pueblos, Inc. (NM)	Total
B.16: 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 basic training in community chronic disease prevention and management services referrals in the target community from baseline to target.					X		X											2
B.17: 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 baseline to target.	X										X			X	X			4
B.18: 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 basic training on WIC services and benefits in the target community from baseline to target.					X	X	X	X			X	X			X	X		8
B.19: Increase the number of [dental offices; health insurance companies; hospitals; mental illness providers; pharmacies; primary care providers; substance abuse facilities; 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 baseline to target.		X																1

OBJECTIVES	1. Crescent City WIC (LA)	2. St. Tammany Parish Hospital (LA)	3. Cumberland Plateau Health District (VA)	4. Angelina County & Cities Health Department (TX)	5. Wichita Falls-Wichita County Public Health District (TX)	6. Geary County Health Department (KS)	7. Tarrant County WIC (TX)	8. Johns Hopkins University WIC (MD)	9. Eastern Shore Health District (VA)	10. Mt. Rogers Health District (VA)	11. Community Clinic, Inc. (MD)	12. East Side Health District (IL)	13. District Health Department #10 (MI)	14. Scott County WIC (IA)	15. Richmond City Health District (VA)	16. Gateway CAP (NJ)	17. Five Sandoval Indian Pueblos, Inc. (NM)	Total
B.21: Increase the number of [other—WIC sites] that have the capacity to bill for preventive nutrition and breastfeeding services outside the scope of the WIC program in the target community from baseline to target.																	X	1
B.22: 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; jurisdictions; non-profit organizations; worksites; farmer's markets; grocery stores; other—please specify] that offer new chronic disease prevention and management services in the target community from baseline to target.	X				X												X	3
C.1: Increase the number of public messages on CPHMC efforts and achievements related to improving access to environments with healthy food and beverage options from baseline to target by the end of the project period	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	17
C.2: Increase the number of public messages on CPHMC efforts and achievements related to improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from baseline to target by the end of the project period	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	17
C.3: Increase the number of partner messages on CPHMC efforts and achievements related to improving access to environments with healthy food and beverage options from baseline to target by the end of the project period	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	17
C.4: Increase the number of partner messages on CPHMC efforts and achievements related to improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from baseline to target by the end of the project period	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	17

Appendix C: Project Profiles

Angelina County & Cities Health District
Project Profile

Angelina County, TX
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Angelina County
Population Total		308,745,538	87,042
Population Density (# people per square mile)	Average	88.23	109
	Range	Varies	Under 51 to Over 1,000
Racial and Ethnic Make-Up	White	74.02%	77.93%
	Black	12.57%	15.28%
	Asian	4.89%	0.94%
	Native American/ Alaska Native	0.82%	0.68%
	Native Hawaiian/ Pacific Islander	0.17%	0%
	Other Race	4.73%	3.55%
	Multiple Races	2.80%	1.52%
	Hispanic	16%	20.15%
Income	Per Capita	$28,154	$20,982
	% Living in Poverty	15.37%	19.35%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	No data

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

Community Health Indicators:

HEALTH INDICATORS*	United States	Angelina County
% Adults Overweight	35.78%	36.14%
% Adults Obese	27.14%	33.60%
% Adults with Heart Disease	4.40%	4.11%
% Adults with Diagnosed Diabetes	9.11%	10.40%
% Adults with high Cholesterol	38.52%	48.09%
% Adults with Hypertension	28.16%	31.90%
% Babies Born with Low Birth Weight	8.20%	9.10%
Infant Mortality Rate (per 1,000 births)	6.52	5.5
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	29.90%
% of Insured Population Receiving Medicaid	20.21%	28.41%
% Adults Without Any Regular Doctor	22.07%	14.65%
% of Population Living in a Health Professional Shortage Area**	34.07%	100%
Food Insecurity Rate	15.94%	19.11%
% Population with Low Food Access***	23.61%	28.66%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	78.80%
WIC Average Monthly Caseload FY2014	8,258,413	No data

*Health indicators data was extracted from the agency's submitted 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*:

Angelina County and Cities Health District and their partners have tackled high food insecurity rates with several intervention strategies. They changed the regional food bank's delivery route to provide monthly produce deliveries to a central food pantry in Angelina County, resulting in providing produce to as many as 16,000 food pantry clients per month at 3 different pantry locations, including 2 rural locations.

Additionally, they've trained local organization employees on their *Guide to Healthy Living* and their *Healthy Food Access Guide*. And, local hospitals and other primary care providers are screening for chronic diseases, healthy behaviors, and low food access. They are giving "prescriptions" for healthy foods and distributing the guides noted above.

They also developed a more robust WIC referral system that includes the

ACCHD Primary Care Clinic, the Immunization office, the ACCHD Texas Health Steps, Daycares, Headstart, Family Crisis Center, and Pregnancy Help Center. They have seen WIC caseload increase since implementation.

Finally, they have engaged 7 grocery stores and community partners to offer and host Cooking Matters at the Store Tours.

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

Angelina County & Cities Health District Project Profile

Starting Capacity and Coalition Partners:

Angelina County and Cities Health District began their project building from an existing coalition in their community. The following partners were a part of the coalition for this project.

Organization Category	Organization Name*
Community Members	From Hospice in the Pines (2 people); Heart to Heart Hospice; Castle Pines Nursing & Rehab Center; Pinecrest; LaVane Consulting; ADAC
Public Health	DSHS (4 people); Angelina County and Cities Health District (7 people)
Healthcare	Family Medicine (2 people); Dr. Todd's Office; CHI St. Luke's Memorial; Woodland Heights Hospital; Angelina Eye Center; Angelina Internal Medicine Associates
Media	The Coalition
Government/Local Elected Officials	Angelina County
Faith-Based	Love, INC; Ministry Representative
Cooperative Extension Employees	Ag. Extension Office
Food Retailers/ Distributors	Christian Information & Services Center (regional food distributor/ food bank)
Local Farmers	Ag. Extension Office
Education	Angelina College; Head Start Programs
Other Local Businesses	Abelt's Pharmacy; Brookshire Brothers Pharmacy; Walgreens Pharmacy (2 people); CVS Pharmacy; Medicine Shoppe Pharmacy
Other	N/A

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, Angelina County and Cities Health District reached **43 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **87,441 people.**

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.13	Increase the number of settings using new tools or resources to create awareness of how to access healthy food options in the community from 0 to 28.	21
A.20	Increase the number of settings participating in the Share Our Strength Cooking Matters at the store program in the target community from 0 to 10.	13
A.24	Increase the number of food banks that offer healthy food and beverage options in the target community from 0 to 3.	3
B.1	Increase the number of settings referring and/or signing clients up for the WIC program from 0 to 10.	19
B.9	Increase the number of settings using new tools or resources to improve awareness of available chronic disease prevention and management services in the community from 0 to 18.	16
B.14	Increase the number of Primary Care Providers that make prescriptions for non-pharmaceutical interventions like exercise from 0 to 8.	4
B.19	Increase the number of 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 from 8 to 12.	2

Settings Reached: Government Agencies (ACCHD Texas Health Steps, Texas A&M AgriLife Extension Office, ACCHD Immunizations, ACCHD Texas Health Steps, ACCHD Primary Care); Group Homes (Family Crisis, Buckner); Hospitals (CHI St. Luke's Health Memorial-Polk Education Center, Lufkin, Livingston); K-12 Schools (Zavalla Elementary, Middle, and High School, Lufkin Middle School, Anderson Elementary School, Herty Elementary School); Non-Profits (C.I.S.C.); Out-of-School Time Providers (Little Panthers, Little Britches, Just Kidz, Kiddie Land, Tiny Town, Headstart); Pharmacies (Lopers Pharmacy, Brookshire Brothers Pharmacy Huntington); Pregnancy Help Centers (Pregnancy Help Center); Primary Care Providers (Drs. Carter, Dr. Johnson, Dr. Hill, Dr. Fercowitz, Dr. Burke, Dr. Arnold, Dr. Caskey/Hafernick, Dr. Rudis, Dr. Krohn); Grocery Stores (Wal-Mart, HEB, Brookshire Brothers locations-Lufkin, Diboll, Huntington, Zavalla); Faith-Based Organizations (Methodist Church); WIC Offices (ACCHD WIC office); Food Banks (Huntington Food Bank, Zavalla Grace Gospel Food Bank, C.I.S.C.)

CCI Health & Wellness Services Project Profile

Montgomery County, MD
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Montgomery County, MD
Population Total		308,745,538	989,474
Population Density (# people per square mile)	Average	88.23	2,014.71
	Range	Varies	51 to Over 5,000
Racial and Ethnic Make-Up	White	74.02%	56.69%
	Black	12.57%	17.21%
	Asian	4.89%	14.08%
	Native American/ Alaska Native	0.82%	0.35%
	Native Hawaiian/ Pacific Islander	0.17%	0.03%
	Other Race	4.73%	7.65%
	Multiple Races	2.80%	3.99%
	Hispanic	16%	17.5%
Income	Per Capita	$28,154	$49,037
	% Living in Poverty	15.37%	6.73%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	39.22

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Montgomery County, MD
% Adults Overweight	35.78%	36.06%
% Adults Obese	27.14%	19%
% Adults with Heart Disease	4.40%	2.88%
% Adults with Diagnosed Diabetes	9.11%	7%
% Adults with high Cholesterol	38.52%	32.12%
% Adults with Hypertension	28.16%	23.4%
% Babies Born with Low Birth Weight	8.20%	7.9%
Infant Mortality Rate (per 1,000 births)	6.52	5.2
% of Mothers with Late or No Prenatal Care	17.25%	4.4%
Adult Uninsured Rate	20.76%	11.52%
% of Insured Population Receiving Medicaid	20.21%	11.44%
% Adults Without Any Regular Doctor	22.07%	16.18%
% of Population Living in a Health Professional Shortage Area**	34.07%	6.33%
Food Insecurity Rate	15.94%	8.32%
% Population with Low Food Access***	23.61%	17.92%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	66.7%
WIC Average Monthly Caseload FY2014	8,258,413	30,143

*Health indicators data was extracted from the agency's submitted 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*:

CCI Health & Wellness Services engaged their Healthy Jumpstart Coalition in many initiatives to strengthen their local health referral system.

They established a resource navigator program, which is an interagency program that connects WIC clients with trained resource navigators who help them get connected to health care and preventive services, including a medical home, by educating them about their options, helping them schedule appointments, and encouraging them to attend their appointments. As a result of the program, 441 participants were linked to primary and preventive services in February 2016 alone, and WIC enrollment has increased. AmeriCorps volunteers currently serve as the navigators. The partners also created an electronic community resource database, which the navigators use as a tool to help clients find what they need. This database has also been shared with other local community health workers and social work interns for use beyond WIC. Finally, they provided cultural competency training to over 250 CCI employees.

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

Website: www.cciweb.org

CCI Health & Wellness Services Project Profile

Starting Capacity and Coalition Partners:

CCI Health and Wellness Services developed a new coalition for this project called the Healthy Jumpstart Coalition.

