The Oregon Healthy Communities Program Evaluation Report

Prepared by The Rede Group July 2016

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June 2016

This report was produced by the Rede Group for
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Health Promotion and Chronic Disease Prevention Section

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Acknowledgments

We would like to thank the following for their contribution to this project:

The Oregon Health Authority, Public Health Division Health Promotion and Chronic Disease Prevention Section:
Sarah Hargand
Leah Fisher
Sabrina Freewynn
Shaun Parkman

Fauna Larkin of the Coquille Indian Tribe
Robin Stalcup of Douglas County (Adapt)
Renee Mulligan of Lane County
Elizabeth Barth of Multnomah County

Thanks also to all Healthy Communities grantees who participated in this project through interviews and other data collection efforts.

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Introduction

Introduction: Purpose and Key Evaluation Questions

Oregon's Healthy Communities Program began in 2008 when the Oregon Health Authority, Health Promotion and Chronic Disease Prevention Section (HPCDP) began supporting and funding local county and tribal health departments to plan and implement strategies to reduce chronic disease through integrated, population-based, policy-focused approaches to reduce tobacco use and obesity.

The purpose of this document is to report the findings from the evaluation of the 2012–2016 Healthy Communities Program.

In 2015, HPCDP contracted with the Rede Group to provide consultation and support in evaluating Healthy Communities Program efforts that took place between 2012 and 2016. The Rede Group's evaluation team for this project included Eric Einspruch, of ELE Consulting.

The Healthy Communities Evaluation was developed using a utilization-focused evaluation framework.[1] Utilization-focused evaluation is an approach based on the principal that an evaluation should be judged on its usefulness to, and its use by, the intended users of the evaluation. Therefore, this evaluation was planned and conducted in ways intended to enhance the utilization of both the findings and the evaluation process itself to inform decisions about future health promotion programs and spending and improve professional practice within the realm of population-based, policy-focused chronic disease prevention. The Rede Group worked closely with nine Healthy Communities Program grantees and HPCDP to design and implement this evaluation.

The primary intended use of the evaluation is to share results with national, state, and local decision makers to add to their understanding about the value of healthy communities programs and efforts, and how these programs might be structured and supported in the future.

Key Evaluation Questions

The key evaluation questions below were identified through the utilization-focused evaluation engagement process.

1. To what extent did the Healthy Communities Programs develop productive partnerships for policy, system, and environmental changes?
2. How many policies, system, and environmental changes were accomplished due (at least in part) to the 2012–2016 Healthy Communities Program?
3. In what ways did the (aforementioned) policies, system, and environmental changes improve conditions to promote health within the place or system affected?
4. Were Healthy Communities Program grantees able to secure additional non-HPCDP funding for chronic disease prevention due (at least in part) to the Healthy Communities Program?

[1] Patton, M.Q. (2008). Utilization-Focused Evaluation, 4th Edition. Thousand Oaks, CA: Sage Publications, Inc.

Introduction: Program Description

The Healthy Communities Program is a HPCDP initiative to plan and implement local, population-based approaches to reduce the burden of chronic disease most closely linked to physical inactivity, poor nutrition, and tobacco use. This approach to addressing chronic diseases fosters new partnerships between public health and community partners. The approach also focuses broadly on policy, environmental, and system changes that influence the prevention and management of chronic diseases, rather than on individual services or health education. The approach helps develop state and local health department capacity and community infrastructure for chronic disease prevention, early detection, and self-management.

Although the vision and goals of the Healthy Communities Program have remained fairly constant since its launch in April of 2008, the program focus and funding capacity has varied from year to year. This variation is mainly because much of the funding for the Healthy Communities Program is disease-specific "pooled funding" that comes from the federal Centers for Disease Control and Prevention (CDC). When the CDC institutes new or changing program requirements, those requirements may be reflected in the Healthy Communities Program grant program requirements.

During the Building Capacity Phase of the program (2008–2012), a total of 32 local public health authorities and seven tribal grantees were funded to participate in a series of chronic disease prevention training institutes. Twenty-four of these grantees subsequently completed a community needs assessment and a community action plan to reduce the burden of chronic disease through best practices and promising approaches for community-level policy, system, and environmental change. The Implementation Phase began in Fiscal Year 2011 (July 2010–June 2011) with 12 of the twenty-four grantees receiving continued funding. Beginning in Fiscal Year 2013 (July 2012–June 2013), a much smaller cohort of 9 counties and 1 tribe (9 grantees total, two counties combined for one grant) continued to receive funding to carry out the work of the Healthy Communities Program.

Three program focus areas have remained constant over time:

1. Creating healthy worksites through the establishment of a worksite wellness committee that advocates for policy, system, and environmental changes in the work environment.
2. Establishing an infrastructure for chronic disease self-management, early detection and tobacco cessation.
3. Community-wide/cross cutting collaborations to promote health and prevent chronic disease.

Tables 1 & 2 on the following pages detail specific program requirements for each fiscal year.

Introduction: Healthy Communities Program Requirements

Table 1: Healthy Communities Program (2012–2016) Program Requirements: Healthy Worksites

Program Requirements	2012-13	2013-14	2014-15	2015-16
Healthy worksites: Establish sustainable, policy-driven worksite wellness committees focused on the topics of tobacco cessation, healthy eating, physical activity, cancer screening, weight management, and self-management of chronic disease.	✓	✓	✓	✓
Early focus on passing wellness policies allowed grantees to work with the larger business community but prioritized government worksites.	✓			
Establish worksite wellness infrastructure and operational plan before attempting policy change. Work must occur in funded government worksite (county/tribal) settings rather than the broader business community and must include increasing coverage and/or systematically promoting Living Well/Tomando Control, Walk w/Ease, and Quit Line.		✓		
Encourage worksite wellness committees to establish policies for nutrition standards (vending machines, food service, meeting foods), lactation accommodation, and to advocate for improvements in healthcare benefits package to include coverage of Living Well, Walk with Ease, National Diabetes Prevention Program, evidence-based weight management, and tobacco cessation programs.			✓	✓

Introduction: Healthy Communities Program Requirements

Table 2: Healthy Communities Program (2012–2016) Program Requirements: Infrastructure for Chronic Disease Self-management, Early Detection and Tobacco Cessation

Program Requirements	2012-13	2013-14	2014-15	2015-16
Infrastructure for self-management, early detection and tobacco cessation: Establish sustainable funding for and referral systems to Living Well/Tomando Control, Walk with Ease and Oregon Tobacco Quit Line.	✓	✓	✓	✓
Work with government agencies (priority), insurers, CCOs, hospitals, patient-centered primary care homes, WIC and Area Agencies on Aging to accomplish this goal. Participate in earned media opportunities for a colorectal cancer screening campaign.	✓			
Work with health systems/community to promote partnerships for sustainable funding and referral systems to self-management, early detection and tobacco cessation programs. Expand earned media efforts for a colorectal cancer screening campaign by securing local earned media, implementing a social media campaign, and collaborating with health systems to address systems improvements to increase screening.		✓	✓	✓
Promote and refer people to the Diabetes Prevention Program. Promote systemic use of provider-client interventions to increase colorectal cancer screenings. Promote adoption of electronic health records as a tool to increase chronic disease related screenings.			✓	✓
Promote Oregon web-based, self-management portal to partner agencies/organizations engaged in this subject matter.				✓

Introduction: Healthy Communities Program Requirements

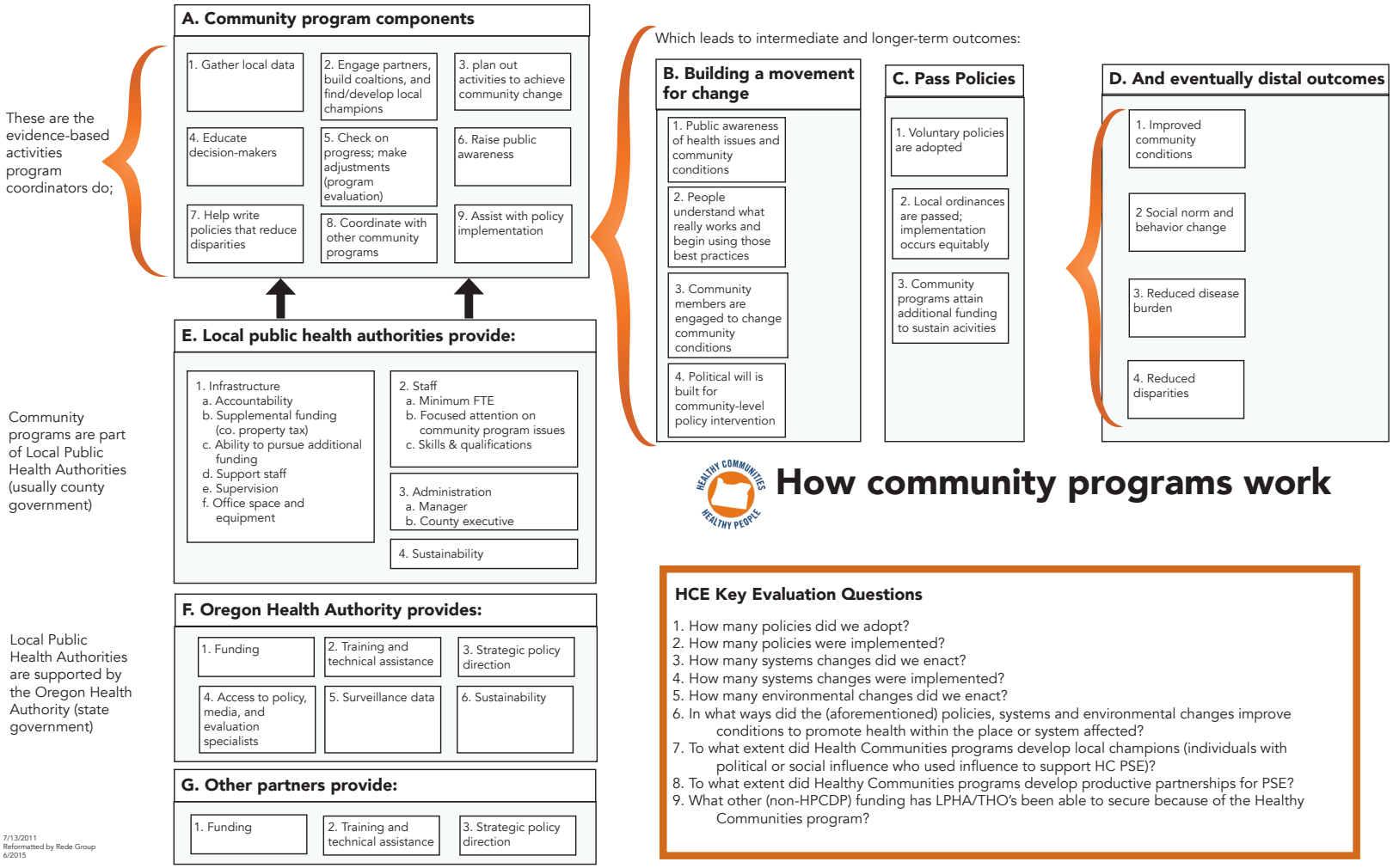
Table 3: Healthy Communities Program (2012–2016) Program Requirements:
Community-Wide/Cross Cutting Collaborations For Health Promotion And Chronic Disease Prevention

Program Requirements: Other	2012-13	2013-14	2014-15	2015-16
Community-wide/cross cutting collaborations for health promotion and chronic disease prevention	✓	✓	✓	✓
Limit access to unhealthy foods and reduce exposure to advertising, promotion, and sponsorship of tobacco and sugary beverages in retail environment.	✓			
Encourage hospitals to pass sugar-sweetened beverages policies and/or adopt nutrition standards relating to sodium and trans fats reduction.		✓	✓	✓
Plan for working with CCOs to accomplish cross cutting objectives in workplan.		✓		
Expand community work into one of the following settings: K-12, built environment, early childhood education, birthing facilities, worksites.				✓

Introduction: Logic Model

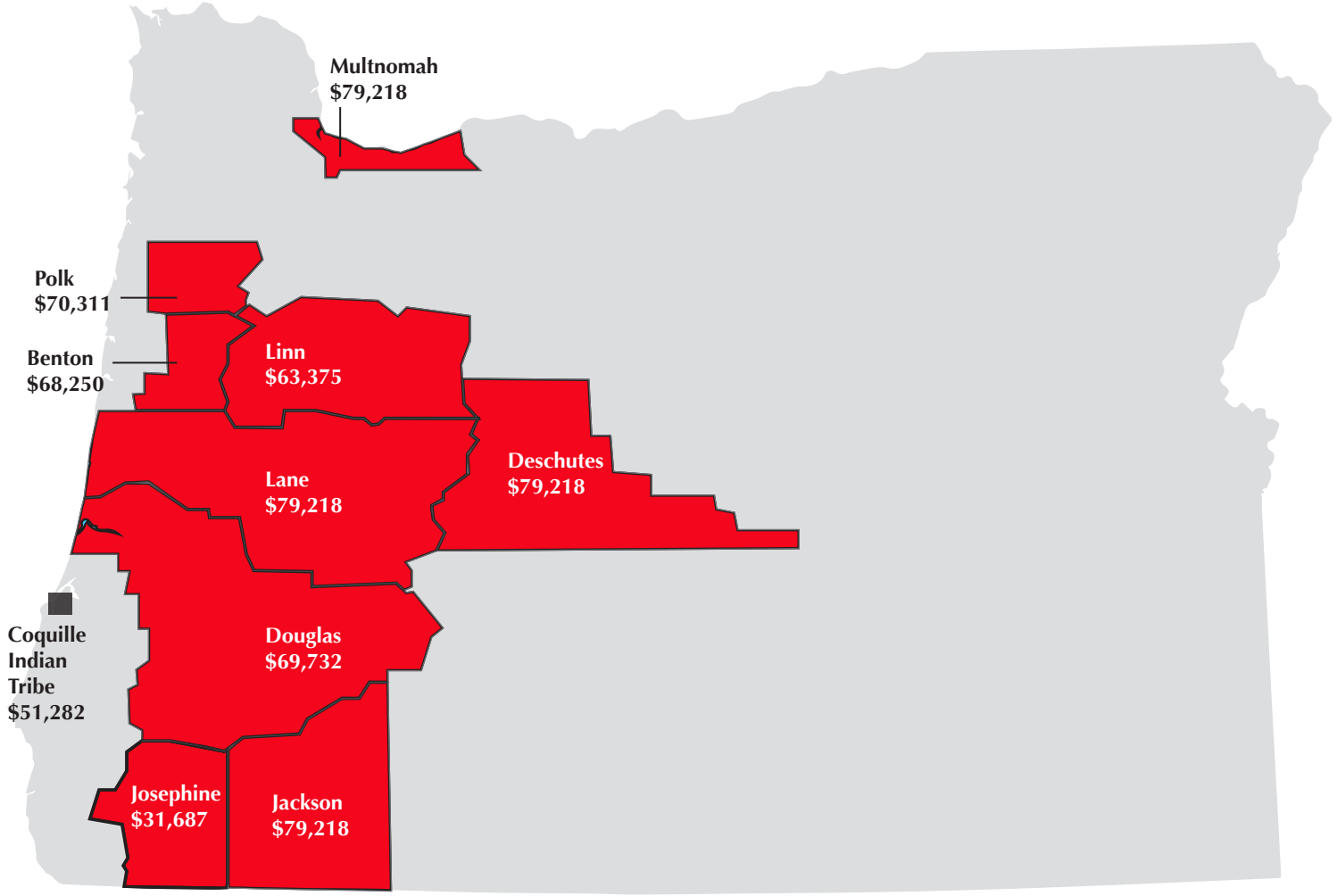
Figure 1: The Healthy Community Program Logic Model

This model was developed by HPCDP in 2011 to describe the theory of change for community-based programs funded and supported by HPCDP to reduce chronic disease throughout Oregon. As a part of the 2012–2016 Healthy Communities Evaluation, grantees reviewed this logic model examining its specific application to the Healthy Communities Program.