Organization Category	Organization Name*
Community Members	2 community members
Public Health	Department of Health and Mental Hygiene Montgomery County; CCI- WIC; CCI Community Navigator
Healthcare	Shady Grove Hospital; Primary Care Coalition; CHW (2 people); CCI- Family Planning
Media	
Government/Local Elected Officials	
Faith-Based	
Cooperative Extension Employees	
Food Retailers/ Distributors	
Local Farmers	
Education	Montgomery County Public Schools
Other Local Businesses	
Other	Americorps; Healthworks

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, CCI Health & Wellness Services reached **54 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **368,379 people**.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.13	Increase the number of settings using new tools or resources to create awareness of how to access healthy food options in the community from 0 to 53.	36
B.1	Increase the number of settings referring and/or signing clients up for the WIC program from 0 to 19.	14
B.12	Increase the number of settings that refer families to health care (a patient-centered medical home) in the target community from 5 to 9.	18
B.17	Increase the number of settings that receive cultural competency training from 0 to 4.	14
B.18	Increase the number of settings that receive basic training on WIC services and benefits from 10 to 65.	24

Settings Reached: Dental Offices (CCI-Kemp Mill, CCI-Gaithersburg, and CCI-Franklin Park); Entertainment Venues (Wheaton Resource Center); Faith-Based Organizations (3 Catholic Charities locations in Montgomery County); Farmers' Markets (3 vendors at Crossroads Farmers Market); Food Banks (Manna Food Bank); Government Agencies (11 locations of the Montgomery County Health Department, Family Services); Grocery Stores (Wheaton Giant); Hospitals (Holy Cross Hospital, Shady Grove Hospital); K-12 Schools (Walkins Mill, Rockville, Kennedy, Blair, Northwood high schools, Georgetown Day School); Mental Illness Providers (CCI -Silver Spring and CCI-Gaithersburg); Military Facilities (Walter Reed Naval Hospital, Walter Reed Fleet and Family Support); Primary Care Providers (3 CCI Health Centers; Flint Hill Med Home); Non-Profits (Casa De Maryland, Hearts and Homes, CASA, The Newborn Foundation, Carefirst); WIC Clinics (CCI-Germantown, CCI- Gaithersburg, CCI-Greenbelt, CCI-Takoma Park, CCI-Wheaton).

Crescent City WIC Services, Inc. Project Profile

Plaquemines Parish, LA
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Plaquemines Parish, LA
Population Total		308,745,538	23,385
Population Density (# people per square mile)	Average	88.23	29.99
	Range	Varies	No data
Racial and Ethnic Make-Up	White	74.02%	71.09%
	Black	12.57%	22.23%
	Asian	4.89%	3.46%
	Native American/ Alaska Native	0.82%	1.37%
	Native Hawaiian/ Pacific Islander	0.17%	0%
	Other Race	4.73%	0.09%
	Multiple Races	2.80%	1.76%
	Hispanic	16%	5.30%
Income	Per Capita	$28,154	$25,747
	% Living in Poverty	15.37%	12.74%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	No data

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Plaquemines Parish, LA
% Adults Overweight	35.78%	32.51%
% Adults Obese	27.14%	34.7%
% Adults with Heart Disease	4.40%	5.76%
% Adults with Diagnosed Diabetes	9.11%	10.80%
% Adults with high Cholesterol	38.52%	40.68%
% Adults with Hypertension	28.16%	30.50%
% Babies Born with Low Birth Weight	8.20%	8.4%
Infant Mortality Rate (per 1,000 births)	6.52	6.4%
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	No data
% of Insured Population Receiving Medicaid	20.21%	No data
% Adults Without Any Regular Doctor	22.07%	36.35%
% of Population Living in a Health Professional Shortage Area**	34.07%	100%
Food Insecurity Rate	15.94%	11.28%
% Population with Low Food Access***	23.61%	No Data
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	No data
WIC Average Monthly Caseload FY2014	8,258,413	No data

*Health indicators data was extracted from the agency's submitted 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*:

Crescent City WIC Services, Inc. established a new coalition that is sustainable and transitioning leadership to the new Plaquemines Parish Medical Center beyond the project period.

The coalition has performed several interventions to improve access to healthy foods and chronic disease prevention and management services.

They certified 4 farmers' markets to accept WIC and Senior Farmers' Market Nutrition Programs vouchers as well as 1 to accept SNAP.

All government facilities in the Parish are now breastfeeding-friendly. And, they worked with a local artist to record breastfeeding jingles in the local New Orleans style to encourage moms to breastfeed and to know their legal rights pertaining to breastfeeding.

Finally, they worked to implement a health education program called Organ Wise Guys in several sites across the Parish.

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

Crescent City WIC Services, Inc. Project Profile

Starting Capacity and Coalition Partners:

Crescent City WIC Services, Inc. started a new coalition in Plaquemines Parish for this project.

Organization Category	Organization Name*
Community Members	
Public Health	
Healthcare	Plaquemines Medical Center, Amerihealth Caritas, Plaquemines Community Care, Amerigroup, Aetna Better Health of Louisiana
Media	
Government/Local Elected Officials	Louisiana WIC Program
Faith-Based	Christian Ministers Missionary Baptist Association of Plaquemines
Cooperative Extension Employees	LSU Ag Center, 4-H Plaquemines Parish
Food Retailers/ Distributors	
Local Farmers	
Education	Plaquemines Parish Head Start, Plaquemines Parish Schools, Tulane University
Other Local Businesses	Stix-N-Stem Nursery
Other	Fresh Breath of Life, Inc., Jagwah Productions

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, Crescent City WIC Services, Inc. reached **26 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **23,042 people**.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.8	Increase the number of Grocery Stores with employees trained to assist shoppers to select healthy foods from 0 to 3.	3
A.12	Increase the number of Farmer's Markets that accept SNAP and/or WIC in target community from 1 to 4.	4
A.20	Increase the number of grocery stores participating in the Share Our Strength Cooking Matters at the Store program in the target community from 0 to 3.	3
A.21	Increase the number of settings that publicly promote/welcome breastfeeding in the target community from 4 to 20.	9
B.17	Increase the number of settings that receive cultural competency training from 0 to 15.	8
B.22	Increase the number of settings that offer new chronic disease prevention and management services in the community from 0 to 5.	6

Settings Reached: Grocery Stores (Fremin's Grocery, Balestra's Grocery, Naval Air Station Commissary); Farmers' Markets (4 Vogt Farms markets); Non-Profits (4 YMCAs); Government Agencies (Plaquemines Parish Government Health Department, Civil Service Department, Animal Control Department, Plaquemines Medical Center, Parish Government Offices); Out-of-School Care Providers (Head Start); Hospitals (Plaquemines Medical Center, Plaquemines Care Center); K-12 Schools (Parish Schools, Head Start, OLPH School); Primary Care Providers (Nurse Family Partnership); Universities (Tulane)

Cumberland Plateau Health District Project Profile

Russell and Tazewell Counties, VA
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Russell County	Tazewell County
Population Total		308,745,538	28,646	44,664
Population Density (# people per square mile)	Average	88.23	60.47	86.11
	Range	Varies	Under 51 to 500	Under 51 to 500
Racial and Ethnic Make-Up	White	74.02%	97.09%	94.92%
	Black	12.57%	1.36%	2.57%
	Asian	4.89%	0.26%	0.37%
	Native American/ Alaska Native	0.82%	0.11%	0.01%
	Native Hawaiian/ Pacific Islander	0.17%	0%	0%
	Other Race	4.73%	0.29%	0.12%
	Multiple Races	2.80%	0.88%	2.01%
	Hispanic	16%	0.003%	0.007%
Income	Per Capita	$28,154	$19,735	$21,357
	% Living in Poverty	15.37%	19.29%	18.3%
	Disparity Index Score, Race /Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	24.13	25.67

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

Community Health Indicators:

HEALTH INDICATORS*	United States	Russell County	Tazewell County
% Adults Overweight	35.78%	27.88%	39.58%
% Adults Obese	27.14%	31%	28.7%
% Adults with Heart Disease	4.40%	5.40%	9.60%
% Adults with Diagnosed Diabetes	9.11%	10.3%	12.5%
% Adults with High Cholesterol	38.52%	72.94%	41.57%
% Adults with Hypertension	28.16%	36.2%	27.1%
% Babies Born with Low Birth Weight	8.20%	7.7%	10.7%
Infant Mortality Rate (per 1,000 births)	6.52	10.6	7.6
% of Mothers with Late or No Prenatal Care	17.25%	No data	No data
Adult Uninsured Rate	20.76%	14.73%	15.30%
% of Population Receiving Medicaid	20.21%	22.21%	22.27%
% Adults Without Any Regular Doctor	22.07%	18.78%	24.50%
% of Population Living in a Health Professional Shortage Area**	34.07%	100%	0%
Food Insecurity Rate	15.94%	13.03%	12.56%
% Population with Low Food Access***	23.61%	2.18%	20.5%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	No data	83%
WIC Average Monthly Caseload FY2014	8,258,413	No data	No data

*Health indicators data was extracted from the agency's submitted 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*:

Reaching out to community partners, Cumberland Plateau started a coalition called the GROW Coalition. Coalition members were unaware of community resources at different organizations and agencies until regular coalition meetings brought these stakeholders together.

The coalition worked together to take inventory of all the existing healthy food, wellness, and social service opportunities, which they translated into a web-based resource guide. Then they implemented "Train the Trainer" training at their coalition meeting, so members could go back to their respective organizations and teach others how to integrate use of the resource guide during their regular interactions with community members. They are also working with FoodCare to translate the guide into a mobile app.

The coalition has also worked to implement a gardening curriculum in 4 local elementary schools and one daycare with accompanying gardens at the sites and has plans for sustaining this effort beyond the project period.

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

Cumberland Plateau Health District Project Profile

Starting Capacity and Coalition Partners:

Cumberland Plateau Health District started building their community coalition with this project as there was no existing coalition or work groups in the community at the start of the project.