Introduction: Funding

Figure 2: Average Annual Funding for 2012–2016 Healthy Communities Program Grantees



*Dollar amounts represent average annual Healthy Community grants per county/tribe since 2012.

Evaluation Methods

Evaluation Methods: Stakeholder Engagement

Stakeholder engagement was a strong focus of the Healthy Communities Evaluation. The evaluation team worked closely with HPCDP to develop the Healthy Communities Evaluation user panel, a small group of primary intended users that included four local grant program coordinators, one each from the Coquille Indian Tribe, Douglas, Lane, and Multnomah Counties and two HPCDP staff.[1] The user panel guided the project to help ensure that the results of the evaluation would be useful and likely to be used.

Over the course of the evaluation, the user panel met in person or over the telephone to collaborate on shaping and executing the evaluation.. The user panel also reviewed project documents and provided written feedback. With the exception of one member who left her job (and therefore the user panel) before the conclusion of the project, all user panel members participated throughout the entire evaluation.

User panel participants were selected based on the following criteria:

- Interest in understanding and improving healthy communities "practice"
- Knowledgeable about the Healthy Communities Program (ideally, at least 1.5 years experience)
- Open to critical reflection, learning, and dialogue
- Connected to an important stakeholder group or constituency
- Credibility among Healthy Communities Program grantees and HPCDP
- Teachable—willing to gain a new outlook and skills in evaluation
- Represent diversity of grantees in terms of geography population size, and agency type
- Available to interact throughout the evaluation process (August 2015–June 2016):
  - Participate in 3, in-person, 5–7 hour meetings at various locations throughout the state
  - Participate in 3–4, 60 minute phone/video conferences
  - Carry out reading and additional assignments related to the evaluation (approximately 3 hours per month)

The user panel helped:

- Refine and define the primary purposes of the evaluation
- Focus the evaluation
- Form key evaluation questions
- Develop data collection methods
- Review simulated results
- Review findings
- Provide insights into analysis, interpretation, judgment, and recommendations based on results

All Grantee Participation

The larger group of all current Healthy Communities Program grantees (9) was also engaged in the evaluation. The user panel communicated with and sought feedback from all grantees via email and webinars. All grantees met in June 2015 to discuss the theory of change/logic model for the Healthy Communities Program and began to talk about the evaluation. Then, in September 2015, all grantees attended a four-hour work session to conceptualize the evaluation questions. In May 2016, all grantees participated in a day-long meeting to review preliminary evaluation findings, develop recommendations (based on the findings), and provide direction on the types of reports that would be most useful for the primary intended users.

[1] See Appendix A for a complete list of user panel members

Evaluation Methods: Design and Data Collection

The evaluation team gathered data from a variety of sources to evaluate the 2012–2016 Healthy Communities Program. The qualitative and quantitative data gathered for this project are described in items 1-7 below.

1. HPCDP Policy Database

This relational database, which is housed at HPCDP, contains all public and private policies that have been passed by HPCDP grantees. Policies covering physical activity, chronic disease self-management, nutrition, tobacco, and worksite wellness are included. For this evaluation, the policy database was queried to generate lists of policies passed by Healthy Communities Program grantees during 2012–2016.[1]

2. HPCDP Grantee Reporting Interview Reports

Data were obtained from program monitoring reports recorded by HPCDP Community Programs Liaisons based on interviews with local program coordinators (LPCs). The reports are available for fiscal years 2013, 2014, 2015 and the first quarter of fiscal year 2016. These data were coded and analyzed to extract county/tribal level information about policy, system, and environmental (PSE) changes implemented and key partnerships formed.

3. Local Program Coordinator Survey

The evaluation team developed and administered a survey to all nine Healthy Communities Program grantees.[2] The survey included questions focused on affirming or augmenting information about policies passed and implemented and other questions about partnerships. The survey was also used to gather information about local program coordinator experiences leveraging Healthy Communities Program grant funds to acquire additional non-HPCDP funding for local chronic diesease prevention programs. LPCs were also asked to identify three to five local Healthy Communities Program partners and champions to participate in a structured individual interview. A follow-up survey[3] was administered to LPCs to gather additional information about funding leveraged through the program.

4. Grantee Budgets

Healthy Communities Program grantee budgets from the beginning of the program in 2008 to present were compiled to create a list of funding allocated to grantees across the lifespan of the program.[4] Information was extracted to calculate the total amount of funding allocated to grantees from 2012–2016.

5. Brief Survey of Non-Healthy Communities Health Departments

HPCDP emailed all Non-Healthy Communities Program (2012–2016) county health departments a brief survey[5] regarding any additional funds secured for tobacco and obesity prevention within the 2012–2016 time frame. Eight of the 25 (32%) Non-Healthy Communities Program (2012–2016) county health departments responded to the question.

Interviews

[1] At the time of this evaluation, the HPCDP Policy Database included partially complete data.
[2] See Appendix B for the Local Program Coordinator Survey Instrument
[3] See Appendix D for the Local Program Coordinator Follow-up Survey of Leveraged Resources
[4] See Appendix E for the Grantee Budgets
[5] See Appendix F for the Brief Survey of Non-Healthy Communities Health Departments

Evaluation Methods: Design and Data Collection

Table 4: Local Program Coordinator Interviewed

Grantee	Interviewee	Title
Benton County	Mac Gillespie	Healthy Communities Coordinator
Coquille Indian Tribe	Fauna Larkin Dennita Antonellis-John	Assistant Health and Human Services Administrator Healthy Communities Coordinator
Deschutes County	Sarah Worthington	Healthy Communities Coordinator
Douglas County	Shawna Hormann Robin Stalcup	Healthy Communities Coordinator TPEP Coordinator, Public Health Lead (Adapt)
Jackson & Josephine County	Kate Roberts Jane Stevenson	Josephine County Healthy Communities Coordinator Jackson County Healthy Communities Coordinator
Lane County	Renee Mulligan	Healthy Communities Coordinator
Linn County	Erin Sadlacek Pat Crozier Kacey Urrutia Joscelyn Stangel	Healthy Communities Coordinator Public Health Program Manager TPEP Coordinator Health Educator
Multnomah County	Elizabeth Barth	Healthy Communities Coordinator
Polk County	Alinna Ghavami	Healthy Communities Coordinator

6. Local Program Coordinator Interview

The evaluation team conducted 45-minute interviews with each of the nine Healthy Communities Program local program coordinators.[6] The interviews gathered information about the chain of events leading to policy advancement or non-advancement with an emphasis on Box A:2 of the "How Community Programs Work" logic model[7] (i.e.," Engage partners, build coalitions, and find/develop local champions"). Subsets of questions were developed to examine factors that contributed to the advancement or non-advancement of policy work as established through data sources 1-3. Another subset of questions about partnerships was developed using resources from the Centers for Disease Control and Prevention,[8] and the Harvard Family Research Project.[9] A document, outlining various stages of PSE change implementation,[10] was created with input from the user panel and HPCDP staff. This tool was provided to grantees in advance of the interview and was used in the interview as a reference to help local program coordinators identify the status of implementation for their PSE change efforts.

The interviews were recorded and transcribed for analysis.

[6] See Appendix G for the Local Program Coordinator Survey Interview Guide
[7] See page 6 for the HPCDP Community Programs logic model
[8] Centers for Disease Control and Prevention, Evaluation Technical Assistance Document: Division of Nutrition, Physical Activity, and Obesity (DNPAO) Partnership Evaluation Guidebook and Resources, 2011
[9] Harvard Family Research Project: Evaluating Partnerships, 2005
[10] See Appendix H for the Implementation Scale

Evaluation Methods: Design and Data Collection

7. Partner Interview

The evaluation team conducted individual interviews with 16 Healthy Communities Program partners identified by LPCs. The interview gathered information about the strength and quality of the partnerships. Partners were asked to discuss key factors that contributed to the success of the Healthy Communities Program projects, the impact of the projects on the community, and benefits from their relationship with the 2012–2016 Healthy Communities Program. The interviews were recorded and transcribed for analysis.[11]

Table 5: Partners Interviewed

Sector	Interviewee	Title	Organization
County or Tribal	Christy Inskip Kylie Menagh-Johnson Matthew Stevenson	TPEP Coordinator Wellness Program Manager TPEP Coordinator	Lane County Public Health Multnomah County Polk County Family & Community Outreach
Agriculture	Bryan Allen	Farm Manager	Zenger Farms
Health Care, CCOs and Insurance	Cindy Norona Dr. Richard Kincade Elaine Knobbs Emily McNulty Hannah Ancel Jenna Bates Kim Prosser Marilyn Carter	Executive Coordinator Physician Director of Programs and Development Health Education Manager Community Engagement Coordinator Transformation Manager Clinic Manager Health Policy & Systems Director	Umpqua Community Health Center Formerly PeaceHealth Hospitals Mosaic Medical Samaritan Health Services Jackson Care Connect Samaritan Health Services Central Health & Wellness Center Adapt
Higher Education	Cheryl Kirk Tina Dodge Vera	Family & Community Health/SNAP-Ed Family and Community Health	Josephine County OSU Extension Service Linn County OSU Extension Service
Parks, Recreation, & Transportation	Kim Curley Stephen DeGhetto	Community Outreach Assistant Director	Commute Options Corvallis Parks and Recreation

[11] See Appendix J for the Community Partner Survey Interview Guide

Evaluation Methods: Design and Data Collection

Table 6 lists the key evaluation questions and indicates the data sources that were used to address each of the questions. The Health Communities Grantee Budgets were used for collecting background information for the evaluation.

Table 6: Key Evaluation Questions and Data Sources

Key Evaluation Questions	Data Sources						
	HPCDP Policy Database	HPCDP Grantee Interview Reports	LPC Survey	LPC Interview	Partner Interview	HC Grantee Budgets	Brief Survey of Non-Healthy Counties CHDs
How many policies, systems, and environmental changes were accomplished due (at least in part) to the 2012–2016 Healthy Communities Program?	✓	✓	✓				
In what ways did the (aforementioned) policies, systems and environmental changes improve conditions to promote health within the place or system affected?				✓	✓		
To what extent did Healthy Communities Programs develop productive partnerships and local champions for policy, systems and environmental changes?		✓	✓	✓	✓		
Were Healthy Communities grantees able to secure additional non-HPCDP funding for chronic disease prevention due (at least in part) to the Healthy Communities program?			✓				✓
Data Compiled for Background Information						✓	

Evaluation Methods: Analysis + Strengths and Limitations

Surveys & Interviews

The evaluation team performed content analyses of responses to open-ended survey questions, LPC interviews, and Partner interviews using Dedoose[12] qualitative analysis software. These analyses identified themes and specific narratives relevant to the evaluation questions. The evaluation team developed a coding scheme based on pre-determined and emerging codes. Survey data and interview transcripts were systematically excerpted and coded. A code table was then generated to examine the frequency of codes overall and by interviewee. Coded excerpts were reviewed a second time to further inform and, in some cases, provide specific detail for the findings and recommendations outlined in this report.

The list of specific policy, system, and environmental changes accomplished by grantees (derived from the HPCDP grantee reports and surveys) was reviewed independently by the evaluation team and HPCDP to ensure that each entry was consistent with the definition of policy, system, or environmental change agreed upon for this project.

Grantee Budget Data

Annual grantee budget amounts were entered into a spreadsheet and descriptive statistics regarding the funding amounts were computed.

Interview Excerpts For Reporting

Excerpts from local program coordinator and community partner interviews were re-reviewed to identify illustrative content for this report. In selecting quotes, care was taken to utilize excerpts from a variety of interviews; quotes included in any given section of this report are not from the same interview.

Strengths and Limitations

This evaluation has strengths and limitations that should be considered when interpreting results.

Strengths

The framework of utilization-focused evaluation created strong engagement and focus on community needs and respect. Moreover, Healthy Communities Program (2012–2016) grantees collaborated in shaping each aspect of the evaluation, including interpreting findings and developing recommendations. This collaboration and level of engagement is intended to facilitate more use and dissemination of evaluation results. The evaluation team employed a mixed method approach to data collection including surveys, grant documents analysis, and in-depth interviews to increase the depth of the evaluation findings. In addition to helping interpret findings, the user panel helped frame the evaluation questions to ensure that useful questions were answered.