Organization Category	Organization Name*
Community Members	
Public Health	Tazewell County Health Department (2 people)
Healthcare	People Incorporated, CHIP Program
Media	
Government/Local Elected Officials	Tazewell County Department of Social Services (2 people); Tazewell County Public Library
Faith-Based	
Cooperative Extension Employees	Virginia Cooperative Extension Office (3 people)
Food Retailers/ Distributers	
Local Farmers	Local farmers (2 people); Virginia Farm Bureau (2 people)
Education	Smart Beginnings/United Way (2 people); Russell County Public Schools
Other Local Businesses	
Other	Cumberland Mountain Community Service Board; Clinch Valley Community Action; Taking Action for Special Kids; Appalachian Sustainable Development; Four Seasons YMCA (2 people)

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, Cumberland Plateau Health District reached **7 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **36,242 people.**

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.13	Increase the number of settings using new tools or resources to create awareness of how to access healthy food options in the community from 0 to 1.	3
A.28	Increase the number of K-12 Schools in the community that successfully implement a gardening curriculum from 0 to 4.	4

Settings Reached: Recreation Areas (Tazewell, Russell, Road Runners); Schools (Cooper Creek Elementary, Givens Elementary, Springville Elementary, Tazewell Elementary)

District Health Department #10 Project Profile

Oceana County, MI
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Oceana County
Population Total		308,745,538	26,245
Population Density (# people per square mile)	Average	88.23	51.68
	Range	Varies	Under 51 to 500
Racial and Ethnic Make-Up	White	74.02%	94.55%
	Black	12.57%	0.46%
	Asian	4.89%	0.28%
	Native American/ Alaska Native	0.82%	0.94%
	Native Hawaiian/ Pacific Islander	0.17%	0%
	Other Race	4.73%	1.95%
	Multiple Races	2.80%	1.82%
	Hispanic	16%	13.85%
Income	Per Capita	$28,154	$18,985
	% Living in Poverty	15.37%	19.9%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	42.56

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Oceana County
% Adults Overweight	35.78%	23.65%
% Adults Obese	27.14%	34%
% Adults with Heart Disease	4.40%	1.8%
% Adults with Diagnosed Diabetes	9.11%	11%
% Adults with high Cholesterol	38.52%	65%
% Adults with Hypertension	28.16%	25%
% Babies Born with Low Birth Weight	8.20%	8.7%
Infant Mortality Rate (per 1,000 births)	6.52	9.0
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	14.8%
% of Insured Population Receiving Medicaid	20.21%	28.82%
% Adults Without Any Regular Doctor	22.07%	2.23%
% of Population Living in a Health Professional Shortage Area**	34.07%	100%
Food Insecurity Rate	15.94%	14.12%
% Population with Low Food Access***	23.61%	9.41%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	No data
WIC Average Monthly Caseload FY2014	8,258,413	827

*Health indicators data was extracted from the agency's submitted 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 developed the Healthy Families of Oceana County (HFOC) coalition.

They improved access to healthy foods by providing on-site labelling and promotions of healthy food at 2 grocery stores and a food pantry, partnering with MSU Extension to do nutrition education, food preparation demonstrations, and classes. They also worked with 3 restaurants to develop healthy menu guides for customers to more easily identify healthy options, consistent with the Dietary Guidelines for Americans.

HFOC also developed a prescription pad for healthcare providers to more easily refer to WIC and trained providers in 5 settings on the tool. Additionally, prescription pads were used to refer patients to insurance enrollment assistance. They also provided health insurance enrollment assistance outreach at 5 community events.

Finally, they developed a website, a Facebook page, an interactive map, and bookmark with chronic disease prevention and management resources available in the community.

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

Facebook Page:
https://www.facebook.com/healthyfamiliesofoceanacounty/?fref=ts

District Health Department #10 Project Profile

Starting Capacity and Coalition Partners:

District Health Department #10 built their coalition as a subcommittee of an existing coalition, recruiting many new community partners to engage. Eventually, they established a separate coalition called the Healthy Families of Oceana County (HFOC) coalition.

Organization Category	Organization Name*
Community Members	Local Community Member (food advocate)
Public Health	District Health Department #10 (7 people)
Healthcare	Northwest Michigan Health Services, Inc.; Mercy Health Physician Partners-Lakeshore Campus, Hart Family Medical, Spectrum Health Physicians Group
Media	Oceana County Press (social media site), Oceana Herald Journal
Government/Local Elected Officials	Michigan Department of Health and Human Services (2 people), Goeff Hansen
Faith-Based	St. Gregory's Parish-Bread of Life Food Pantry; Love, INC (In the Name of Christ), New Era Christian Reformed
Cooperative Extension Employees	MSU Extension Program (2 people)
Food Retailers/ Distributors	Gale's IGA, Cherry Hill Supermarket, Feeding America of West Michigan
Local Farmers	Rennhack Orchards Market
Education	Shelby Schools Food Service; Hart Public Schools (2 people); Shelby Schools/ Shelby Early Childhood Center, Telemon Corporation
Other Local Businesses	Daniel's Restaurant, Trailside Restaurant
Other	Great Start Collaborative (3 people); United Way of Lakeshore; TrueNorth Community Services; Oceana Hispanic Center, Health Project, Hart/Silver Lake Chamber of Commerce

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, District Health Department #10 reached **19 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **26,245 people.**

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.7	Increase the number of settings with new on-site and in-store placement and promotion strategies for healthy foods from 0-3	3
A.13	Increase the number of settings using new tools or resources to create awareness of how to access healthy food options in the community from 0 to 7	11
A.14	Increase the number of Restaurants/Bars using nutrition labeling to identify healthy menu options in the target community from 0 to 3	2
B.1	Increase the number of settings that refer to WIC from 0 to 5	7
B.2	Increase the number of settings referring and/or signing patients up for healthcare in the target community from 0 to 5	7
B.9	Increase the number of settings using new tools or resources to improve awareness of available chronic disease prevention and management services in the community from 0 to 7	11

Settings Reached: Food Pantries (Bread of Life Food Pantry and food bank); Grocery Stores (Cherry Hill Store, Gale's IGA) ; Government Agencies (Michigan Department of Health and Human Services, District Health Department #10; MSU Extension Office); Hospitals (NW Michigan Health Services); Schools (Walkersville School); Primary Care Providers (Mercy Health Physician Partners, Hart Family Medical, Spectrum Health Family Medicine); Restaurants (Trailside Restaurant, Daniel's Restaurant, Hart Pizza); Recreation Areas (Project Homeless Connect, Farm Worker Appreciation Night, Maxine's Closet); Food Bank/Pantry (Mobile Food Pantry)

East Side Health District Project Profile

East St. Louis, IL
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	St. Clair County, IL
Population Total		308,745,538	268,939
Population Density (# people per square mile)	Average	88.23	No data
	Range	Varies	No data
Racial and Ethnic Make-Up	White	74.02%	65.22%
	Black	12.57%	30.15%
	Asian	4.89%	1.18%
	Native American/ Alaska Native	0.82%	0.19%
	Native Hawaiian/ Pacific Islander	0.17%	0.01%
	Other Race	4.73%	No data
	Multiple Races	2.80%	No data
	Hispanic	16%	3%
Income	Per Capita	$28,154	$26,234
	% Living in Poverty	15.37%	17.61%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	23.38

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

Community Health Indicators:

HEALTH INDICATORS*	United States	St. Clair County, IL
% Adults Overweight	35.78%	34.60%
% Adults Obese	27.14%	31.7%
% Adults with Heart Disease	4.40%	6.45%
% Adults with Diagnosed Diabetes	9.11%	11.3%
% Adults with high Cholesterol	38.52%	42.04%
% 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	8.1
% of Mothers with Late or No Prenatal Care	17.25%	6.18%
Adult Uninsured Rate	20.76%	11.5%
% of Insured Population Receiving Medicaid	20.21%	24.18%
% Adults Without Any Regular Doctor	22.07%	7.25%
% of Population Living in a Health Professional Shortage Area**	34.07%	26.38%
Food Insecurity Rate	15.94%	16.95%
% Population with Low Food Access***	23.61%	40.13%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	82.5%
WIC Average Monthly Caseload FY2014	8,258,413	3,800

*Health indicators data was extracted from the agency's submitted 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*:

East Side Health District built a diverse coalition of engaged stakeholders and community members that took ownership of this project and making change in their community. They named it the Make Health Happen Coalition.

East Side Health District successfully implemented food systems changes in their community by working with local convenience store owners to stock and promote healthier food options in the community of East St. Louis in St. Clair County, which faced substantial food access challenges with the majority if residents living in a food dessert. Fresh and frozen vegetable options increased from 2 options to 10 or more options in 5 of the 6 stores they worked with. Signage and in-store education and cooking demonstrations highlighted healthy foods at each store. Store owners also reported that they sold more produce than before participating in the program. They also created and distributed 1000 food resource guides and 5000 food pantry wallet cards. And, they made 18 bulletin boards with resource information, which they placed throughout the community.

They also trained local OBGYN and Pediatric offices on WIC and how to refer to WIC.

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

Facebook Page:
https://www.facebook.com/makehealthhappenESL

East Side Health District Project Profile

Starting Capacity and Coalition Partners:

East Side Health District built a new coalition in their community for this project as there was no existing one.

Organization Category	Organization Name*
Community Members	WIC Mom
Public Health	East Side Health District (2 people)
Healthcare	St. Elizabeth Hospital; SIUE Nursing
Media	
Government/Local Elected Officials	City government; Housing Authority
Faith-Based	New Life Community Church
Cooperative Extension Employees	University Extension of Illinois (2 people);
Food Retailers/ Distributors	Jeremiah's Food Pantry; Local Vendors (3)
Local Farmers	Local Farmer
Education	SLU; SIUE Headstart
Other Local Businesses	
Other	AARP; Lessie Bates; WPT; SIHF; American Heart Association; Get Up and Go; YMCA; Harmony; East Side Aligned; United Way

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, East Side Health District reached **25 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **26,598 people.**

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.3	Increase the number of settings that expand their inventory of healthy foods from 1 to 6	7
A.7	Increase the number of settings with new on-site and in-store placement and promotion strategies for healthy foods from 2-6	7
A.9	Increase the number of convenience stores that offer cash or coupon incentives for purchase of healthy foods from 0 to 4.	2
A.10	Increase the number of farmers' markets that offer cash or coupon incentives for purchase of healthy foods from 0 to 2	1
A.13	Increase the number of settings using new tools or resources to create awareness of how to access healthy food options in the community from 0 to 2	2
B.18	Increase the number of primary care providers/their staff that receive basic training on WIC services and benefits from 0 -10	12

Settings Reached: Grocery Stores (Save-A-Lot; Gateway Market); Convenience Stores (Bond Ave Fish and Poultry, Eddy's Meat Market, East Side Meat Market, Highway 15 Market, Healthy Choice Market); Farmers' Markets (Fresh Market); Primary Care Providers (Southern Illinois Healthcare Foundation, St. Elizabeth, Scott Air Force Base, SIHF Sites); Hospitals (St. Elizabeth's Hospital); Food Banks/Pantries (Food Pantry); WIC clinics (East St. Louis, Fairmont, Cahokia); Faith-Based Organizations (New Life Community Church, Mt. Zion); Out-of-School Time Providers (Hope's Kids); Recreation Areas (Jacki Joyner-Kersee Center)

All too often partnerships that started as a result of grant funding come to a close at the end of the grant period. Perhaps one of the most remarkable successes of the Make Health Happen Partnership is that eight months after the grant ended, the partnership continues to meet and work towards improving access and healthy eating without dedicated funds to support these efforts. The partnership is made up of a diverse group of organizations and agencies harnessing their resources and talents to collectively improve the food environment and health outcomes in East St. Louis. Additionally, as a result of these efforts a recognizable logo and brand that promotes health and wellness has been created --and even more noteworthy is that this brand has been embraced by a nearby county. The fact that this brand has the potential to become more regional, speaks to the success over just a short period of time.