Limitations

The evaluation has some limitations for consideration: The number of grant programs evaluated (9) was relatively small. However, all grantees were included in the evaluation. Although this remains a limitation (small number), it was handled to make it as strong as possible (i.e., all grantees). And, because the grantees were selected based on competitive applications, the sample may be biased toward counties and tribes that are already interested in, supportive of, or skilled in chronic disease prevention policy, system, and environmental change programs. Also, community partners interviewed for this study were not randomly selected but, rather, identified by local program coordinators, possibly introducing a positive bias. Although the partners were not randomly selected, they were purposively selected so that we spoke to knowledgeable people. Finally, this evaluation may have been strengthened by a more proactive approach to gathering program evaluation data at earlier stages in the program. In some cases, interviewees were either not involved in the program in previous years or were asked to recall events that happened several years ago.

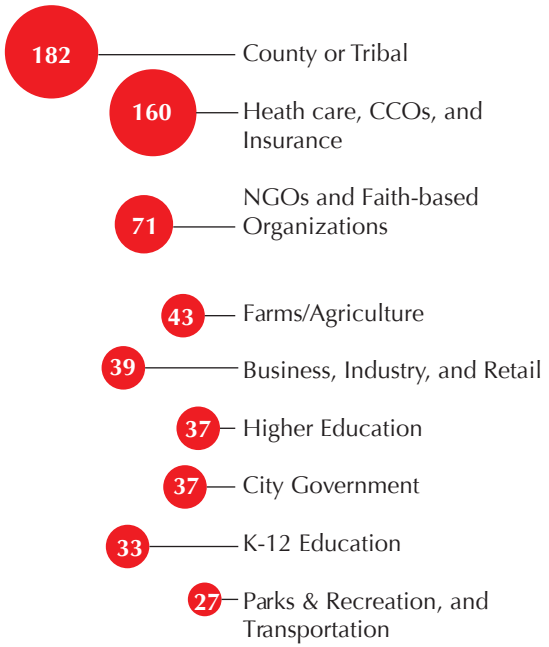
[12] Http://www.dedoose.com/

Findings

Findings: Partners and Champions

The Healthy Communities Program logic model includes activities to "engage partners, build coalitions and find/develop local champions." Information about partnerships was gathered from HPCDP Grantee Reporting Interview Reports and Local Program Coordinator Surveys and Interviews.

Figure 3: Grantee Partnerships
Grantees reported the majority of partnerships from the following types of organizations:



Key Themes: Partners

- Local program coordinators identified over 800 individuals, committees, organizations, and agencies with whom they had partnered in the course of their 2012–2016 Healthy Communities Program work. Each grantee identified between 50 and 135 community partners.
- All grantees identified one or more partners from the following sectors (as identified and coded by the evaluation team):
  - Business/Industry/Retail
  - City Government
  - Committees/Workgroups/Coalitions/ Networks/Consortia
  - County/Tribal Government
  - Coordinated Care Organizations
  - Healthcare Providers (other than Coordinated Care Organizations)
  - Schools (Pre-k through 12)
  - Non-governmental social service or faith-based organizations
  - Other Counties/Tribes
- All but one of the grantees partnered with people working at an institution of higher education.
- Five grantees partnered with their local Oregon State University Extension Service.
- Six grantees also partnered with their local food bank and one or more farmer's markets.
- Approximately 20% of partners were internal to the grantee health department.
- Grantees partnered with a variety of non-governmental organizations. National non-governmental organizations with whom grantees partnered included:

  American Cancer Society, American Heart Association, Planned Parenthood, Salvation Army, YMCA, Urban League, Boys & Girls Club, United Way, AmeriCorps, American Red Cross, and American Association of Retired People.

  Local non-governmental organizations with whom grantees partnered included:

  Oregon Public Health Institute, Northwest Health Foundation, housing authorities, food banks, and community development corporations.

Findings: Partners and Champions

Local program coordinators were asked to identify champions developed through the course of their work. The term "champion" was defined as a person with political or social influence who used their influence to support or advance Healthy Communities Program work.

Key Themes: Champions

- All grantees reported success in finding and developing champions. They further noted that these champions were key to the success of various policy, system, or environmental change initiatives.

- Local program coordinators reported having champions from various sectors including higher education, city governments, hospitals and Coordinated Care Organizations, and county commissioners.

"I think of them as like part of my core team, even though we're in different departments and have different funding streams."

—Community Partner

- When asked if they believed that the champions they developed would continue supporting healthy communities type work in the future, local program coordinators felt optimistic that local champions would continue to support policy, system, and environmental changes to prevent obesity and tobacco use.

"We've done a good job of talking about the importance of it, and I think that they believe and have really bought into it. They're doing this good work, we're really providing technical assistance and support to really beef it up."

—Local Program Coordinator

- Several local program coordinators spoke about the importance of internal (i.e., to the county or tribal health department) champions.

"It might seem like that's not that significant, but I think to have a supervisor and boss who is so supportive and will advocate for staff and what they are trying to do is really, really important and has really contributed to our program and our efforts being successful."

—Local Program Coordinator

"I feel like I've proved myself as a worthy partner and someone who doesn't just put it on them. I go there and I help them with some of it. I think now that we've got some momentum with it, they're excited to keep it going."

—Local Program Coordinator

"It comes back to knowing that their values align with yours, with the healthy communities idea. That comes through relationship building; knowing where they stand, what they value, what kind of work they do and meeting with them regularly. It's been so key, being able to be out there, and it's not just attending meetings, it is going and having coffee, it is having lunch, it is doing all of those things."

—Local Program Coordinator

"We pooled together extra funding from different grants and sent the whole crew, including all the department heads, a couple of our county commissioners, and a few of us from the health department to the Smart Growth Conference in Seattle. It was a whole team of us that went together, and it was a turning point moment; we hung out with them, and it just made it more like we're all real people to each other. It was a great conference, and then we did a lot of follow up afterward ...
Since then, we'll send a whole team of people to a conference and then really use that as a galvanizing way of saying, 'Let's get together and meet afterward. Let's share ideas. Let's implement something together, ideas that we have.' Really, it's almost less to do with the work itself but more just the relationships, just feeling like I know these folks, I can just call them up on the phone, they get where I'm coming from, I get where they're coming from."

—Local Program Coordinator

Important Narratives: Relational Work

Findings: Policy, System, and Environmental Change

Using the information from the HPCDP Policy Database and HPCDP Grantee Interview Reports, the evaluation team generated lists of policy, system, and environmental (PSE) changes that grantees accomplished. Grantees were then asked to verify or augment these lists as part of the local program coordinator survey. The lists were then reviewed by HPCDP and the evaluation team to ensure that all entries met the following definitions for the Healthy Communities Evaluation:

Policy Change

Written statements of organizational position, decision or course of action such as ordinances, mandates, guidelines or rules.

System and Environmental Change

A System change includes changes in organizational procedure or practice that impact all elements of an organization or system such as personnel, clinical practices, and sustained resource allocation. Environmental changes are defined as physical, observable changes in the built, economic, or social environment.

Policy: Key Findings

From 2012–2016, a total of 35 local policies were passed, due in some part to the Healthy Communities Program, in communities with Healthy Communities Program funding. The most frequently adopted policy changes were related to food and tobacco. Less common policy changes included those related to Chronic Disease Self-Management, fragrance in workplaces, breastfeeding, and wellness committees.

Table 7 details the number and breadth of policy topics that Healthy Communities Programs had a role in successfully passing. The table shows the type of policies passed, a list of the type of policies passed in greater detail, and the number of grantees that passed each type of policy.

System and Environmental Change: Key Findings

In this study, system and environmental changes were combined into one category. From 2012–2016, a total of 85 local system and environmental changes were implemented, due in some part to the Healthy Communities Program, in communities with Healthy Communities Program funding. The most frequently adopted system and environmental changes related to food, Chronic Disease Self-Management, and tobacco. Less frequently adopted system and environmental changes related to breastfeeding, exercise and fitness, worksite wellness committees, and gardening programs.

Table 8 details the number and breadth of the system and environmental change topics that Healthy Communities Programs had a role in successfully creating. The table shows the types of system and environmental changes that were implemented, a list of the type of change in greater detail, and the number of grantees that implemented each type of change.

Findings: Policy Change

Table 7: Policy Changes

Types of Policy Change	Total	Policy Change in Detail	Number of Changes Passed by Grantees	Number of Grantees that Passed a Related Policy
Food Policy	18	Healthy Meeting/Events Food Healthy Vending Machines Sugar Sweetened Beverages Traditional Food	8 8 2 1	5 5 2 1
Tobacco Policy	10	Tobacco-Free Properties Campuses/Worksites/Events Tobacco Cessation Electronic Cigarette	7 2 1	7 2 1
Breastfeeding Policy	3	Breastfeeding Policy	3	3
Chronic Disease Self Management Policy	2	Chronic Disease Self-Management Referral Policy	2	2
Wellness Committee Policy	2	Wellness Committee	2	2
Fragrance-Free Policy	1	Fragrance-Free Policy	1	1

Table Notes:
A single policy change may be counted in multiple categories.

1. The number of policies in Column Two adds to 36 while the total number of policies passed is 35. This is because one of the policies is a referral policy that involves tobacco cessation and Chronic Disease Self-Management. This policy is counted under both the tobacco policy type and the CDSM policy type.

2. The total number of food policies in Column Four adds to 19 while the number of food policies in Column Two is 18. This is because a single food policy involving sugar-sweetened beverages in vending machines is counted as both a sugar-sweetened beverages policy and a healthy vending policy in column two.

Findings: System and Environmental Changes

Table 8: System and Environmental Changes

System & Environmental Change	Total	Type of Change	Number of Changes	Number of Grantees
Food Policy	37	Healthy Option Identification Vending Machines Sugar Sweetened Beverages Healthy Meetings Sodium Reduction	14 11 10 3 1	6 6 5 3 1
Chronic Disease Self Management	19	Living Well Program Referral System Diabetes and Chronic Pain Colorectal Cancer Campaign Diabetes Prevention Classes Cancer Screening System-wide	9 9 2 1 1 1	6 6 1 1 1 1
Tobacco	13	Tobacco Cessation & Quit Line Referral Tobacco-free Spaces and Cessation Program Signage Tobacco-free Worksites	10 2 1	6 2 1
Wellness Committee	9	Wellness Incentive Programs Hiring Additional Staff Employee Health Risk Assessment Flex Schedule	4 2 1 1	4 2 1 1
Exercise & Fitness	7	Discounted Gym Membership/fitness rooms Walk with Ease Parks & Rec. Family Assistance Program Physical Activity Programs in Schools	3 2 1 1	3 2 1 1
Breastfeeding	3	Breastfeeding Room	3	3
Other System & Environmental Changes	3	Health & Wellness section in training catalog Free Ride to Medical Appointments Blood Pressure Monitor	1 1 1	1 1 1
Gardening Programs	2	Employee Garden Community Gardens Master Plan	1 1	1 1

Table Notes:
A single system or environmental change may be counted in multiple categories.

1. The number of system and environmental changes in Column Two adds to 93 while the total number of system and environmental changes implemented is 85. This is because some of the system and environmental changes fall under more than one type. For example, one system change involves healthy vending and physical activity in schools. This system change is counted under both the food and the exercise & fitness type of change.

2. The total number of the food-related system and environmental changes in Column Four is greater than the number of food changes in column one because some food changes are counted in more than one detailed type. For example, one of the food related system and environmental changes was signage to identify healthy options in vending machines. This change is counted under the healthy option identification type as well as the vending machine type of change.

Findings: Policy, System, and Environmental Change by Sector

Table 9: Policy, System, and Environmental Change by Sector

Sector of Implementation	Number of Policy, System, and Environmental Changes	Number of Grantees
Health Department	30	8
County-wide	29	7
Hospital/Health System	27	8
Tribal Organization	10	2
Other County Agencies	8	5
Coordinated Care Organization	7	5
Retail Stores	3	2
Schools	3	3
Farmer's Market	2	1
Parks & Recreation	2	1
Community Garden	1	1
Local Non-Profit	1	1

Table Notes:
A single PSE change could have been applied to more than one sector. For example, OSU Extension and two Federally Qualified Health Centers are piloting the Go 4 Real Food Prescription RX programs for a diabetic group, teen parenting class, and a home visiting program targeting individuals with chronic diseases. This system change is counted under both the schools sector and the hospital/health system sector. For this reason, the total number of changes in the second column is greater than the 120 policy, system, and environmental changes accomplished.

Policy, System, and Environmental Change: Sector
The 120 policy, system and environmental changes identified above were implemented in a variety of sectors. Most policy, system, and environmental changes occurred in county health departments, county-wide, or within hospital/health systems. Less common sectors experiencing policy, system, and environmental changes included tribal organizations, county agencies other than health departments, coordinated care organizations, retail stores, schools, farmers markets, city parks & recreation, community gardens, and local non-profit organizations.

Table 9 shows the sectors where policy, system, and environmental changes were implemented, the number of policy, system, and environmental changes implemented in each sector, and the number of grantees that implemented a change in each sector.

Findings: Grantee Perspectives on Policy, System, and Environmental Change Efforts

Healthy Communities Program (2012–2016) coordinators were asked to select two local policy, system, and environmental (PSE) changes they achieved that made the most difference or progress towards achieving their Healthy Communities Program objectives. Coordinators were also asked to select two PSE changes they worked on but were unable to make substantial progress toward achieving. Some coordinators identified greater or fewer than two "most" or "less" successful PSE changes.

Most Successful PSE

Grantees listed a variety of types of PSE changes as their "most successful" with food policies being the most commonly mentioned.

Figure 4 details the number of grantees who indicated each type of policy as being most successful. The figure shows that seven grantees indicated a food policy as being most successful. Figure 5 illustrates the number of most successful PSE that were indicated for each type of policy. Nine of the most successful PSE that were identified by grantees were food policies. Figure 6 shows in greater detail the number of most successful PSE that were listed for each type of food policy.