Eastern Shore Health District Project Profile

Accomack and Northampton Counties, VA
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Accomack County	Northampton County
Population Total		308,745,538	33,289	12,339
Population Density (# people per square mile)	Average	88.23	74.08	58.32
	Range	Varies	Under 51 to 500	Under 51 to 500
Racial and Ethnic Make-Up	White	74.02%	68.23%	60.99%
	Black	12.57%	28.5%	37.88%
	Asian	4.89%	0.09%	0.45%
	Native American/ Alaska Native	0.82%	0.39%	0.03%
	Native Hawaiian/ Pacific Islander	0.17%	0%	0%
	Other Race	4.73%	1.48%	0.49%
	Multiple Races	2.80%	1.32%	0.16%
	Hispanic	16%	8.78%	7.43%
Income	Per Capita	$28,154	$22,702	$23,472
	% Living in Poverty	15.37%	20.55%	24.35%
	Disparity Index Score, Race /Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	37.70	34.01

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

Community Health Indicators:

HEALTH INDICATORS*	United States	Accomack County	Northampton County
% Adults Overweight	35.78%	31.94%	46.06%
% Adults Obese	27.14%	37%	35.2%
% Adults with Heart Disease	4.40%	3.46%	15.56%
% Adults with Diagnosed Diabetes	9.11%	9.7%	12.2%
% Adults with High Cholesterol	38.52%	63.03%	67.70%
% Adults with Hypertension	28.16%	28.2%	46.9%
% Babies Born with Low Birth Weight	8.20%	9.7%	9.9%
Infant Mortality Rate (per 1,000 births)	6.52	8.9	8.8
% of Mothers with Late or No Prenatal Care	17.25%	No data	No data
Adult Uninsured Rate	20.76%	24.8%	24.6%
% of Insured Population Receiving Medicaid	20.21%	17.85%	26.19%
% Adults Without Any Regular Doctor	22.07%	17.16%	4.24%
% of Population Living in a Health Professional Shortage Area**	34.07%	No data	No data
Food Insecurity Rate	15.94%	14.62%	17.17%
% Population with Low Food Access***	23.61%	2.19%	0.31%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	No data	79.2%
WIC Average Monthly Caseload FY2014	8,258,413	1331	

*Health indicators data was extracted from the agency's submitted 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*:

Eastern Shore Health District hosted a Food Summit. They convened 80 community leaders to develop an action-based strategy to increase awareness of existing resources, expand upon existing programs, and adopt best practices from other communities. At the end of the summit, they passed a resolution to hold community leaders accountable for sustaining the efforts of the Food Summit by bringing an end to food insecurity. They also had over 20 people sign up for the work group to continue to work on food insecurity awareness and alleviation in their community.

They also added two additional restaurants to their Healthy Options program, which highlights healthy options at local restaurants. Eight restaurants already in the program expanded their healthy options selection. Overall, 50 new healthy items had been added to local restaurants.

Additionally, Eastern Shore Health District implemented a breastfeeding policy in their agency. They also developed a business case for breastfeeding policy that included a wellness toolkit that has been presented to 40 businesses and organizations for adoption. Working with the local Head Start programs, they are also signing people up for WIC on-site.

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

Website: www.eshealthycommunities.org

Eastern Shore Health District Project Profile

Starting Capacity and Coalition Partners:

Eastern Shore Health District built their coalition from an existing coalition and recruited new members to support the project.

Organization Category	Organization Name*
Community Members	
Public Health	Eastern Shore Health District (2 people)
Healthcare	Shore-Riverside Hospital; Eastern Shore Virginia Medical School (EVMS); Eastern Shore Rural Health Systems, Inc. (2 people)
Media	
Government/Local Elected Officials	Accomack County Administration; Northampton County Administration; The Planning Council; Accomack County Planning Department
Faith-Based	St. John's UM Church; Horntown UM Church
Cooperative Extension Employees	Northampton County Extension Office
Food Retailers/ Distributors	Onancock Farmers Market
Local Farmers	
Education	Eastern Shore Community College; Accomack County Public Schools; Northampton County Public Schools; Head Start; Early Childhood Obesity Prevention; Smart Beginnings
Other Local Businesses	Blue Crab Bay Co.
Other	YMCA; Eastern Shore RC&D Council; No Limits Eastern Shore; YMCA Camp Silver Beach; The Nature Conservancy Eastern Shore

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, Eastern Shore Health District reached **20 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **45,273 people.**

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.13	Increase the number of counties that have food summits in the community from 0 to 1.	1
A.15	Increase the number of restaurants/bars with new "healthy" menu options in the target community from 13 to 18.	9
A.21	Increase the number of settings that publicly promote/welcome breastfeeding in the target community from 1 to 18.	5
B.1	Increase the number of settings referring and/or signing clients up for the WIC program from 0 to 9.	7
B.2	Increase the number of Out of School Providers and/or signing patients up for healthcare in the target community from 0 to 3.	3

Settings Reached: Counties (Eastern Shore); Restaurants/Bars (DaVinci's Italian Kitchen, Seaside Grill and Island House, Sea Star Café, Mallard's Restaurant Inn, Garden Café, The Shanty, Healthy Options Restaurant, Island House, Janet's Café, Blarney Stone, Becca's); Government Agencies (Eastern Shore Health Department OB/Delivery Department, ES Rural Health, Eastern Shore Health Department Site, VA Cooperative Extension); Primary Care Providers (Eastern Shore Rural Health); Food Banks (Food Banks of Southeastern Virginia and the Eastern Shore); Non-Profit Organizations (Eastern Shore Coalition Against Domestic Violence, Headstart (2), Migrant Head Start and the Planning Council)

Edgerton Women's Health Center/ Scott County WIC Project Profile

Scott County, IA
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Scott County, IA
Population Total		308,745,538	167,080
Population Density (# people per square mile)	Average	88.23	364.83
	Range	Varies	No data
Racial and Ethnic Make-Up	White	74.02%	86.45%
	Black	12.57%	7.59%
	Asian	4.89%	2.08%
	Native American/ Alaska Native	0.82%	0.22%
	Native Hawaiian/ Pacific Islander	0.17%	0%
	Other Race	4.73%	0.97%
	Multiple Races	2.80%	2.69%
	Hispanic	16%	5.79%
Income	Per Capita	$28,154	$28,948
	% Living in Poverty	15.37%	13.09%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	No data

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Scott County, IA
% Adults Overweight	35.78%	32.46%
% Adults Obese	27.14%	30.8%
% Adults with Heart Disease	4.40%	4.19%
% Adults with Diagnosed Diabetes	9.11%	7.7%
% Adults with high Cholesterol	38.52%	34.65%
% Adults with Hypertension	28.16%	21.5%
% Babies Born with Low Birth Weight	8.20%	7%
Infant Mortality Rate (per 1,000 births)	6.52	5.3
% of Mothers with Late or No Prenatal Care	17.25%	25.56%
Adult Uninsured Rate	20.76%	10.16%
% of Insured Population Receiving Medicaid	20.21%	16.33%
% Adults Without Any Regular Doctor	22.07%	17.52%
% of Population Living in a Health Professional Shortage Area**	34.07%	0%
Food Insecurity Rate	15.94%	13.82%
% Population with Low Food Access***	23.61%	14.16%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	79.4%
WIC Average Monthly Caseload FY2014	8,258,413	No data

*Health indicators data was extracted from the agency's submitted 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*:

Edgerton Women's Health Center/ Scott County WIC focused on building a strong relationship with a local grocery store chain (Hyvee), 2 Walmart Stores and a Save-A-Lot to work towards making the healthy choice the easy choice. They created signs highlighting healthy foods and brochures for resources like WIC to highlight in the stores. They also worked with store dieticians to provide store tours of shopping for healthy foods using a supplemental grant from Share Our Strength, using their Cooking Matters at the Store curriculum.

They also developed a partnership between the local food bank and the WIC agency. As a result, the food bank donated produce to WIC clients.

Finally, they coordinated a cultural competency training for local health care providers and non-profit organization staff.

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

Edgerton Women's Health Center/ Scott County WIC Project Profile

Starting Capacity and Coalition Partners:

Edgerton Women's Health Center/Scott County WIC built their coalition with members from an existing coalition in their community.

Organization Category	Organization Name*
Community Members	Scott County WIC Participant
Public Health	Edgerton Women's Health Center/ Scott County WIC (3 people)
Healthcare	
Media	
Government/Local Elected Officials	
Faith-Based	
Cooperative Extension Employees	Iowa State University Extension and Outreach
Food Retailers/ Distributors	Quad City Food Hub; River Bend Food Bank
Local Farmers	
Education	
Other Local Businesses	
Other	Two Rivers YMCA

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, Edgerton Women's Health Center/Scott County WIC reached **15 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **85,193 people**.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.7	Increase the number of Grocery Stores with new on-site and in-store placement and promotion strategies for healthy foods from 3 to 18.	5
A.13	Increase the number of settings using new tools or resources to create awareness of how to access healthy food options in the community from 0 to 291.	11
A.20	Increase the number of Grocery Stores participating in the Share Our Strength Cooking Matters at the store program in the target community from 0 to 21.	4
B.1	Increase the number of settings referring and/or signing families up for WIC in the target community from 0 to 11.	3

Settings Reached: Grocery Stores (4 Hyvee stores—East, West, Locus, Rockingham, Save-A-Lot, 2 Walmart stores); Government Agencies (Edgerton Women's Health Center); WIC Clinics (2 Scott County WIC locations); Colleges (Western University); Recreation Areas (Community Health Care Center, Women's Lifestyle Health Fair)

Gateway Community Action Partnership Project Profile

Camden, NJ
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Camden, NJ
Population Total		308,745,538	77,356
Population Density (# people per square mile)	Average	88.23	14,234.30
	Range	Varies	No data
Racial and Ethnic Make-Up	White	74.02%	13.51%
	Black	12.57%	48.83%
	Asian	4.89%	2.29%
	Native American/ Alaska Native	0.82%	0.84%
	Native Hawaiian/ Pacific Islander	0.17%	0.01%
	Other Race	4.73%	30.2%
	Multiple Races	2.80%	4.31%
	Hispanic	16%	47.35%
Income	Per Capita	$28,154	$12,911
	% Living in Poverty	15.37%	39.83%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	No Data

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Camden, NJ
% Adults Overweight	35.78%	35.57%
% Adults Obese	27.14%	29%
% Adults with Heart Disease	4.40%	4.5%
% Adults with Diagnosed Diabetes	9.11%	No Data
% Adults with high Cholesterol	38.52%	33.89%
% Adults with Hypertension	28.16%	30.2%
% Babies Born with Low Birth Weight	8.20%	92%
Infant Mortality Rate (per 1,000 births)	6.52	7.9%
% of Mothers with Late or No Prenatal Care	17.25%	No Data
Adult Uninsured Rate	20.76%	17.98%
% of Insured Population Receiving Medicaid	20.21%	59.2%
% Adults Without Any Regular Doctor	22.07%	13.26%
% of Population Living in a Health Professional Shortage Area**	34.07%	No Data
Food Insecurity Rate	15.94%	14.13%
% Population with Low Food Access***	23.61%	4.31%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	73.8%
WIC Average Monthly Caseload FY2014	8,258,413	6,000

*Health indicators data was extracted from the agency's submitted 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*:

Gateway Community Action Partnership focused on several initiatives to improve access to breastfeeding-friendly spaces and chronic disease prevention and management services with their coalition

They started a Breastfeeding-Friendly Establishment recognition program, providing low-cost window clings for businesses and organizations that met the designation criteria.

They also implemented a non-pharmaceutical prescription pad as a tangible way to strengthen their local referral system to WIC, training local organization staff and providers on WIC and breastfeeding. They are looking to include the referral system in the Electronic Medical Record (EMR) as the local hospital changes to an EMR system. Additionally, partnering with Camden Coalition, they are working on a pilot program to reconnect post-partum mothers with their primary care providers by offering a $20 gift card incentive upon completion of their visit. The Camden Coalition also helps arrange appointments and transportation.

Related to the food environment in their community, they are marketing WIC foods as healthy lifestyle options for all with in-store signage.

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

Facebook Page:
https://www.facebook.com/CPHMCProject/

Gateway Community Action Partnership Project Profile

Starting Capacity and Coalition Partners:

Gateway Community Action Partnership

Organization Category	Organization Name*
Community Members	Puerto Rican Unity for Progress(PRUP), Center for Family Services, Hispanic Family Center
Public Health	Camden Coalition, Camden County Health Department, NJ AAP
Healthcare	Cooper Health System, Virtua Health System, CamCare-FQHC
Media	
Government/Local Elected Officials	Camden County Department of Children's Services, CC Board of Social Services
Faith-Based	Cathedral Kitchen
Cooperative Extension Employees	Rutgers Cooperative Extension of Camden- SNAP ED
Food Retailers/ Distributors	Cousins Super market, Price Rite
Local Farmers	
Education	Acelero Learning Center- Head Start
Other Local Businesses	Miguel's Pharmacy
Other	Southern New Jersey Perinatal Consortium

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, Gateway Community Action Partnership reached **19 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **76,903 people**.

Intervention Objectives and Outcome Summary

Objective #	Objective Description	# Settings Reached
A.3	Increase the number of Grocery Stores that expand inventory of healthy foods from 2 to 11.	2
A.21	Increase the number of settings that publicly promote/welcome breastfeeding in the target community from 0 to 6.	5
B.1	Increase the number of Hospitals that refer/sign up to WIC from 0 to 1.	1
B.2	Increase the number of settings referring and/or signing patients up for healthcare in the target community from 0 to 8.	9
B.10	Increase the number of WIC Clinics that use an enhanced WIC referral list with new community-based chronic disease prevention and management services added from 0 to 1.	1
B.15	Increase the number of Hospitals with providers and/or staff that receive basic training in breastfeeding in the target community from 0 to 2.	3
B.18	Increase the number of settings that receive basic training on WIC services and benefits in the target community from 0 to 6.	7

Settings Reached: Grocery Stores (Cousins Supermarket, Jonathon Grocery, Price Rite, Save-A-Lot); Convenience Stores (Family Dollar); Pharmacies (Miguel's Pharmacy); WIC Clinics (Mt. Ephraim WIC Clinic, Camden); Hospitals (Lourdes Hospital System, Cooper Health System, Cooper Hospital); Coalitions (Camden Coalition); Care Consortia (Southern New Jersey Perinatal Consortium); Non-Profits (Puerto Rican Unity for Progress, Center for Family Services); Food Banks (Cathedral Kitchen); Government Agencies (Acelero Learning Center Head Start, Camden County Department of Children's Services, Board of Social Services)

Geary County Health Department Project Profile

Geary County, KS
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Geary County, KS
Population Total		308,745,538	35,583
Population Density (# people per square mile)	Average	88.23	92.54
	Range	Varies	No data
Racial and Ethnic Make-Up	White	74.02%	69.54%
	Black	12.57%	16.2%
	Asian	4.89%	2.83%
	Native American/ Alaska Native	0.82%	0.48%
	Native Hawaiian/ Pacific Islander	0.17%	0.78%
	Other Race	4.73%	1.12%
	Multiple Races	2.80%	9.05%
	Hispanic	16%	13.36
Income	Per Capita	$28,154	$21,407
	% Living in Poverty	15.37%	12.14%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	24.10

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Geary County, KS
% Adults Overweight	35.78%	35.34%
% Adults Obese	27.14%	31.3%
% Adults with Heart Disease	4.40%	2.42%
% Adults with Diagnosed Diabetes	9.11%	10.1%
% Adults with high Cholesterol	38.52%	24.75%
% Adults with Hypertension	28.16%	28.6%
% Babies Born with Low Birth Weight	8.20%	7.8%
Infant Mortality Rate (per 1,000 births)	6.52	10.1
% of Mothers with Late or No Prenatal Care	17.25%	24.86%
Adult Uninsured Rate	20.76%	10.56%
% of Insured Population Receiving Medicaid	20.21%	13.94%
% Adults Without Any Regular Doctor	22.07%	29.49%
% of Population Living in a Health Professional Shortage Area**	34.07%	100%
Food Insecurity Rate	15.94%	17.68%
% Population with Low Food Access***	23.61%	35.12%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	82.2%
WIC Average Monthly Caseload FY2014	8,258,413	1476

*Health indicators data was extracted from the agency's submitted 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*:

Geary County Health Department's WIC worked to solidify an existing work group by incorporating the coalition as a non-profit with the name Live Well Geary County, Inc.

As a result of this coalition's efforts, the local farmers' market now accepts SNAP EBT. They promoted this new opportunity county-wide. They also are partnering with a local community garden group to align efforts moving forward as well as participating in piloting *Summer Picnic Parties* child feeding program at 6 sites.

They also focused on improving breastfeeding, engaging the Geary *County Breastfeeding Coalition* and *Delivering Change: Healthy Mothers, Healthy Babies*. These groups worked together to host a summit, educating 170 physicians, lactation consultants, nurses, dietitians, and others on current breastfeeding practices. Promoting the state breastfeeding campaigns, *Business Case for Breastfeeding* and *Breastfeeding Welcome Here*, the coalition partners also enrolled 6 businesses and 11 businesses, respectively, in their community.

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

Website:
http://www.livewellgearycounty.org/

Geary County Health Department Project Profile

Starting Capacity and Coalition Partners:

Geary County Health Department used two existing coalitions as a vehicle for organizing this project, the Access to Healthy Foods Work Group and the Geary County Breastfeeding Coalition. The food access group eventually evolved into Live Well Geary County, Inc. and officially incorporated as a non-profit organization.

Organization Category	Organization Name*
Community Members	2 Community Members
Public Health	Fetal Infant Mortality Review; Geary County WIC (2 people); Fort Riley Army Installation Department of Public Health; Geary County Health Department (2 people)
Healthcare	Geary County Hospital; Flint Hills OB/GYN; Irwin Army Hospital; Rural Health Group
Media	
Government/Local Elected Officials	Chamber of Commerce; Geary County Commissioner; City of Junction City
Faith-Based	Wheels of Hope
Cooperative Extension Employees	Geary County Extension
Food Retailers/ Distributors	
Local Farmers	A& H Farms, Oatie Beef
Education	School District; Parents as Teachers
Other Local Businesses	First National Bank; Kollhoff Pharmacy
Other	Geary County Senior Center; Perinatal Coalition; Kansas Breastfeeding Coalition; Infant Toddler Program

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, Geary County Health Department reached **187 different settings/providers** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **37,384 people**.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.12	Increase the number of Farmer's Markets that accept SNAP and/or WIC in target community from 0 to 1.	1
A.20	Increase the number of stores participating in the Share our Strength Cooking Matters Tour from 0 to 3.	2
A.21	Increase the number of settings that publicly promote/welcome breastfeeding in the target community from 0 to 11.	14
B.1	Increase the number of settings that refer/sign up to WIC from 0 to 9.	10
B.9	Increase the number of Counties using tools or resources to improve awareness of available chronic disease prevention and management services in the community from 0 to 1.	1
B.15	Increase the number of settings with providers and/or staff that receive basic training in breastfeeding in the target community from 0 to 1.	134
B.18	Increase the number of providers that receive basic training on WIC services and benefits in the target community from 0 to 23.	24

Settings Reached: Farmers' Markets (Geary County Community Farmers' Market); Government Agencies (Geary County Health Department, Head Start, DCF Social Services); Primary Care Providers (Flint Hills OB/GYN, Junction City Pediatrics, Rural Health Clinic, Alpha Care); Hospitals (Pediatric Therapy Services of Geary Community Hospital, Geary County Community Hospital Labor and Delivery, Irwin Army Community Hospital, St. Francis); K-12 Schools (Spring Valley Elementary School); Pharmacy (K Kollhoff Pharmacy); Restaurants/Bars (Bliss Bistro); Work Sites (Mi Lady's Escape Hair and Nail Salon, Genie's Beauty Supply, Divine Nails and Tanning, Eyewear Junction LLC, Quilter's Yard, Waters True Value, Dorothy's Pet Shop); Settings of 134 Breastfeeding Summit attendees; Non-Profits (Delivering Change, Parents as Teaches, Early Childhood Network); Grocery Stores (Walmart, Kroger's)

Johns Hopkins University
Bloomberg School of Public Health
WIC Program Project Profile

Baltimore, MD
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Baltimore, MD
Population Total		308,745,538	621,445
Population Density (# people per square mile)	Average	88.23	7,679.53
	Range	Varies	1,001-Over 5,000
Racial and Ethnic Make-Up	White	74.02%	30.27%
	Black	12.57%	63.2%
	Asian	4.89%	2.39%
	Native American/ Alaska Native	0.82%	0.37%
	Native Hawaiian/ Pacific Islander	0.17%	0.04%
	Other Race	4.73%	1.41%
	Multiple Races	2.80%	2.32%
	Hispanic	16%	4.31%
Income	Per Capita	$28,154	$24,750
	% Living in Poverty	15.37%	23.79%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	31.35

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Baltimore, MD
% Adults Overweight	35.78%	30.57%
% Adults Obese	27.14%	34.1%
% Adults with Heart Disease	4.40%	4.20%
% Adults with Diagnosed Diabetes	9.11%	12.4%
% Adults with high Cholesterol	38.52%	35.60%
% Adults with Hypertension	28.16%	33.4%
% Babies Born with Low Birth Weight	8.20%	12.3%
Infant Mortality Rate (per 1,000 births)	6.52	12.4
% of Mothers with Late or No Prenatal Care	17.25%	7.22%
Adult Uninsured Rate	20.76%	13.12%
% of Insured Population Receiving Medicaid	20.21%	34.17%
% Adults Without Any Regular Doctor	22.07%	19.60%
% of Population Living in a Health Professional Shortage Area**	34.07%	67.96%
Food Insecurity Rate	15.94%	22.64%
% Population with Low Food Access***	23.61%	3.32%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	75.6%
WIC Average Monthly Caseload FY2014	8,258,413	No data

*Health indicators data was extracted from the agency's submitted 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 Johns Hopkins University Bloomberg School of Public Health WIC Program tapped into and enhanced the efforts of an existing healthy food access initiative with a fresh WIC perspective and capacity.