Figure 4: Most Successful PSE by Grantee

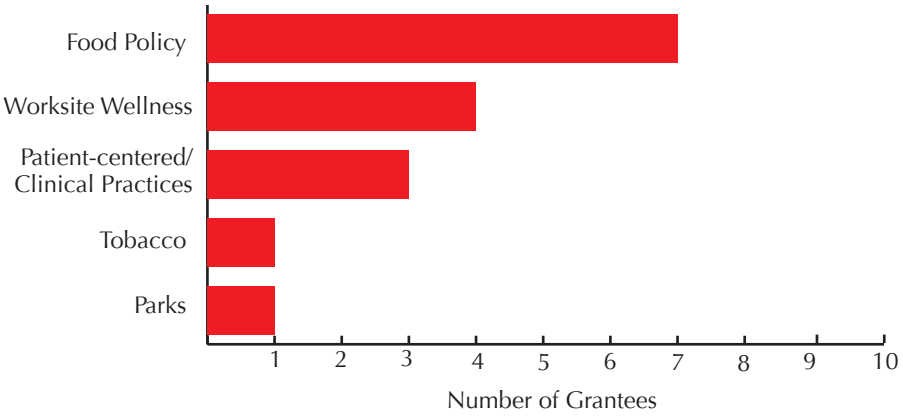


Figure 5: Most Successful PSE by Policy

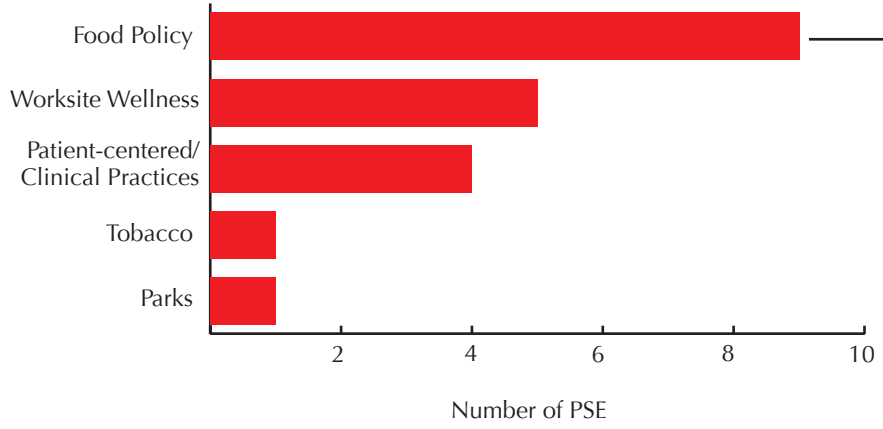
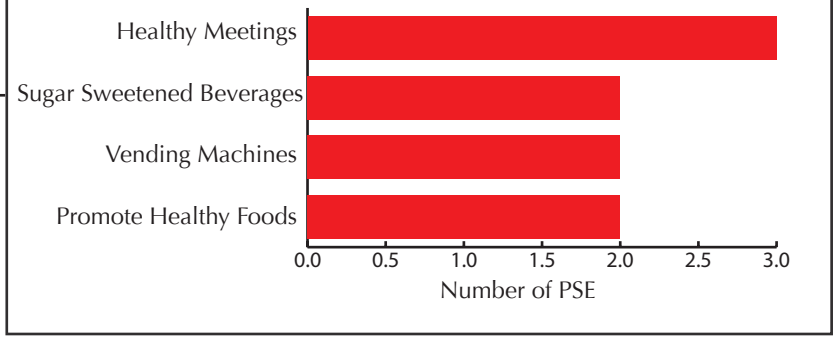


Figure 6: Food Policy Breakdown (Most Successful)



Findings: Grantee Perspectives on Policy, System, and Environmental Change Efforts

Less Successful PSE

Grantees listed many different types of PSE changes that proved difficult to achieve. Food-related changes were more frequently listed as being "less successful" or more challenging to accomplish than other changes.

Figure 7 details the number of grantees who indicated each type of policy as being less successful. The figure shows that eight grantees indicated a food policy as being less successful. Figure 8 displays the number of less successful PSE that were indicated for each type of policy. Of the 17 less successful PSE identified by grantees, 10 of them were food policies. Figure 9 shows in greater detail the number of less successful PSE that were listed for each type of food policy.

Figure 7: Less Successful PSE by Grantee

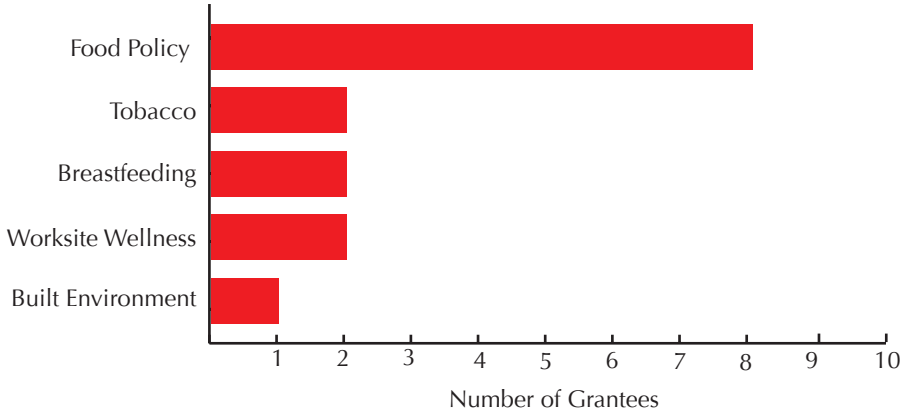


Figure 8: Less Successful PSE by Policy

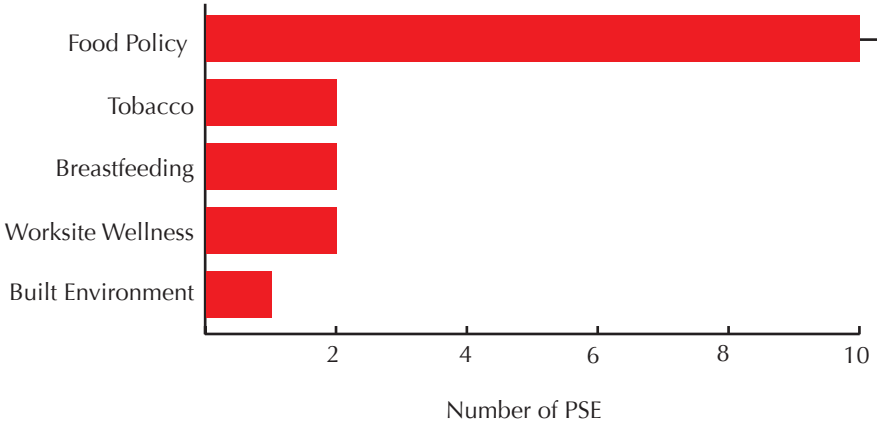


Figure 9: Food Policy Breakdown (Less Successful)

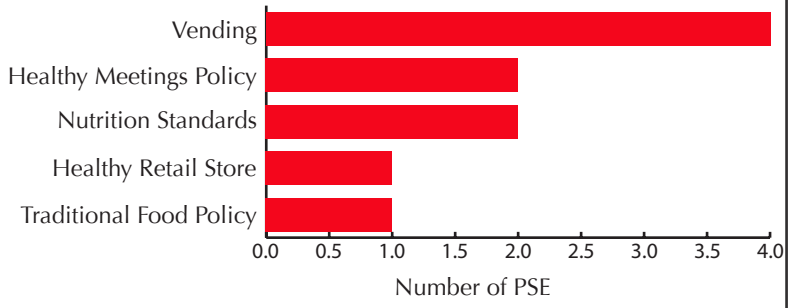
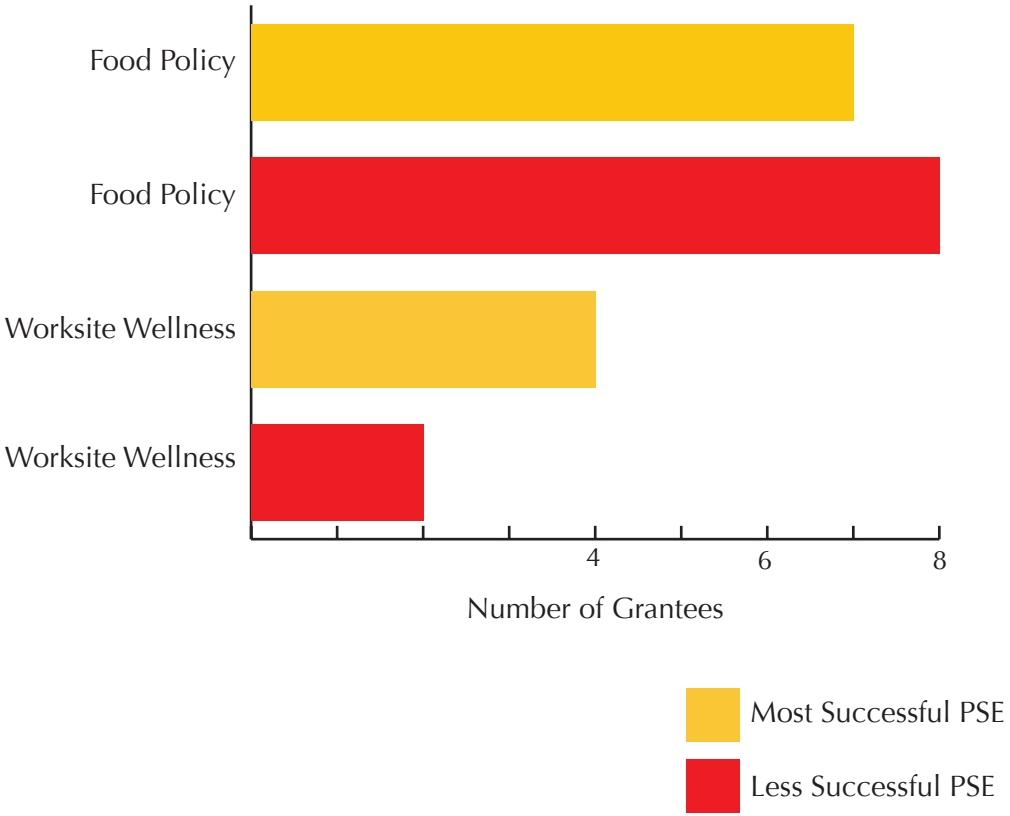


Figure 10: Comparison of Most/Less Successful PSE by Grantee



Most and Less Successful PSE

While coordinators noted success in food-related and worksite wellness policy efforts, food-related and worksite wellness efforts were also frequently listed as being "less successful" or more challenging to accomplish than other changes. This is due to the fact that some coordinators listed more than one item in response to the "most successful" and "less successful" PSE change questions; and, over the course of the 2012–2016 Healthy Communities Program, individual grantees worked on numerous food-related PSE change initiatives. For example, a "Corner Store" initiative may have been listed by one grantee as one of their less successful policy change efforts and the same grantee may have listed a sugar-sweetened beverage policy as their most successful policy.

Figure 10 compares the number of grantees that indicated food policies as being most successful to the number of grantees that indicated food policies as being less successful. The figure also compares the number of grantees that indicated worksite wellness policies as being most successful to the number of grantees that indicated them as less successful.

Findings: Grantee Perspectives on Policy, System, and Environmental Change Efforts

Key factors Leading to PSE Success

Local program coordinators were asked what key factors led to success in achieving PSE changes. Coordinators listed a wide variety of factors that led to success in PSE changes.

Key Factors Leading to a Lack of PSE Progress

Coordinators were also asked what key factors led to the lack of progress in achieving the PSE changes they described as less successful. Interviewees mentioned a broad spectrum of factors, with very few dominant themes emerging.

Figure 11 illustrates the key factors leading to successful PSE implementation mentioned by grantees and the number of grantees that indicated each key factor. The figure shows that six grantees identified leadership support as a key factor that lead to PSE success. Figure 12 shows the most commonly mentioned key factors that lead to a lack of PSE progress and the number of grantees that indicated each factor. The figure shows that six grantees identified a lack of leadership support or political reasons as being a key factor that lead to a lack of PSE progress. Figure 13 compares the number of grantees who listed leadership support, funding, or community support as a key factor leading to success to the number of grantees that indicated leadership support, funding, or community support as a key factor leading to lack of PSE progress.

Figure 11: Key Factors Leading to PSE Success

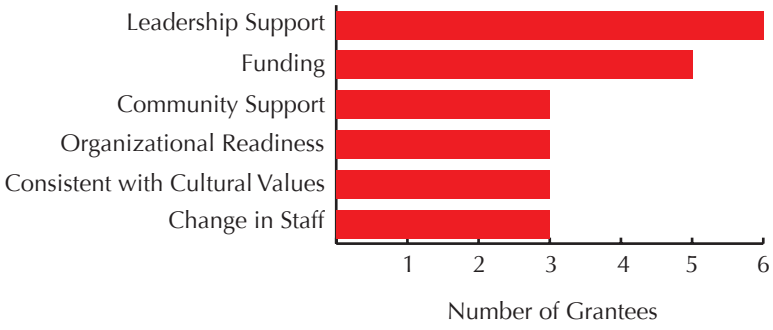


Figure 12: Key Factors Leading to Lack of PSE Progress

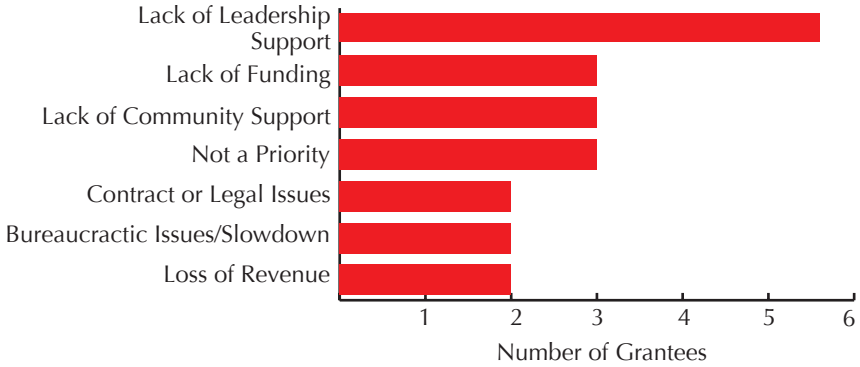
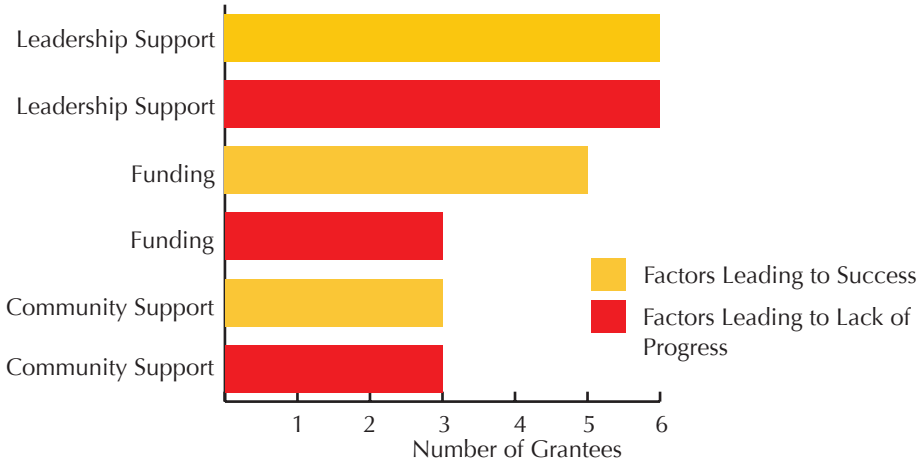


Figure 13: Comparison of Factors Leading to Success/Lack of Progress



"The Health Director here fights to get funding for the program and fights through this as priority, so she's not a champion on any particular issue, but she does support this work in an ongoing way."