The Baltimore City Baltimarket Healthy Stores Initiative, a coalition partner, assists corner stores in marketing, merchandising and selling healthy food options. Baltimarket also sponsors the Virtual Supermarket Initiative which provides Baltimore residents with access to healthy foods at supermarket prices, especially food deserts where healthy food access is limited, through online ordering at locations such as senior apartments and libraries. Johns Hopkins WIC was integral to the implementation of these activities. 30 healthy corner stores were launched and inventory was improved at 16 existing stores. Additionally, at least 6 virtual markets sites were established.

Additionally, the Baltimore Food System Map, *an effort led by coalition partner The Johns Hopkins Center for a Livable Future*, was updated to incorporate Nutrition Assistance programs including WIC clinics, WIC retailers, and SNAP Retailers. And, the Baltimore City Council passed the Personal Property Tax Credit--Food Desert Incentive Areas.

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

Website:
http://www.baltimoresustainability.org/projects/baltimore-food-policy-initiative/food-pac/

Johns Hopkins University Bloomberg School of Public Health WIC Program Project Profile

Starting Capacity and Coalition Partners:

Johns Hopkins University Bloomberg School of Public Health WIC Program built their project coalition from an existing coalition called the Baltimore Food Policy Initiative, a group that was commissioned by the Mayor of Baltimore to increase access to healthy food.

Organization Category	Organization Name*
Community Members	
Public Health	Baltimore City Health Department
Healthcare	Kaiser Permanente; Maryland Hospitals for a Healthy Environment, American Heart Association, America Group Community Care, Baltimore City Health Department
Media	
Government/Local Elected Officials	City Government; Food and Nutrition Service, Baltimore City Departments of Planning, Recreation and Parks
Faith-Based	Associated Black Charities; Episcopal Community Services; Franciscan Center
Cooperative Extension Employees	
Food Retailers/ Distributors	Baltimore Food Hub; Food Depot; Korean Association of Grocers; Lexington Market, B. Green Wholesalers
Local Farmers	MD Farmers' Market Association; Future Harvest; Mount Clair Community Garden; Real Food Farm
Education	American Institute of Wine and Food; Baltimore City Public Schools; JHU Center for Human Nutrition; JHU Center for a Livable Future
Other Local Businesses	CUPS Coffee House and Kitchen
Development	American Communities Trust, Baltimore Office of Sustainability
Other	Abell Foundation; Annie E Casey Foundation; Baltimarket; Baltimore Community Foundation; Baltimore Development Corporation; Baltimore Greenworks, Baltimore Greenspace; Family League; Maryland Hunger Solutions, Maryland Out of School Time; Reservoir Hill Improvement Council; Institute for Integrative Health, Arabbers Preservation Society

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, the Johns Hopkins University Bloomberg School of Public Health WIC Program reached **42 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **622,104 people**.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.2	Increase the number of Stores that sell healthy foods from 43 to 62.	30
A.3	Increase the number of Stores that expand their inventory of healthy foods from 55 to 62.	16
A.7	Increase the number of Grocery Stores with new on-site and in-store placement and promotion strategies for healthy foods from 0 to 4.	1
B.18	Increase the number of settings that receive basic training on WIC services and benefits from 0 to 10.	4

Settings Reached: Stores (Cherry Hill Senior Manor, Cherry Hill Library, Wayland Village Apartments, The POWER House at Perkins Homes, Mount Clare Overlook Apartments, Everything Cheap, Lafayette Market, Mosher Food Market, McCulloh Convenience Store, Mosher Mini Mart); Convenience Stores (Penn Mart, Family Food Market, Rossiter Corner Grocery, AJ's Mini Mart, Fenwick Food Market, Green Mart & Deli, Reisterstown Rd. Convenience Store, Danny Market, Poppleton Food Market, Economy Mart), NM Caroll Market, Bolton North; Grocery Stores (Fresh Crates Stores, Luz Supermarket, City Hall, Save-A-Lot, Corona Grocery, Sun Grocery, Taxation and Finance Economic Development Committee, A and Ms. Dots Grocery, Bus Stop Grocery, Food Depot); K-12 Schools (Benjamin Franklin High School, Arundel Elementary/Middle School); Non-Profits (Wald Clinic); Out of School Providers (Judy Center)

Mount Rogers Health District Project Profile

Carroll and Grayson Counties, VA; Galax City, VA
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Carroll County, VA	Grayson County, VA	Galax City, VA
Population Total		308,745,538	29,979	15,377	6,977
Population Density (# people per square mile)	Average	88.23	63.17	34.79	846.99
	Range	Varies	Under 51 to 500	Under 51 to 500	1001-5,000
Racial and Ethnic Make-Up	White	74.02%	97.69%	96.19%	93.62%
	Black	12.57%	0.77%	2.04%	3.12%
	Asian	4.89%	0.12%	0.03%	0.11%
	Native American/ Alaska Native	0.82%	0%	0%	0.46%
	Native Hawaiian/ Pacific Islander	0.17%	0%	0.88%	0%
	Other Race	4.73%	0.2%	0.32%	0%
	Multiple Races	2.80%	1.22%	0.55%	2.68%
	Hispanic	16%	2.83%	2.74%	14.66%
Income	Per Capita	$28,154	$19,385	$20,591	$21,769
	% Living in Poverty	15.37%	No data	No data	No data
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	37.01	34.88	47.62

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Carroll County, VA	Grayson County, VA	Galax City, VA
% Adults Overweight	35.78%	39.27%	27.25%	No Data
% Adults Obese	27.14%	31.2%	33.8%	28.8%
% Adults with Heart Disease	4.40%	9.50%	10.31%	No Data
% Adults with Diagnosed Diabetes	9.11%	9%	8.9%	9.4%
% Adults with high Cholesterol	38.52%	62.42%	47.19%	No Data
% Adults with Hypertension	28.16%	45%	No data	No data
% Babies Born with Low Birth Weight	8.20%	6.5%	7.8%	8.5%
Infant Mortality Rate (per 1,000 births)	6.52	7	6.8	6.1
% of Mothers with Late or No Prenatal Care	17.25%	No data	No data	No data
Adult Uninsured Rate	20.76%	16.86%	13.34%	14.96%
% of Insured Population Receiving Medicaid	20.21%	24.81%	27.55%	31.07%
% Adults Without Any Regular Doctor	22.07%	20.96%	15.18%	No Data
% of Population Living in a Health Professional Shortage Area**	34.07%	0%	0%	0%
Food Insecurity Rate	15.94%	12.24%	12.81%	15.27%
% Population with Low Food Access***	23.61%	4.99%	17.51%	5.64%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	No data	No data	No data
WIC Average Monthly Caseload FY2014	8,258,413	4,650		

*Health indicators data was extracted from the agency's submitted 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 Health Access and Nutrition Development Services (H.A.N.D.S) developed a Healthy Corner Store Pilot Business Plan in partnership with the Office of Economic Development at VA Tech. Providing store training and technical assistance to assure that healthy changes are profitable and sustainable; the coalition was able to get two local stores to sell and market healthier items. The Health District's Wellness Team also provided health screenings and referrals for store owners and employees as part of the Health Corner Store Network initiative.

As part of their breastfeeding initiative, H.A.N.D.S. coordinated the implementation of 4 lactation rooms, 1 in the local pediatric office and 3 in the school systems. They also sponsored mobile breastfeeding stations at 4 festivals, trained 25 businesses and agencies in breastfeeding in the workplace, trained 42 health professionals, 22 of which were WIC staff to be Certified Lactation Counselors, produced a breastfeeding media campaign that included billboards and theatre advertisement, and disseminated breastfeeding resource guides to WIC clinics, pediatric offices, and social services.

Finally, the coalition commissioned a farmers' market feasibility study by VA Tech, resulting in a stronger local farmers' market infrastructure, cooperative extension training of local farmers on food safety best practices for market growers, and plans to bring community-clinical linkages to the markets.

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

Website: www.tcprevent.org

Mount Rogers Health District Project Profile

Starting Capacity and Coalition Partners:

Mount Rogers Health District built a sub-group from the existing Twin County Prevention Coalition called the Health Access and Nutrition Development Services (H.A.N.D.S) taskforce.

Organization Category	Organization Name*
Community Members	WIC Peer Counselor, La Leche League
Public Health	Mount Rogers Health District (6 people)
Healthcare	TCRH (2 people)
Media	
Government/Local Elected Officials	MRCSB (2 people); Town of Hillsville local official
Cooperative Extension Employees	Extension-Carroll, Galax, Grayson, Wythe county
Food Retailers/ Distributors	Corner Stores Managers/Owners (2)
Local Farmers	Farmers' Market Managers (2)
Education	VA Tech University (2 people)
Other Local Businesses	
Other	

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, Mount Rogers Health District reached **19 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **52,079 people**.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.3	Increase the number of existing corner stores that expand their inventory of healthy food from 0 to 1.	2
A.11	Increase the number of Farmer's Markets in the target community from 3 to 4, and strengthen the stability of existing farmers' markets.	3
A.20	Increase the number of community partners participating in the Share Our Strength Cooking Matters at the Store program in the target community from 0 to 8.	7
A.21	Increase the number of settings that publicly promote/welcome breastfeeding in the target community from 1 to 3.	9

Settings Reached: Grocery Stores (Rixie's Market, Hillsville Family Mart-Citgo); Farmers' Markets (Independence Farmers' Market, Galax City Farmers' Market, Hillsville Farmers' Market); Government Agencies (Virginia Cooperative Extension Office); Hospitals (Twin County Regional Hospital); K-12 Schools (Carrol County Schools, Galax City Schools, Grayson County Schools); Non-Profits (Mount Rogers Community Service Board); Senior Centers (Community Senior Center); Jurisdictions (Grayson County, Carroll County, Galax County); WIC Clinics (Mount Rogers WIC Services); Primary Care Providers (Twin City Pediatrics)

Richmond City Health District Project Profile

Richmond, VA
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Richmond City, VA
Population Total		308,745,538	207,878
Population Density (# people per square mile)	Average	88.23	3,476.84
	Range	Varies	1,001 to Over 5,000
Racial and Ethnic Make-Up	White	74.02%	43.39%
	Black	12.57%	49.15%
	Asian	4.89%	2.25%
	Native American/ Alaska Native	0.82%	0.33%
	Native Hawaiian/ Pacific Islander	0.17%	0.03%
	Other Race	4.73%	1.41%
	Multiple Races	2.80%	3.43%
	Hispanic	16%	6.24%
Income	Per Capita	$28,154	$27,184
	% Living in Poverty	15.37%	25.61%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	46.17

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Richmond City, VA
% Adults Overweight	35.78%	28.67%
% Adults Obese	27.14%	29.7%
% Adults with Heart Disease	4.40%	4.22%
% Adults with Diagnosed Diabetes	9.11%	11.1%
% Adults with high Cholesterol	38.52%	38.61%
% Adults with Hypertension	28.16%	30.3%
% Babies Born with Low Birth Weight	8.20%	11.7%
Infant Mortality Rate (per 1,000 births)	6.52	12.5
% of Mothers with Late or No Prenatal Care	17.25%	No Data
Adult Uninsured Rate	20.76%	17.66%
% of Insured Population Receiving Medicaid	20.21%	25.49%
% Adults Without Any Regular Doctor	22.07%	28.11%
% of Population Living in a Health Professional Shortage Area**	34.07%	40.91%
Food Insecurity Rate	15.94%	21.68%
% Population with Low Food Access***	23.61%	No Data
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	69.5%
WIC Average Monthly Caseload FY2014	8,258,413	5,456

*Health indicators data was extracted from the agency's submitted 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*:

Richmond City Health District worked with their partners to develop a stronger referral system between WIC and health care providers. Project staff developed and provided WIC 101 trainings to 182 staff in 14 community organizations, 216 pediatric care providers in 20 offices/hospitals, and 119 OB/GYN care providers in 10 offices/hospitals. Providers received referral tools for their offices, including a tear pad with WIC information, a prescription pad for WIC, and stickers to put in children's books in waiting rooms with WIC information. They also developed a liaison program, which will engage health care providers with monthly check-ins after the trainings moving forward.

In order to improve healthy food procurement at local stores, Richmond City Health District and partners developed a point-of-sale labeling system for WIC-approved items at a local wholesale distributor where small and medium-sized stores obtain their inventory. It help encourage stocking healthy WIC foods to work towards WIC approval, to expand existing healthy food stock for WIC and other clients, and expand healthy options regardless of WIC store status. In partnership with the Richmond Health Corner Store Initiative, they also provided training on healthy food procurement to 4 stores.

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

Richmond City Health District Project Profile

Starting Capacity and Coalition Partners:

Richmond City Health District began a new coalition for this project and reached out to others working on other coalitions or work groups related to healthy food access and chronic disease prevention and management in their city.

Organization Category	Organization Name*
Community Members	Gap Tooth Diva
Public Health	Richmond City Health District (1 people); Richmond City WIC
Healthcare	Richmond City Health District Community Clinic
Media	
Government/Local Elected Officials	
Faith-Based	
Cooperative Extension Employees	Virginia Cooperative Extension
Food Retailers/ Distributors	Feedmore Food Distributors (Food Bank)
Local Farmers	Byrd House Market
Education	
Other Local Businesses	
Other	Nurture RVA/ Richmond Healthy Start; Family Lifeline

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, Richmond City District reached **132 different settings/ providers** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **83,131 people**.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.2	Increase the number of Stores/Distributors that sell healthy foods from 0 to 4.	2
A.3	Increase the number of Convenience Stores that expand their inventory of healthy foods from 0 to 6.	4
B.1	Increase the number of settings/providers that refer/sign up to WIC from 0 to 55.	77
B.17	Increase the number of Government Agencies that receive cultural competency training from 0 to 2.	2
B.18	Increase the number of Non-Profit Organizations/providers that receive basic training on WIC services and benefits from 0 to 6.	7

Settings Reached: Stores (Cash & Carry, Wholesale Distributor, Stop-N-Go, Hopkin's Market, RS Express, 701 Express); Libraries (Main Branch and Broadrock); Hospitals (Chippenham Hospitals, Johnston-Willis Hospital, St. Mary's Hospital, VCU Hospital OBs and Social Workers); Faith-Based Organizations (Bethany Christian Services, Thomas Episcopal Church); Universities (Virginia Commonwealth University); Non-Profits (Communities in Schools, 49 FeedMore Local Agencies, East End Pregnancy, Family Lifeline, VCU Center for Health Disparities); Primary Care Providers (Dr. Richard Bennett, Vernon Harris Clinic, Commonwealth Pediatrics, East End Pediatrics, The Pediatric Center, Monument Pediatrics, Dr. Joseph Boatwright, Drs. Myers, Day & Loving, Crossover Clinic, VA Complete Care for Women OB & Pediatric offices, Dr. Joseph Hadad, Bon Secours' Health System, St. Mary's Hospital, Central Virginia Pediatric Nurses, VCU Center on Health Disparities, MCV VCU Ob-GYN Grand Rounds, Commonwealth Pediatrics, Drs. Myers, Day and Loving, Alliance Women's Health, Capital OB-GYN; Crossover Ministry-South Side x 2; The Pediatric Center-East End, West End and VCC Clinics, Johnston Willis Hospital General Nursing Grand Rounds, VCU School of Nursing; Richmond Healthy Start's Lay Health Promotors, VCU Pediatric Residents); Work Sites (Post Office of Richmond City, Richmond City Health District Environmental Health Department); Government Agencies (Downtown WIC Office, Southside WIC Office, Community Hospital WIC Office); Non-Profit (East End Pregnancy Center, Food Access and Equity Task Force, Partnership for Families, Family Lifeline, Richmond City DDS, Feed More, SCAN)

St. Tammany Parish Hospital Project Profile

Covington and Mandeville, LA
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Covington and Mandeville, LA (St. Tammany Parish)
Population Total		308,745,538	21,545
Population Density (# people per square mile)	Average	88.23	1,678.32
	Range	Varies	501 to 5,000
Racial and Ethnic Make-Up	White	74.02%	81.63%
	Black	12.57%	13.64%
	Asian	4.89%	1.79%
	Native American/ Alaska Native	0.82%	0.19%
	Native Hawaiian/ Pacific Islander	0.17%	0.04%
	Other Race	4.73%	1.34%
	Multiple Races	2.80%	1.37%
	Hispanic	16%	6.19%
Income	Per Capita	$28,154	$33,128
	% Living in Poverty	15.37%	11.07%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	No data (26.15)

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Covington and Mandeville, LA (St. Tammany Parish)
% Adults Overweight	35.78%	40.36%
% Adults Obese	27.14%	No data
% Adults with Heart Disease	4.40%	5.22%
% Adults with Diagnosed Diabetes	9.11%	No data (9.2%)
% Adults with high Cholesterol	38.52%	38.94%
% Adults with Hypertension	28.16%	29.7%
% Babies Born with Low Birth Weight	8.20%	8.4%
Infant Mortality Rate (per 1,000 births)	6.52	6.1
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	14.24%
% of Insured Population Receiving Medicaid	20.21%	15.08%
% Adults Without Any Regular Doctor	22.07%	21.71%
% of Population Living in a Health Professional Shortage Area**	34.07%	No data
Food Insecurity Rate	15.94%	9.67%
% Population with Low Food Access***	23.61%	20.71%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	80.2%
WIC Average Monthly Caseload FY2014	8,258,413	2,030

*Health indicators data was extracted from the agency's submitted 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*:

St. Tammany Parish Hospital initiated and grew the Healthy Bites, Healthy Living Coalition. An early success that has gained momentum is their Eat Fit North Shore healthy menu labelling initiative, modeled after Eat Fit NOLA. They have worked with 15 local restaurants to analyze their menus and have helped them add over 88 menu options that meet the Eat Fit guidelines. They also partnered with FoodCare to create a consumer-facing App for the program.

They were also successful in planning and maintaining 4 community gardens. The mayors' offices helped obtain the land for the gardens, and local groups, including the local Farm to School Program, helped to develop a curriculum and add a teaching component to the gardens. Produce from two of the gardens is donated to local food banks.

A task force is currently working towards a Baby-Friendly Hospital designation for St. Tammany Parish Hospital. This project has helped train health care providers and community partner staff on the basics of breastfeeding. They also worked to implement breastfeeding classes for WIC clients as well as a breastfeeding support group and a "drop-in" café at the Community Wellness Center.

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

St. Tammany Parish Hospital Project Profile

Starting Capacity and Coalition Partners:

St. Tammany Parish Hospital brought together partners to develop the Healthy Bites, Healthy Living Coalition for this project as there was no existing coalition.

Organization Category	Organization Name*
Community Members	Community Member
Public Health	CWC WIC (4 people); CWC STPH (3 people)
Healthcare	Nurse Family Partnership Program (2 people); STPH; Ochsner
Media	STPH Communications Department (2 people)
Government/Local Elected Officials	City of Covington Mayor's Office (3 people); City of Mandeville Mayor's Office; Mandeville Mayor; SNAP
Faith-Based	Mt. Zion Church
Cooperative Extension Employees	LSU Ag Center (2 people)
Food Retailers/ Distributors	Food retailer
Local Farmers	
Education	SELU College Intern
Other Local Businesses	
Other	Covington Boys and Girls Club; Wellness Works; YMCA; Abita Grows; CWC Parenting Center (2 people); Amerigroup Insurance (2 people); Samaritan Center (3 people); STPH New Family Center (2 people); Helping Hands

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, St. Tammany Parish Hospital reached **32 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **21,545 people**.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.15	Increase the number of settings with new healthy menu options/ Eat Fit Northshore option from 0 to 9.	15
A.20	Increase the number of Grocery Stores participating in the Share Our Strength Cooking Matters at the store program in the target community from 0 to 4.	4
A.29	Increase the number of Gardens in targeted community from 0 to 3.	4
B.15	Increase the number of settings with providers and/or staff that receive basic training in breastfeeding in the target community from 0 to 5.	5
B.19	Increase the number of organizations that obtain healthy "Well Ahead Louisiana Well Spot Certification" from 0 to 6.	7

Settings Reached: Gardens (YMCA Covington, STPH Community Wellness Center Covington, Klebber St Samaritan Center in Mandeville, W 2nd St Covington); Grocery Stores (Swegg's, Rouse's Grocery Store, Walmart, 2 Winn Dixie Stores); Hospitals (St. Tammany Parish Hospital); Restaurants/Bars (Abita Roasting Co, Gio's Villa Vancheri, Trey Yuen, LaCarreta, Times Grill, Rusty Pelican, Sweet Daddy's, Coffee Rani, St. Tammany Parish Hospital Cafeteria, Swegg's, Garcia's, Live Fit Smoothies, George's, Fazzio's); Primary Care Providers (STPH Community Wellness, STPH Parenting Center); Well Ahead Louisiana Well Spot Certification locations (Bambi's, Little Red, School House, Lil Lighthouse Christian Academy, Circle of Love, Little Ducklings Daycare, Covington Head Start and Early Start)

Tarrant County Public Health Project Profile

Tarrant County, TX
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Tarrant County, TX
Population Total		308,745,538	1,848,423
Population Density (# people per square mile)	Average	88.23	2,140.92
	Range	Varies	51 to Over 5,000
Racial and Ethnic Make-Up	White	74.02%	70.07%
	Black	12.57%	15%
	Asian	4.89%	4.73%
	Native American/ Alaska Native	0.82%	0.53%
	Native Hawaiian/ Pacific Islander	0.17%	0.18%
	Other Race	4.73%	6.89%
	Multiple Races	2.80%	2.61%
	Hispanic	16%	27%
Income	Per Capita	$28,154	$28,265
	% Living in Poverty	15.37%	15.18%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	35.45

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Tarrant County, TX
% Adults Overweight	35.78%	36.34%
% Adults Obese	27.14%	27.8%
% Adults with Heart Disease	4.40%	4.86%
% Adults with Diagnosed Diabetes	9.11%	11.3%
% Adults with high Cholesterol	38.52%	38.93%
% Adults with Hypertension	28.16%	28%
% Babies Born with Low Birth Weight	8.20%	8.2%
Infant Mortality Rate (per 1,000 births)	6.52	7.4
% of Mothers with Late or No Prenatal Care	17.25%	No data
Adult Uninsured Rate	20.76%	21.35%
% of Insured Population Receiving Medicaid	20.21%	18.43%
% Adults Without Any Regular Doctor	22.07%	27.66%
% of Population Living in a Health Professional Shortage Area**	34.07%	No data
Food Insecurity Rate	15.94%	17.96%
% Population with Low Food Access***	23.61%	34.49%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	75.5%
WIC Average Monthly Caseload FY2014	8,258,413	52,214

*Health indicators data was extracted from the agency's submitted 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*:

Tarrant County Public Health and partners developed and implemented Breastfeeding Boot Camp, which trained over 300 staff at 2 hospitals on 6 modules of breastfeeding practices, using an evidence-based curriculum and offering continuing education hours for nurses that completed the modules. Tarrant County Public Health will continue to implement the training beyond the project period at minimal cost and intends to partner with additional hospitals and organizations in 2017.