—Local Program Coordinator

"Having a good relationship, positive relationship with the county leadership has been a factor in our success."

—Local Program Coordinator

"Diabetes prevention program had a multitude of factors leading to success. Our director has been involved in offering that program for years. She just considers it a necessity that public health should be offering this program. She was very motivated for us to find a way to offer it."

—Local Program Coordinator

"The risk manager at human resources is really committed to this. After the Wellness Committee was formed and started doing activities, the HR director actually said, 'Hey our health claims are down.' He had some hard data that he was attributing to the Wellness Committee. The Risk Manager championed the plan and also presented it to the Employee Benefits Committee. She was a contact throughout that and then having the Human Resources director basically said, 'Oh yeah this is actually saving us money right now' was as key."

—Local Program Coordinator

Important Narratives: Leadership Support

Findings: What Changed

Coordinators were asked what changed in the physical environment, worksite culture or clinical practices as a result of the policy, system, and environmental (PSE) changes implemented by their Healthy Community Program.

In general, local program coordinators struggled with this question and several mentioned a desire to have had the direction and ability (i.e., time and other resources) to focus on tracking outputs and outcomes. Interviewees thought a number of people may have been affected by the PSE change (6/9 interviewees) but were generally unable to provide a specific estimate.

Findings

The food environment (7/9 grantees) was most frequently mentioned in response to the question about what had changed. By way of example, interviewees mentioned the following changes in the food environment:

- Healthy vending policies were implemented
- Healthy food policy (e.g., at meetings or events) were implemented
- Providing healthy options became part of the department's culture
- Food options were added rather than taking options away
- Dessert portion sizes were reduced
- Enlisted participation of local corner stores
- Cappuccino machine was replaced with fruit-infused water
- Cafeteria setting looks different because they changed their ordering practices
- Food policy change started in one hospital (in a larger hospital system) and then became region-wide
- Change in product placement (made healthier choices at eye-level)
- Implemented specific nutrition standards

In addition to changes in the food environment, interviewees mentioned other changes resulting from PSE change:

Employee and general public health screening (2/9 interviewees).

- A blood pressure monitoring machine is now in an open space in the courthouse that anyone can easily access.

Access to, or increased participation in, self-management (2/9 interviewees).

- The self-management programs are now complemented with the diabetes prevention program.

Closed-loop referral (2/9 interviewees).

- Clinics are providing referrals to resources that can help solve problems not addressed by the clinic.

Employees are more active (2/9 interviewees).

- Employees engage in exercise challenge events; the program has built relationships with local gyms to provide partial memberships for employees.

Wellness Committee (2/9 interviewees).

- More interest in the wellness committee among employees; some new members; established a committee; committee has established and promoted new policies; increased leadership and administrative support for the wellness program.

Clinical services: tobacco (2/9 interviewees).

- Clinical service policy now has more trauma-informed content about tobacco use.

Access to healthy foods (1/9 interviewees).

- Clients receive coupons (with monetary value) for the farmers market, giving lower income populations access to fruits and vegetables, hopefully introducing the market to their kids, who hopefully when they're older introduce it to their kids.

Cultural change within the agency or organization (1/9 interviewees).

- Change in agency (Parks and Recreation) culture about how to reach out to families and provide service for families in the community.

"They could now go to the farmers market to get their WIC vouchers for the entire month, not just farmers market vouchers. It brought people that didn't normally go into that type of environment. It's allowing our lower income population to have the access to those fruits and veggies. It's giving them a little bit of incentive to go and so therefore hopefully introducing it to those kids. When those kids are older, they'll introduce it to their kids."

—Local Program Coordinator

"There is more leadership and administrative support for wellness programming. Our wellness committee has been re-established, and we've been able to move some initiatives forward. It seems like there is a lot more momentum now than there was in the past when there were wellness efforts without having a charter established in place because there wasn't that leadership."

—Local Program Coordinator

"Doctors will prescribe fresh fruits and vegetables, exercise, or less screen time instead of a prescription medication. Instead of saying, 'these people with diabetes need to be put on this medication,' they might try affecting diet or affecting exercise."

—Local Program Coordinator

"There is one row of sodas in the vending machine, and they put them all at the bottom, and the rest is water. The same thing with the snack machines, they put the healthier items at eye level."

—Local Program Coordinator

Important Narratives: What Changed

Findings: Additional Leveraged Funding

Grantees were asked if their Healthy Communities program funding was leveraged to secure additional funding for obesity, chronic disease self-management, and/or tobacco prevention.

Findings

- Seven of nine grantees reported receiving additional funding due, at least in part, to local Healthy Communities Program efforts.
- According to their reports, grantees leveraged a total of $5,168,466 from 2012–2016. As shown in Figure 14, additional funds were leveraged from a variety of sources.
- Among counties who did receive additional health promotion funding, amounts leveraged by individual grantees (2012–2016) ranged from $161,499 to $3,460,475.

Figure 14: Source and Amount of Funding Leveraged with Healthy Communities Program Funds

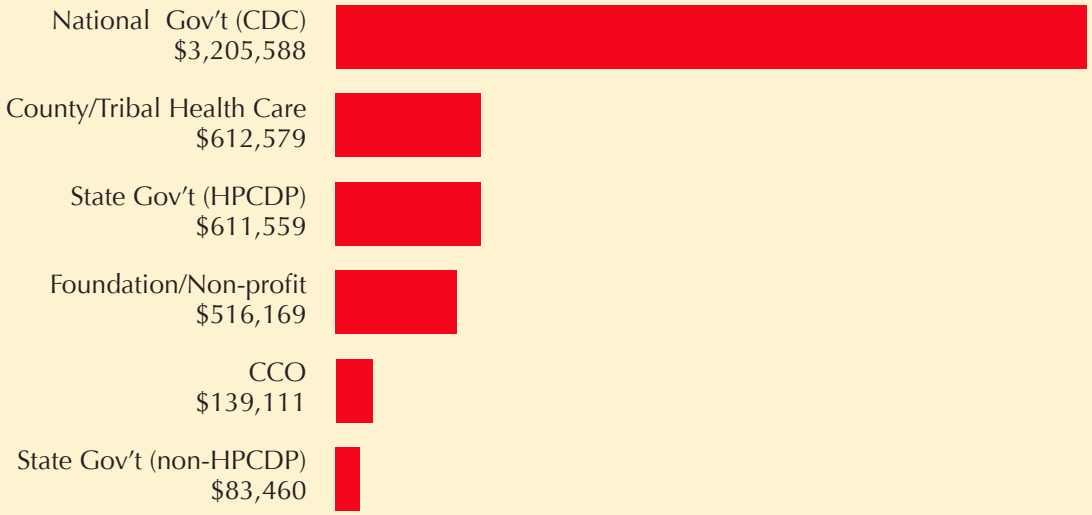


Table 10 details the amount of additional revenue Healthy Communities Program grantees leveraged, by the year it was awarded.

Table 10: Revenue Leveraged by Year Awarded

Year	Revenue
2012	$229,895
2013	$698,950
2014	$3,431,969
2015	$651,962
2016	$155,690
Total	$5,168,466

Brief Survey of Non-Healthy Communities Program County Health Departments

HPCDP surveyed the 27 Oregon county health departments who are not currently receiving Healthy Communities funding to ask the amount of funding they had leveraged from 2012–2016 for obesity, self-management, and/or tobacco prevention. Eight of the 27 counties (30%) responded to the survey. Four of the eight counties reported that they had received some funding ($300,000 cumulatively), and four of the counties reported that they received no additional funding.

"This never would've happened without the Healthy Communities Program. That's a pretty important factor—that the funding was there to be able to support something like this."

—Community Partner

"Before the Healthy Communities Program, the grant and the collaboration with the county, we did not have that program here."

—Community Partner

"Funding, consistency, staff availability, and connection to the community. You have to have those other three things in place to be able to consistently have connection to the community and hear the needs of the community."

—Community Partner

"The ongoing financial supporting staff capacity to support the classes and collect the data and do evaluation of trainers and track the participants and things like that. For sure, staffing capacity."

—Community Partner

"Definitely the funding made it possible just to have that stable funding source to implement it.

—Community Partner

Important Narratives: Funding

Conclusions and Recommendations

Conclusions

- Healthy Communities Program (2012–2016) grantees were:
  - Effective in creating partnerships and champions for local population-based, policy-focused chronic disease prevention efforts.
  - Successful in developing and implementing policy, system, and environmental change (PSE) efforts.
  - Effective in leveraging Healthy Communities Program funding to bring additional health promotion funding into their health departments and communities.

- Local lead health agency leadership (county or tribal) was a critical factor leading to success (or lack of progress) in carrying out the 2012–2016 Healthy Communities Program PSE change efforts.

- Relational work was essential for success in the 2012–2016 Healthy Communities Program grantees' PSE change efforts. Grantees reported that spending time building relationships was important for their work. Community partners echoed this belief.

- Healthy Communities Programs have benefited from consistent funding. The investment in these programs has yielded PSE changes. It has also resulted in new funding, leveraged from the existing funding.

- Collectively and in some cases individually, grantees experienced success and a lack of progress on food policies, tobacco policies, and worksite wellness policies. This result may be attributable to differences in the specific types of food/tobacco/wellness policies pursued, changing circumstances over the grant history (2012–2016), or differences among grantees.

- In addition to success on tobacco and obesity related policies, grantees also experienced successes in a broad spectrum of other chronic disease prevention PSE changes. The fact that funders allowed grantees a variety of options regarding the type of policies efforts they were allowed to undertake may have allowed for a greater overall number of PSE change achievements because grantees had the flexibility to pursue different policy options when a certain option was not currently politically viable.

- Some grantees felt ill-equipped to implement local-level program evaluation activities (for example, tracking and calculating program outputs and outcomes), and therefore struggled to clearly articulate the effects of their local PSE changes. Evaluation activities were not required by HPCDP until FY 2016. Nonetheless, many grantees were able to point to specific changes related to the food environment, achieved through their local programs.

Recommendations

- Funding for healthy communities work can come from a variety of sources including federal, state, and local governments, health care, and other non-governmental sources. County and tribal health departments seeking to improve community health by reducing obesity and tobacco use and increasing screening and self-management should seek funding from all possible sources.

- Decision makers with an interest in improving community health should provide funding to county and tribal health departments to support healthy communities work as a way to accomplish population-based, policy- focused chronic disease prevention. The level of funding and support provided to the 2012–2016 Healthy Communities Program grantees was adequate to produce results in a relatively short period of time.

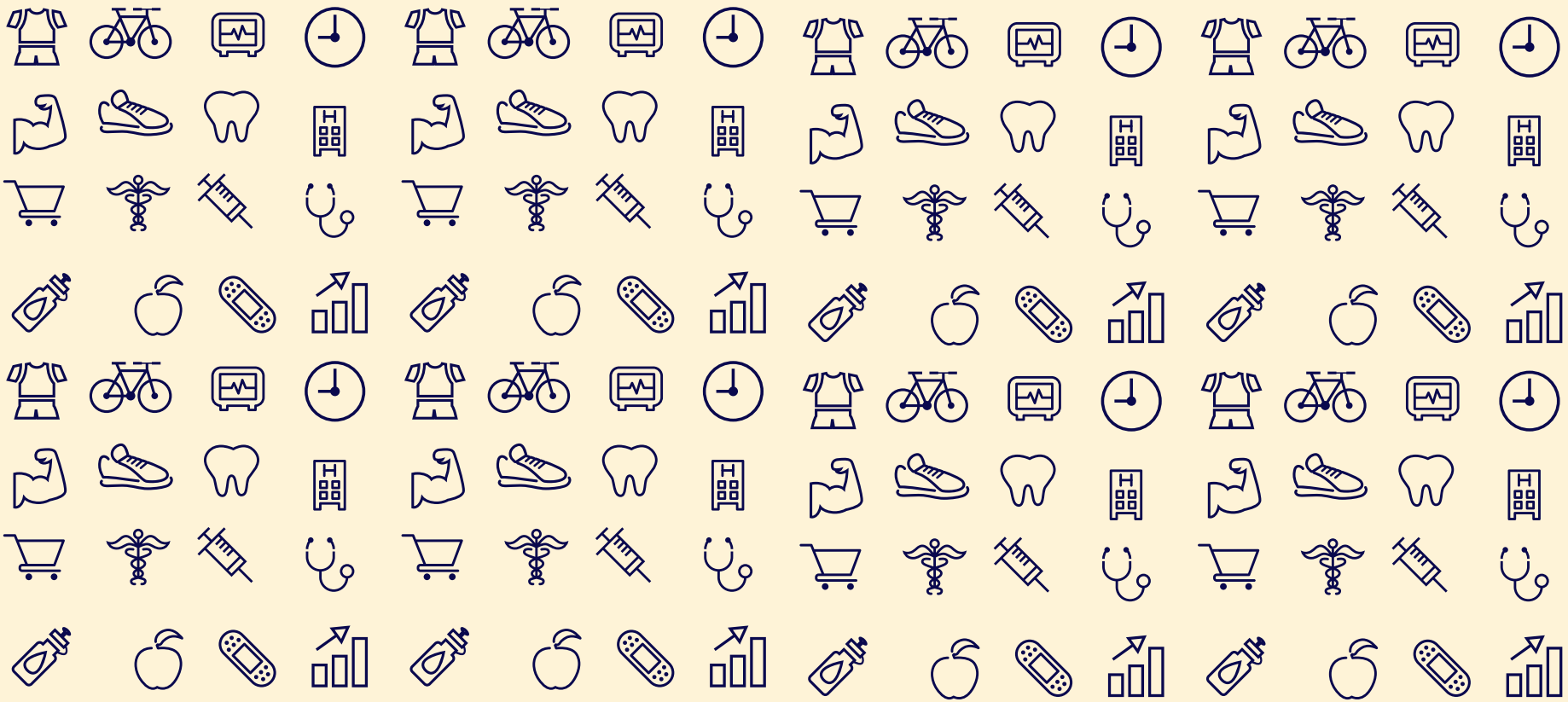
- In order to achieve a greater overall number of policy, system and environment changes accomplished, funders should structure grant programs to allow for a variety of options regarding the types of best practice PSE changes grantees pursue rather than requiring grantees to narrowly focus only on one or two policy options. This may allow grantees to more efficiently navigate policy change process and external factors affecting them.