Additionally, the coalition worked to pass an ordinance to allow mobile fresh food vendors in residential areas in Fort Worth with the intention of using these food carts as ways to address food deserts in the area.

The coalition also worked to strengthen the referral system to health and social services. Grounded in enhancing the existing WIC referral resources, coalition members created an updated resource guide and a clinic display as well as promoted the existing databases to WIC staff and community members.

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

Website: www.tarrantcountyfoodpolicycouncil.org

Tarrant County Public Health Project Profile

Starting Capacity and Coalition Partners:

Tarrant County Public Health built their coalition from the existing Tarrant County Food Policy Council.

Organization Category	Organization Name*
Community Members	Community Member
Public Health	Tarrant County Public Health
Healthcare	JPS Hospital
Media	
Government/Local Elected Officials	Tarrant County Commissioners Office
Faith-Based	
Cooperative Extension Employees	Texas Hunger Initiative
Food Retailers/ Distributors	Tarrant Area Food Bank
Local Farmers	Texas Master Gardeners
Education	Texas Christian University; UNTHSC (2 people)
Other Local Businesses	
Other	Meals on Wheels

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, Tarrant County Public Health reached **14 different settings** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **148,685 people**.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.8	Increase the number of Grocery Stores with employees trained to assist shoppers to select healthy foods from 2 to 4.	1
A.13	Increase the number of WIC Clinics using new tools or resources to create awareness of how to access healthy food options in the community from 0 to 8.	7
A.26	Increase the number of government agencies that have enacted policies to support selling healthy foods from 0 to 1.	1
B.9	Increase the number of WIC Clinics using tools or resources to improve awareness of available chronic disease prevention and management services in the community from 0 to 6.	7
B.10	Increase the number of WIC Clinics that use an enhanced WIC referral list with new community-based chronic disease prevention and management services added from 0 to 1.	7
B.15	Increase the number of settings that receive basic training in breastfeeding in the target community from 0 to 2.	2
B.16	Increase the number of settings that receive basic training in community chronic disease prevention and management services referrals from 0 to 8. (All WIC, PMC, JPS)	3
B.18	Increase the number of settings with providers and/or staff that receive basic training on WIC services and benefits in the target community from 0 to 4.	2

Settings Reached: WIC Clinics (Resource Connection, Southwest, Miller, Southside, East Side, Fiesta Plaza, La Gran Plaza, Tarrant County WIC, Texas Hunger Initiative, Tarrant Food Bank); Mobile Food Carts (City of Forth Worth); Grocery Stores (Kroger); Hospitals (John Peter Hospital, Medical Center Arlington); Government Agencies (PMC Clinic)

Wichita Falls-Wichita County Public Health District Project Profile

Wichita County, TX
January 1, 2015 – April 1, 2016

Community Characteristics:

COMMUNITY CHARACTERISTICS*		United States	Wichita County, TX
Population Total		308,745,538	131,358
Population Density (# people per square mile)	Average	88.23	209.3
	Range	Varies	Under 51-Over 5,000
Racial and Ethnic Make-Up	White	74.02%	81.09%
	Black	12.57%	10.4%
	Asian	4.89%	2.09%
	Native American/ Alaska Native	0.82%	0.71%
	Native Hawaiian/ Pacific Islander	0.17%	0.02%
	Other Race	4.73%	2.62%
	Multiple Races	2.80%	3.07%
	Hispanic	16%	17.08%
Income	Per Capita	$28,154	$22,905
	% Living in Poverty	15.37%	15.6%
	Disparity Index Score, Race/ Ethnicity (0 = no disparity; 1-40= some; over 40 = high)	29.2	26.67

*Community characteristics data was extracted from the agency's submitted Community Health Need Assessment, which was informed by data from the U.S. Census and local health department sources.

Community Health Indicators:

HEALTH INDICATORS*	United States	Wichita County, TX
% Adults Overweight	35.78%	39.37%
% Adults Obese	27.14%	28.9%
% Adults with Heart Disease	4.40%	7.67%
% Adults with Diagnosed Diabetes	9.11%	9.9%
% Adults with high Cholesterol	38.52%	55.63%
% Adults with Hypertension	28.16%	43.3%
% Babies Born with Low Birth Weight	8.20%	8.2%
Infant Mortality Rate (per 1,000 births)	6.52	8.1
% of Mothers with Late or No Prenatal Care	17.25%	23.41%
Adult Uninsured Rate	20.76%	19.14%
% of Insured Population Receiving Medicaid	20.21%	20.12%
% Adults Without Any Regular Doctor	22.07%	16.58%
% of Population Living in a Health Professional Shortage Area**	34.07%	100%
Food Insecurity Rate	15.94%	17.97%
% Population with Low Food Access***	23.61%	29.14%
% of Adults with Inadequate Fruit and Vegetable Consumption	75.67%	81.7%
WIC Average Monthly Caseload FY2014	8,258,413	4,138

*Health indicators data was extracted from the agency's submitted 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*:

Wichita Falls-Wichita County Health District and their coalition partners had several food systems and health systems change successes.

They worked with the Texas Area Food Bank to establish a new farmers' market site at the Health District, the location where WIC clients also pick up their Farmers' Market Nutrition Program vouchers.

They also implemented the 'Por Vida' healthy restaurant initiative, helping over 20 local restaurants to analyze their menu items. Healthy items meeting guidelines were labelled for customers to know quickly what is a healthy item.

Working to strengthen referral networks and access to chronic disease prevention and management resources, they created WIC shopping guides specific to shopping for WIC foods at local stores, created a project website with information about the food access resources noted above, translated an existing resource website into an App, and have trained staff at community organizations and providers about WIC, breastfeeding, and chronic disease prevention and management resources in the community.

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

Facebook Page:
https://www.facebook.com/northtexasabc/

Wichita Falls-Wichita County Public Health District Project Profile

Starting Capacity and Coalition Partners:

Wichita Falls- Wichita County Public Health District developed their project coalition as the Healthy Eating Active Living (HEAL) Subcommittee of the Health Coalition of Wichita County.

Organization Category	Organization Name*
Community Members	WIC
Public Health	Wichita Falls-Wichita County Public Health Department (6 people)
Healthcare	Clinics of North Texas; Community Healthcare Center (2 people)
Media	
Government/Local Elected Officials	City of Wichita Falls (2 people)
Faith-Based	
Cooperative Extension Employees	
Food Retailers/ Distributors	Wichita Falls Area Food Bank
Local Farmers	
Education	Midwestern State University
Other Local Businesses	Anytime Fitness
Other	Sheppard Airforce Base (2 people); Hospice of Wichita Falls; YMCA; MPO; Downtown Proud

*A list of partners was extracted from the agency's final coalition reporting form.

Project Reach:

Overall, Wichita Falls-Wichita County Public Health District reached **79 different settings/ providers** in their community, cumulatively, with their food systems change and health systems change interventions, reaching as many as **132,047 people**.

Intervention Objectives and Outcome Summary:

Objective #	Objective Description	# Settings Reached
A.7	Increase the number of Grocery Stores with new on-site and in store-placement and promotion strategies for healthy foods from 0 to 9.	9
A.11	Increase the number of Farmer's Markets in the target community from 3 to 4.	1
A.13	Increase the number of settings using new tools or resources to create awareness of how to access healthy food options in the community from 1 to 5.	13
A.14	Increase the number of Restaurants/Bars using nutrition labeling to identify healthy menu options in the target community from 0 to 20.	19
A.19	Increase the number of K-12 Schools that make plain drinking water available throughout the day at no cost to students from 4 to 7.	1
B.9	Increase the number of Non-Profit Organizations using new tools or resources to improve awareness of available chronic disease prevention and management services in the community from 0 to 3.	3
B.13	Increase the number of settings that receive basic training in community chronic disease prevention and management services referrals from 0 to 8.	12
B.14	Increase the number of settings that make prescriptions for non-pharmaceutical interventions like exercise from 0 to 3.	3
B.15	Increase the number of Primary Care Providers with providers and/or staff that receive basic training in breastfeeding in the target community from 0 to 8.	4
B.16	Increase the number of providers that refer families to other chronic disease prevention and management services in the community from 20 to 32.	21
B.18	Increase the number of settings with providers and/or staff that receive basic training on WIC services and benefits in the target community from 5 to 29.	8
B.22	Increase the number of settings that offer new chronic disease prevention and management services in the target community from 20 to 39.	7

Settings Reached: Grocery Stores (Market Street, Wal-Mart, Davenports, Lowe's, Cash Saver, 3 United Supermarkets, Electra Food Market, Sheppard Air Force Base Commissary, Local WIC Agency, Cash Saver); Farmers' Markets (Market Street); Government Agencies (Health Department, WIC Agency); Restaurants/Bars (4 McDonald's, Gyros and Kebobs, Olive Garden, 3 Golden Chicks, Gypsy Kit, Luby's Cafeteria, Gutierrez Restaurant, Market Street, United Supermarkets, Hospital Cafeteria); K-12 Schools (Sheppard Elementary); Non-Profits (First Step, Faith Refuge, NAMI, League of Women Voters, Texas Home Visiting); Colleges (Midwestern State University): Primary Care Providers (5 individual providers, Quad Med, Falls Home Health); Other Providers (Internist, Nephrology, Radiology, Home Health, Pediatrician, Family Practice, OB-GYN, Family and Marriage Counselor, Speech Therapist); Military Facilities (Sheppard Airforce Base); Hospitals (Clinics of North Texas, Texoma Primary Care, United Regional Health Care System Wichita Falls Family Residency, Iowa Park Clinic); WIC Clinics (1); Faith-Based Organizations (Floral Heights Methodist Church)