- Funders must understand the critical role of health department leadership in ensuring the success of policy-focused, chronic disease prevention programs and should structure programs in a way that either: 1) funds only those agencies where supportive leadership is present, or 2) builds supportive leadership as a function of the grant.

- Individuals coordinating local policy-focused, chronic disease prevention efforts should be allowed time and flexibility to build trusting relationships with community partners. Support for this time allocation must exist among funders and local agency leadership.

- While allowing time for building trusting relationships is important, the program focus should remain on PSE change, and local coordinators should be able to explain or demonstrate how their partnership efforts are setting the stage for eventual PSE change.

- Funders should plan for and incorporate evaluation activities into grant requirements from the onset of the program.



Executive Summary Report

Executive Summary Report

The following pages contain an executive summary report. Rede Group produced this report as a stand alone document for the Healthy Communities Program Evaluation.

The Oregon Healthy Communities Program (2012-2016) Evaluation Summary

+800 Community partnerships established

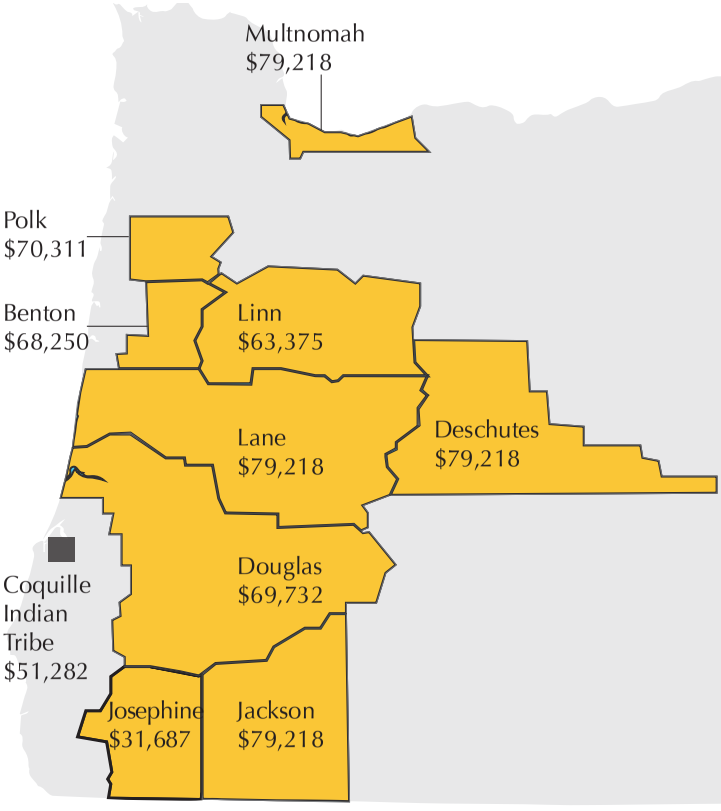
120 Health policy, system, or environmental changes

$5,100,000 Additional funds leveraged for local health promotion

Healthier communities help to cultivate a healthy, more productive workforce fueling future economic growth.*

Policy, system, and environmental change are the building blocks to healthier communities because they help to create environments where all people have access to healthy options.

Healthier communities attract more talented employees and a healthier customer base, which can strengthen their economies.*



Dollar amounts represent average annual Healthy Community grants per county/tribe since 2012.

Program Description

The Oregon Healthy Communities Program focuses on policy, system, and environmental changes such as making sure that healthy foods are available to the entire community, creating systems to ensure that people access cancer screenings, and creating environments where walking and biking are safer.

Through the program, which is funded by the Oregon Health Authority, Health Promotion and Chronic Disease Prevention Section, county and tribal health departments receive small amounts of money, based on a competitive process. Overall the goals of the program are to prevent obesity and tobacco use and promote cancer screening and disease self-management.

During 2012 – 2016, ten local public health departments (nine counties and one tribe) received Healthy Communities Program funding.

*Robert Wood Johnson Foundation, Healthy Communities Issue Brief, April 2016

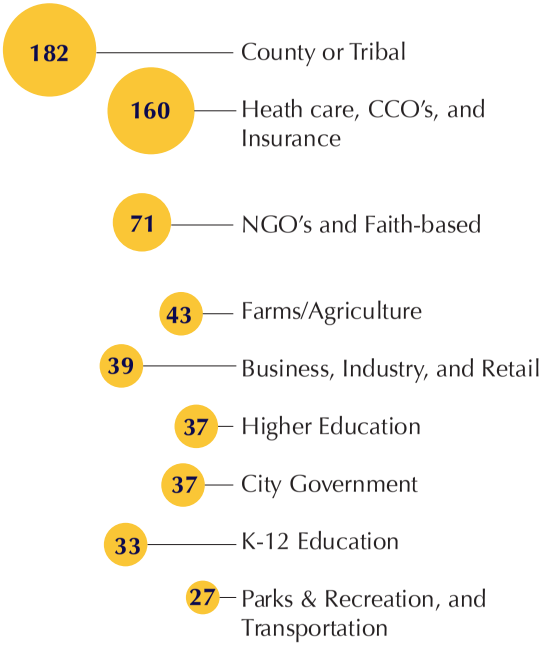
Partnerships

+800 **Community partnerships established**

Strong partnerships create the foundation for achieving sustainable change in communities. In the Healthy Communities Program evaluation, partnerships were described as a key factor leading to success.

Healthy Communities grantees were highly effective in establishing and maintaining partnerships. Overall, they partnered with over 800 organizations. All grantees reported having established between 50 and 135 partnerships individually.

There is a broad cross-section of partner organizations, including but not limited to:



- All grantees partnered with their local Coordinated Care Organization (CCO) and with a county or tribe other than their own.
- Most grantees partnered with their local OSU Extension Service; many also partnered with their local food bank or farmer's markets.

"We really see ourselves as the convener. We're good at bringing people together and starting conversations. I think without us, these conversations wouldn't necessarily happen."

—Mac Gillespie, Benton County

"Having a method where we can share the benefits of promoting each other's ideas has been amazing."

—Kim Curley, Deschutes County

Policy, System, and Environmental Change

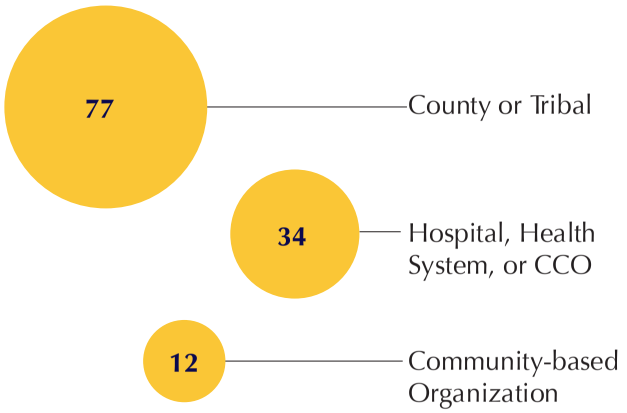
120 **Policy, system, or environmental changes**

Policy, system, and environmental change are the building blocks to healthier communities because they help to create environments all people have access to healthy options.

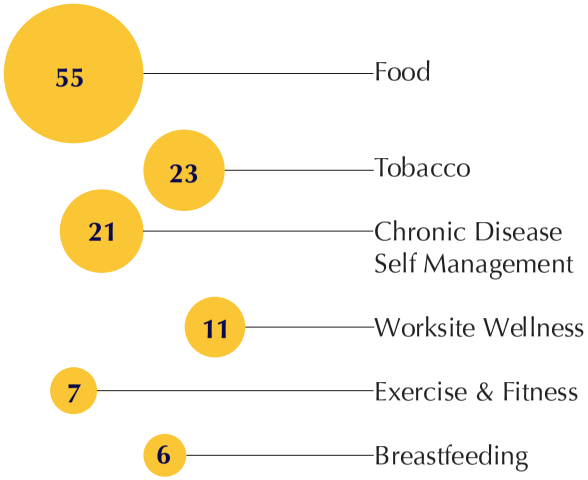
Local Healthy Communities programs passed a total of 120 policy, system, or environmental changes from 2012- 2016, averaging 30 per year.

Policy, system, and environmental changes covered a compendium of chronic disease prevention topics across a broad spectrum of types of organizations.

Sectors affected by policy, system, and environmental changes:



Types of policy, system, or environmental changes:



"It really became a part of our department's culture to have and provide healthy and positive options."

—Alinna Ghavami, Polk County

Examples of how policy, system, and environmental changes made a difference in Oregon communities:

Access to healthy foods was increased, and access to unhealthy foods was decreased.

- Multiple vending machine, meeting food, and sugar sweetened beverage policies made more healthy foods available at health departments, health systems and county agencies.

Employees at many workplaces had better access to physical activity.

- Employees participated in physical activity challenge events and some healthy communities programs built relationships with local gyms to provide partial memberships for employees.

Employees and general public received health screenings.

- A blood pressure monitoring machine was put in an open space in a county courthouse where anybody can access it.

Closed-loop referral process and clinical services were put into place at various clinics.

- Clinics provided referrals to resources that can help solve problems not addressed by the clinic.

Employees experienced worksites that promoted health.

- Worksite Wellness Committees were developed and activated in many grantee organizations, establishing policies that support breastfeeding in some cases.

Increased access to or utilization of physical activity for community members.

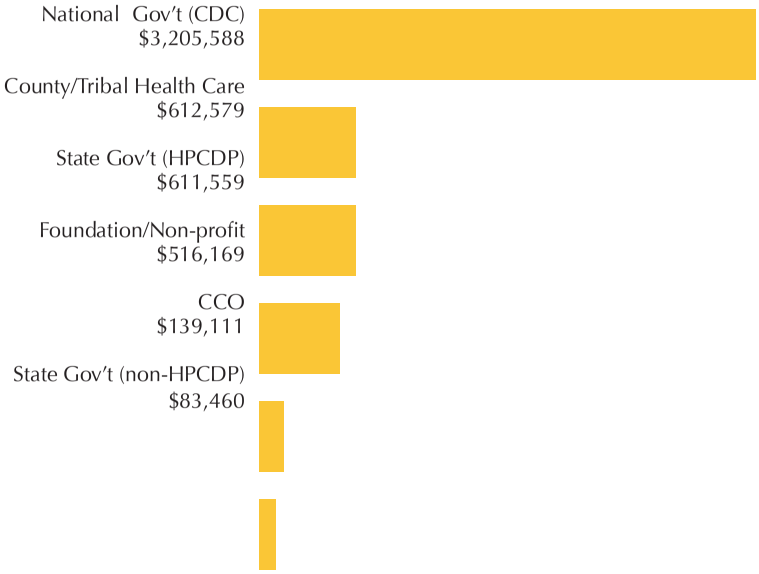
- A parks department was mentored by a Healthy Communities Program in how to reach out to specific communities; their efforts dramatically increased use.

Additional Leveraged Funding

$5,100,000 **Additional funds leveraged**

Healthy Communities counties were far more successful in leveraging resources than non-healthy communities counties. Throughout the program, they generated a conservative estimate of $5.1 million.

Additional funds were leveraged from:



Why were HC programs successful?

Leadership support

Leadership support within County Health/ HHS departments was mentioned by more program staff than any other factor contributing to policy, system, or environmental change success.

Dedicated funding

Dedicated funding for chronic disease prevention work, whether provided by the Healthy Communities grant or another leveraged source, was also critical to PSE success.

Supportive Environment

Supportive community partners, organizational readiness, and staff changes that lead to a supportive environment, and the policy, system, or environmental change being a good fit with the

The Healthy Communities Program is an effective model and well worth the investment.

Conclusions

- The Healthy Communities Program was worth the investment. A lot was accomplished in a short amount of time.
- Provided with additional and continued funding, Healthy Communities grantees could generate even more revenue for local health promotion.
- Consistent funding is crucial for Healthy Communities efforts to continue to develop the breadth of policy, system, and environmental change work and for it to be sustainable overtime.
- Leadership support is very important in achieving policy, system, and environmental changes
- Success looks different for each county, allowing for a broad use of grant funding will result in more success for all grantees
- Allowing grantees time and space to foster community partnerships as well as flexibility to work on various policy, system, and environmental change efforts were critical

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For a complete summary report of this evaluation or for more information contact: sarah.hargand@state.or.us

Appendices

User Panel Members

User Panelist	Title	Organization
Sarah Hargand	Evaluation Specialist	Oregon Public Health Division
Leah Fisher	Community Programs Liaison	Oregon Public Health Division
Elizabeth Barth	Healthy Communities Coordinator	Multnomah County
Fauna Larkin	Assistant Health and Human Services Administrator	Coquille Indian Tribe
Renee Mulligan	Healthy Communities Coordinator	Lane County
Robin Stalcup	TPEP Coordinator, Public Health Lead	Adapt

Healthy Communities Survey

If you have any questions or concerns about the survey please call Rede Group at (503) 764-9696 and ask to speak with Alex McFerrin or Jill Hutson. We are more than willing to assist with the survey in any way we can or administer the survey in another format if that is helpful.

POLICY, SYSTEMS, and ENVIRONMENTAL CHANGES ENACTED

The first three questions ask about public and private policy, systems, and environmental changes that were enacted through your local Healthy Communities Program. The goal of these questions is to form a complete and refined list of all the policy, systems, and environmental changes that were enacted through your local Healthy Communities Program (Fiscal Years 2013-2016). To help you respond to these questions, you may wish to jot down a list of policy, systems, and environmental changes that have changed as a result of your local Healthy Communities Program (Fiscal Years 2013 – 2016). If there are periods of time during this grant (Fiscal Year 2013 – 2016) that you were not involved with this program, you may wish to check with your supervisor or others in your health department to help create the list.

1. Based on a review of the HPCDP Policy Database and grantee interview summaries, your county has passed the following **public or private policies:**

a. Are there any policies listed above that are incorrect, duplicated, or ones that your local Healthy Communities Program was not involved in passing (that is, they were accomplished solely by the tobacco program or others in the community)? If so, please delete them from the list.

b. Are there public or private policies that were passed as a result (in whole or part) of your local Healthy Communities Program that are not listed? If so, please list them here including the name of the policy change and the organization, entity, or worksite affected. For example: Healthy meeting food policy, Oregon Public Health Division. Only include policies that have changed or passed – do not include policies that are in progress at this time:

2. Based on a review of grantee interview summaries the following Systems and Environmental Changes were enacted as a result (in whole or part) of work accomplished through your local Healthy Communities Program:

a. Are there any systems and environmental changes listed above that are incorrect, duplicated, or ones that your local Healthy Communities Program was not involved in passing (that is, they were accomplished solely by the tobacco program or others in the community)? If so, please delete them from the list.

b. Are there systems or environmental changes that were passed as a result (in whole or part) of your local Healthy Communities Program that are not listed? If so, please list them here including the name of the systems or environmental change and the organization, entity, or worksite affected. For example: Worksite Wellness Committee established with dedicated five year resource allocation, Oregon Public Health Division. Only include systems and environmental changes that are in place – do not include items that are in progress at this time:

3. Based on a review of grantee interview summaries the following policy, systems, and environmental change efforts are underway at your county:

a. Are there any policies, system, and environmental change efforts listed above that are incorrect, duplicated, or ones that your local Healthy Communities Program is not currently involved in (that is, that were already accomplished or that you are no longer working on)? If so, please delete them from the list.

b. Are there policy, systems, and environmental changes missing from this list? If so, please list them here including the policy, systems, or environmental change and the organization, entity, or worksite that it will affect. For example, healthy vending, Boys and Girls Club of America.
List items here:

PARTNERSHIPS

This section of the survey asks questions about partnerships that have been developed through your local Healthy Communities Program. With the understanding that there are different levels of partnerships, Questions 4 a. and b. ask about all partnerships (**any** entity/individual involved with you in healthy communities work).

4. Based on a review of grantee interview summaries the following list of agencies/individuals that are/were engaged as partners, in

some way, with your local Healthy Communities Program (Fiscal Years 2013-2016):

a. Are there entities/individuals listed above that are incorrect, duplicated, or ones that you would not consider a partner in some aspect of your local Healthy Communities Program? If yes, please delete them from the list.

b. Are there entities/individuals who are or have been partners that are not listed above? If yes, please list them here:

c. Looking back at the list of policy, systems, and environmental changes from Questions 1-3, think about which partners participated in your policy, systems, and environmental changes. List the partners below:

d. Of all the partners involved in your Healthy Communities Program, which if any, would you consider to be strategic partners. Strategic partners are entities/individuals who share your mission to improve health and are in a position to have a substantial impact on your efforts. Strategic partners may be internal or external to your agency. They are partners who:

- Had a direct impact on policy, systems, and environmental changes accomplished through the Healthy Communities Program
- Shared a goal(s) that is aligned with Healthy Communities goals
- Have demonstrated long term (more than two years) commitment to the success of the Healthy Communities Program

List strategic partners below (entries may overlap with 4 c. above):

e. Please provide the names of 4 to 5 individuals that we can contact to conduct a brief (20 minutes or less) interview about the partnerships that have been formed through your local Healthy Communities Program. Your list might include individuals from within your health department and external partners. In providing a list try, to include partners that represent various and diverse sectors within your communities with whom you've developed partnerships. You do not need to include policy makers but may if you choose. Rede will conduct interviews with 2 to 3 of these partners but will not contact them until we have your permission to do so; providing names on this survey is solely for the purpose of developing a list.

LEAVERAGED RESOURCES

In this section you'll be asked to supply information about whether or not Healthy Communities funding was used to secure additional funding for obesity, self-management, and/or tobacco prevention. If you're unfamiliar with the history of funding to your health department or community, you might want to check with your supervisor or community partners to identify funding that came into the community as a result (in whole or part) of your local Healthy Communities Program. You'll want to know the funding source, amount,

and year as well as the role (in very general terms) that your local Healthy Communities Program played in securing funding.

In the spaces provided below, please provide information about funding for obesity and tobacco prevention that was secured due in whole or part to the Healthy Communities Program funding/work. For example:

Fund/Grant Title: HEAL Grants
Source: Oregon Public Health Institute
Amount: $4,000.00
Year: 2014
Role of Healthy Communities Coordinator in Securing Funding: The Healthy Communities Coordinator collaborated with the City of Dallas to secure a HEAL City Grant from the Oregon Public Health Institute.

Please complete the following for each item of leveraged funding:

Item 1
Name:
Source:
Amount:
Year:
Role of Healthy Communities Program in securing funding:

Item 2
Name:
Source:
Amount:
Year:
Role of Healthy Communities Program in securing funding:

Item 3
Name:
Source:
Amount:

Year:
Role of Healthy Communities Program in securing funding:

Item 4
Name:
Source:
Amount:
Year:
Role of Healthy Communities Program in securing funding:

If you have additional sources of funding you may copy and paste from above for additional items.

Local Program Coordinators Surveyed

Interviewee	Title	Organization
Mac Gillespie	Healthy Communities Coordinator	Benton County
Dennita Antonellis-John	Healthy Communities Coordinator	Coquille Indian Tribe
Sarah Worthington	Healthy Communities Coordinator	Deschutes County
Shawna Hormann	Healthy Communities Coordinator	Douglas County
Kate Roberts	Healthy Communities Coordinator	Josephine County
Jane Stevenson	Healthy Communities Coordinator	Jackson County
Renee Mulligan	Healthy Communities Coordinator	Lane County
Erin Sadlacek	Healthy Communities Coordinator	Linn County
Elizabeth Barth	Healthy Communities Coordinator	Multnomah County
Alinna Ghavami	Healthy Communities Coordinator	Polk County

Local Program Coordinator Follow-up Survey of Leveraged Resources Instrument

Dear Local Program Coordinator,

Rede Group administered a Healthy Communities Evaluation survey asking you to provide information about additional resources that were leveraged using Healthy Communities resources.

We have compiled your list of additional funding for obesity, self-management, and/or tobacco prevention that was secured in whole or part of Healthy Communities Program funding/work.

In the document I have provided below we have listed the name of the funding, the type of funding, the funding source, the total amount of funding awarded, the year the funding was awarded, and the term of the funding. This list also includes a brief description of the role of Healthy Communities Program in securing the funding.

We ask that you review this list and verify that it is correct. We are mostly looking for you to verify that the total amount funded and the year the amount was awarded is correct. If there is any funding that is not included in this list please add that information.

Could you please either respond that the list is correct or respond with an updated list.

Let me know if you have any questions.

Thank you,

XXX Leveraged Resources

County/Tribe	Name	Type of Funding	Source	Total Amount Funded	Year Funding Awarded	Term of Funding	Role of Healthy Communities Program in securing funding
XXX	Sodium Reduction in Communities	State Government	OHA, HPCDP	$102,000	2014	2014-16	Coordinator, secured the funding.
XXX	Delivery System Transformation to **XXX** County Public Health, Colorectal Cancer Screening Project	CCO	IHN-CCO	$41,000	2015	2015-16	Coordinator, reached out to CCO, **XXX** and **XXX** and secured funding.
XXX	HEAL Grant to City of **XXX**	Health Care	Oregon Public Health Institute	$8,600	2015		Letter of Support
XXX	**XXX** Health Equity Alliance	State Government	OHA	$16,200	2013	2013-15	Collaborated internally to secure funding.
XXX	**XXX** Health Equity Alliance	State Government	OHA	$9,000	2014	2014-15	Collaborated internally to secure funding.
XXX	SRCH	State Government	OHA	$11,121	2015		Collaborated internally to secure funding.
XXX	Recreational Trails Grant: **XXX**	State Government	Oregon Parks and Recreation Department	$21,520	2014		Letter of Support

Healthy Communities Program Grantee Budgets 2008–2016				
Grantee	**Months**	**Years**	**Total Requested**	**Funding Cycle**
Multnomah County	March-June	2008	$11,691	2008-2009 TROCD Cohort 1
Multnomah County	July-December	2008	$20,804	2008-2009 TROCD Cohort 1
Jackson County	July-December	2008	$25,898	2008-2009 TROCD Cohort 1
Jackson County	April-June	2008	$6,606	2008-2009 TROCD Cohort 1
Deschutes County	March-June	2008	$13,000	2008-2009 TROCD Cohort 1
Deschutes County	July-December	2008	$19,500	2008-2009 TROCD Cohort 1
Coos County	March-June	2008	$12,871	2008-2009 TROCD Cohort 1
Coos County	July-December	2008	$19,643	2008-2009 TROCD Cohort 1
Marion County	July-December	2008	$19,925	2008-2009 TROCD Cohort 1
Marion County	March-June	2008	$12,575	2008-2009 TROCD Cohort 1
Columbia County	March-June	2008	$11,274	2008-2009 TROCD Cohort 1
Columbia County	July-December	2008	$21,216	2008-2009 TROCD Cohort 1
Klamath County	July-December	2008	$16,673	2008-2009 TROCD Cohort 1
Klamath County	March-June	2008	$15,827	2008-2009 TROCD Cohort 1
Yamhill County	July-December	2008	$20,172	2008-2009 TROCD Cohort 1
Yamhill County	March-June	2008	$12,328	2008-2009 TROCD Cohort 1
Clatsop County	July-December	2008	$19,000	2008-2009 TROCD Cohort 1
Clatsop County	March-June	2008	$13,500	2008-2009 TROCD Cohort 1
Jefferson County	April-June	2008	$10,830	2008-2009 TROCD Cohort 1
Jefferson County	July-December	2008	$21,668	2008-2009 TROCD Cohort 1
Benton County	March-June	2008	$13,000	2008-2009 TROCD Cohort 1
Lane County	March-June	2008	$13,000	2008-2009 TROCD Cohort 1
Lane County	July-December	2008	$19,500	2008-2009 TROCD Cohort 1
Multnomah County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Lane County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Klamath County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Jefferson County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Jackson County (budget extension)	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Coos County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1

Deschutes County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Clatsop County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Yamhill County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Columbia County	Jan-June	2009	$16,250	2008-2009 TROCD Cohort 1
Yamhill County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Washington County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Lincoln County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Tillamook County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Wallowa County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Union County	July 2009-June 2010	2009-2010	$32,493	2008-2009 TROCD Cohort 2
Linn County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Josephine County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Wasco County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Umatilla County	July 2009-June 2010	2009-2010	$32,498	2008-2009 TROCD Cohort 2
Polk County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Hood River County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Crook County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Benton County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Clatsop County	July 2009-June 2010	2009-2010	$48,750	2009-2010 TROCD
Columbia County	July 2009-June 2010	2009-2010	$48,750	2009-2010 TROCD
Coos County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Deschutes County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Jackson County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Jefferson County	July 2009-June 2010	2009-2010	$48,750	2009-2010 TROCD
Klamath County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Lane County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Marion County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Multnomah County	July 2009-June 2010	2009-2010	$81,250	2009-2010 TROCD
Yamhill County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Baker County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Clackamas County	July 2010-June 2011	2010-2011	$29,037	2010-2011 HC Building Capacity

Crook County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Curry County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Douglas County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Harney County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Hood River County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Josephine County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Lincoln County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Linn County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Malheur County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Morrow County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
North Central (Wasco, Sherman, and Gilliam County)	July 2010-June 2011	2010-2011	$97,500	2010-2011 HC Building Capacity
Polk County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Tillamook County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Umatilla County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Union County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Wallowa County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Washington County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Wheeler County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Benton County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Clatsop County	July 2010-June 2011	2010-2011	$48,750	2010-2011 HC Implementation
Columbia County	July 2010-June 2011	2010-2011	$48,750	2010-2011 HC Implementation
Coos County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Deschutes County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Jackson County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Jefferson County	July 2010-June 2011	2010-2011	$48,750	2010-2011 HC Implementation
Klamath County	July 2010-June 2011	2010-2011	$64,992	2010-2011 HC Implementation
Lane County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Marion County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Multnomah County	July 2010-June 2011	2010-2011	$81,250	2010-2011 HC Implementation
Yamhill County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Benton County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation

Clatsop County	July 2011-June 2012	2011-2012	$48,750	2011-2012 HC Implementation
Coos County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation
Deschutes County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation
Klamath County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation
Lane County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation
Multnomah County	July 2011-June 2012	2011-2012	$81,250	2011-2012 HC Implementation
Columbia County	July 2011-June 2012	2011-2012	$48,750	2011-2012 HC Implementation
Marion County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation
Yamhill County	July 2011-June 2012	2011-2012	$93,961	2011-2012 HC Implementation
Deschutes County	July 2012-June 2013	2012-2013	$81,250	2012-2013 HC Implementation
Benton County	July 2012-June 2013	2012-2013	$70,000	2012-2013 HC Implementation
Coquille Indian Tribe	July 2012-June 2013	2012-2013	$52,597	2012-2013 HC Implementation
Douglas County	July 2012-June 2013	2012-2013	$71,520	2012-2013 HC Implementation
Jackson County	July 2012-June 2013	2012-2013	$81,250	2012-2013 HC Implementation
Josephine County	July 2012-June 2013	2012-2013	$32,500	2012-2013 HC Implementation
Lane County	July 2012-June 2013	2012-2013	$81,250	2012-2013 HC Implementation
Linn County	July 2012-June 2013	2012-2013	$65,000	2012-2013 HC Implementation
Multnomah County	July 2012-June 2013	2012-2013	$81,250	2012-2013 HC Implementation
Polk County	July 2012-June 2013	2012-2013	$45,620	2012-2013 HC Implementation
Benton County	July 2013-June 2014	2013-2014	$70,000	2013-2014 HC Implementation
Coquille Indian Tribe	July 2013-June 2014	2013-2014	$52,597	2013-2014 HC Implementation
Douglas County	July 2013-June 2014	2013-2014	$71,520	2013-2014 HC Implementation
Jackson County	July 2013-June 2014	2013-2014	$81,250	2013-2014 HC Implementation
Josephine County	July 2013-June 2014	2013-2014	$32,500	2013-2014 HC Implementation
Multnomah County	July 2013-June 2014	2013-2014	$81,250	2013-2014 HC Implementation
Polk County	July 2013-June 2014	2013-2014	$81,250	2013-2014 HC Implementation
Lane County	July 2013-June 2014	2013-2014	$81,250	2013-2014 HC Implementation
Linn County	July 2013-June 2014	2013-2014	$65,000	2013-2014 HC Implementation
Deschutes County	July 2013-June 2014	2013-2014	$81,250	2013-2014 HC Implementation
Benton County	July 2014-June 2015	2014-2015	$70,000	2014-2015 HC Implementation
Douglas County	July 2014-June 2015	2014-2015	$71,520	2014-2015 HC Implementation

Coquille Indian Tribe	July 2014-June 2015	2014-2015	$52,597	2014-2015 HC Implementation
Deschutes County	July 2014-June 2015	2014-2015	$81,250	2014-2015 HC Implementation
Jackson County	July 2014-June 2015	2014-2015	$81,250	2014-2015 HC Implementation
Josephine County	July 2014-June 2015	2014-2015	$32,500	2014-2015 HC Implementation
Polk County	July 2014-June 2015	2014-2015	$81,250	2014-2015 HC Implementation
Multnomah County	July 2014-June 2015	2014-2015	$81,250	2014-2015 HC Implementation
Lane County	July 2014-June 2015	2014-2015	$81,250	2014-2015 HC Implementation
Linn County	July 2014-June 2015	2014-2015	$65,000	2014-2015 HC Implementation
Benton County	July 2015-June 2016	2015-2016	$63,000	2015-2016 HC Implementation
Deschutes County	July 2015-June 2016	2015-2016	$73,125	2015-2016 HC Implementation
Douglas County	July 2015-June 2016	2015-2016	$64,368	2015-2016 HC Implementation
Josephine County	July 2015-June 2016	2015-2016	$29,250	2015-2016 HC Implementation
Jackson County	July 2015-June 2016	2015-2016	$73,125	2015-2016 HC Implementation
Lane County	July 2015-June 2016	2015-2016	$73,125	2015-2016 HC Implementation
Linn County	July 2015-June 2016	2015-2016	$58,500	2015-2016 HC Implementation
Polk County	July 2015-June 2016	2015-2016	$73,125	2015-2016 HC Implementation
Multnomah County	July 2015-June 2016	2015-2016	$73,125	2015-2016 HC Implementation
Coquille Indian Tribe	July 2015-June 2016	2015-2016	$47,337	2015-2016 HC Implementation

Healthy Communities TROCD Cohort 1 (2008–2009) Grantee Budgets				
Grantee	**Months**	**Years**	**Total Requested**	**Funding Cycle**
Multnomah County	March-June	2008	$11,691	2008-2009 TROCD Cohort 1
Multnomah County	July-December	2008	$20,804	2008-2009 TROCD Cohort 1
Jackson County	July-December	2008	$25,898	2008-2009 TROCD Cohort 1
Jackson County	April-June	2008	$6,606	2008-2009 TROCD Cohort 1
Deschutes County	March-June	2008	$13,000	2008-2009 TROCD Cohort 1
Deschutes County	July-December	2008	$19,500	2008-2009 TROCD Cohort 1
Coos County	March-June	2008	$12,871	2008-2009 TROCD Cohort 1
Coos County	July-December	2008	$19,643	2008-2009 TROCD Cohort 1
Marion County	July-December	2008	$19,925	2008-2009 TROCD Cohort 1
Marion County	March-June	2008	$12,575	2008-2009 TROCD Cohort 1
Columbia County	March-June	2008	$11,274	2008-2009 TROCD Cohort 1
Columbia County	July-December	2008	$21,216	2008-2009 TROCD Cohort 1
Klamath County	July-December	2008	$16,673	2008-2009 TROCD Cohort 1
Klamath County	March-June	2008	$15,827	2008-2009 TROCD Cohort 1
Yamhill County	July-December	2008	$20,172	2008-2009 TROCD Cohort 1
Yamhill County	March-June	2008	$12,328	2008-2009 TROCD Cohort 1
Clatsop County	July-December	2008	$19,000	2008-2009 TROCD Cohort 1
Clatsop County	March-June	2008	$13,500	2008-2009 TROCD Cohort 1
Jefferson County	April-June	2008	$10,830	2008-2009 TROCD Cohort 1
Jefferson County	July-December	2008	$21,668	2008-2009 TROCD Cohort 1
Benton County	March-June	2008	$13,000	2008-2009 TROCD Cohort 1
Lane County	March-June	2008	$13,000	2008-2009 TROCD Cohort 1
Lane County	July-December	2008	$19,500	2008-2009 TROCD Cohort 1
Multnomah County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Lane County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Klamath County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Jefferson County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Jackson County (budget extension)	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Coos County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1

Deschutes County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Clatsop County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Yamhill County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1
Columbia County	Jan-June	2009	$16,250	2008-2009 TROCD Cohort 1
Yamhill County	January-June	2009	$16,250	2008-2009 TROCD Cohort 1

Healthy Communities TROCD Cohort 2 (2008–2009) Grantee Budgets				
Grantee	**Months**	**Years**	**Total Requested**	**Funding Cycle**
Crook County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Hood River County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Josephine County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Lincoln County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Linn County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Polk County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Tillamook County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Umatilla County	July 2009-June 2010	2009-2010	$32,498	2008-2009 TROCD Cohort 2
Union County	July 2009-June 2010	2009-2010	$32,493	2008-2009 TROCD Cohort 2
Wallowa County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Wasco County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2
Washington County	July 2009-June 2010	2009-2010	$32,500	2008-2009 TROCD Cohort 2

Healthy Communities TROCD (2009–2010) Grantee Budgets				
Grantee	**Months**	**Years**	**Total Requested**	**Funding Cycle**
Benton County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Clatsop County	July 2009-June 2010	2009-2010	$48,750	2009-2010 TROCD
Columbia County	July 2009-June 2010	2009-2010	$48,750	2009-2010 TROCD
Coos County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Deschutes County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Jackson County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Jefferson County	July 2009-June 2010	2009-2010	$48,750	2009-2010 TROCD
Klamath County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Lane County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Marion County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD
Multnomah County	July 2009-June 2010	2009-2010	$81,250	2009-2010 TROCD
Yamhill County	July 2009-June 2010	2009-2010	$65,000	2009-2010 TROCD

Healthy Communities Building Capacity (2010–2011) Grantee Budgets				
Grantee	**Months**	**Years**	**Total Requested**	**Funding Cycle**
Baker County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Clackamas County	July 2010-June 2011	2010-2011	$29,037	2010-2011 HC Building Capacity
Crook County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Curry County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Douglas County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Harney County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Hood River County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Josephine County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Lincoln County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Linn County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Malheur County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Morrow County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
North Central (Wasco, Sherman, and Gilliam County)	July 2010-June 2011	2010-2011	$97,500	2010-2011 HC Building Capacity
Polk County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Tillamook County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Umatilla County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Union County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Wallowa County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Washington County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity
Wheeler County	July 2010-June 2011	2010-2011	$32,500	2010-2011 HC Building Capacity

Healthy Communities Implementation (2010–2011) Grantee Budgets				
Grantee	**Months**	**Years**	**Total Requested**	**Funding Cycle**
Benton County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Clatsop County	July 2010-June 2011	2010-2011	$48,750	2010-2011 HC Implementation
Columbia County	July 2010-June 2011	2010-2011	$48,750	2010-2011 HC Implementation
Coos County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Deschutes County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Jackson County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Jefferson County	July 2010-June 2011	2010-2011	$48,750	2010-2011 HC Implementation
Klamath County	July 2010-June 2011	2010-2011	$64,992	2010-2011 HC Implementation
Lane County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Marion County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation
Multnomah County	July 2010-June 2011	2010-2011	$81,250	2010-2011 HC Implementation
Yamhill County	July 2010-June 2011	2010-2011	$65,000	2010-2011 HC Implementation

Healthy Communities Implementation (2011–2012) Grantee Budgets				
Grantee	**Months**	**Years**	**Total Requested**	**Funding Cycle**
Benton County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation
Clatsop County	July 2011-June 2012	2011-2012	$48,750	2011-2012 HC Implementation
Columbia County	July 2011-June 2012	2011-2012	$48,750	2011-2012 HC Implementation
Coos County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation
Deschutes County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation
Klamath County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation
Lane County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation
Marion County	July 2011-June 2012	2011-2012	$65,000	2011-2012 HC Implementation
Multnomah County	July 2011-June 2012	2011-2012	$81,250	2011-2012 HC Implementation
Yamhill County	July 2011-June 2012	2011-2012	$93,961	2011-2012 HC Implementation

Healthy Communities Implementation (2012–2013) Grantee Budgets				
Grantee	**Months**	**Years**	**Total Requested**	**Funding Cycle**
Benton County	July 2012-June 2013	2012-2013	$70,000	2012-2013 HC Implementation
Coquille Indian Tribe	July 2012-June 2013	2012-2013	$52,597	2012-2013 HC Implementation
Deschutes County	July 2012-June 2013	2012-2013	$81,250	2012-2013 HC Implementation
Douglas County	July 2012-June 2013	2012-2013	$71,520	2012-2013 HC Implementation
Jackson County	July 2012-June 2013	2012-2013	$81,250	2012-2013 HC Implementation
Josephine County	July 2012-June 2013	2012-2013	$32,500	2012-2013 HC Implementation
Lane County	July 2012-June 2013	2012-2013	$81,250	2012-2013 HC Implementation
Linn County	July 2012-June 2013	2012-2013	$65,000	2012-2013 HC Implementation
Multnomah County	July 2012-June 2013	2012-2013	$81,250	2012-2013 HC Implementation
Polk County	July 2012-June 2013	2012-2013	$45,620	2012-2013 HC Implementation

Healthy Communities Implementation (2013–2014) Grantee Budgets				
Grantee	**Months**	**Years**	**Total Requested**	**Funding Cycle**
Benton County	July 2013-June 2014	2013-2014	$70,000	2013-2014 HC Implementation
Coquille Indian Tribe	July 2013-June 2014	2013-2014	$52,597	2013-2014 HC Implementation
Deschutes County	July 2013-June 2014	2013-2014	$81,250	2013-2014 HC Implementation
Douglas County	July 2013-June 2014	2013-2014	$71,520	2013-2014 HC Implementation
Jackson County	July 2013-June 2014	2013-2014	$81,250	2013-2014 HC Implementation
Josephine County	July 2013-June 2014	2013-2014	$32,500	2013-2014 HC Implementation
Lane County	July 2013-June 2014	2013-2014	$81,250	2013-2014 HC Implementation
Linn County	July 2013-June 2014	2013-2014	$65,000	2013-2014 HC Implementation
Multnomah County	July 2013-June 2014	2013-2014	$81,250	2013-2014 HC Implementation
Polk County	July 2013-June 2014	2013-2014	$81,250	2013-2014 HC Implementation

Healthy Communities Implementation (2014–2015) Grantee Budgets				
Grantee	**Months**	**Years**	**Total Requested**	**Funding Cycle**
Benton County	July 2014-June 2015	2014-2015	$70,000	2014-2015 HC Implementation
Coquille Indian Tribe	July 2014-June 2015	2014-2015	$52,597	2014-2015 HC Implementation
Deschutes County	July 2014-June 2015	2014-2015	$81,250	2014-2015 HC Implementation
Douglas County	July 2014-June 2015	2014-2015	$71,520	2014-2015 HC Implementation
Jackson County	July 2014-June 2015	2014-2015	$81,250	2014-2015 HC Implementation
Josephine County	July 2014-June 2015	2014-2015	$32,500	2014-2015 HC Implementation
Lane County	July 2014-June 2015	2014-2015	$81,250	2014-2015 HC Implementation
Linn County	July 2014-June 2015	2014-2015	$65,000	2014-2015 HC Implementation
Multnomah County	July 2014-June 2015	2014-2015	$81,250	2014-2015 HC Implementation
Polk County	July 2014-June 2015	2014-2015	$81,250	2014-2015 HC Implementation

Healthy Communities Implementation (2015–2016) Grantee Budgets				
Grantee	**Months**	**Years**	**Total Requested**	**Funding Cycle**
Benton County	July 2015-June 2016	2015-2016	$63,000	2015-2016 HC Implementation
Coquille Indian Tribe	July 2015-June 2016	2015-2016	$47,337	2015-2016 HC Implementation
Deschutes County	July 2015-June 2016	2015-2016	$73,125	2015-2016 HC Implementation
Douglas County	July 2015-June 2016	2015-2016	$64,368	2015-2016 HC Implementation
Jackson County	July 2015-June 2016	2015-2016	$73,125	2015-2016 HC Implementation
Josephine County	July 2015-June 2016	2015-2016	$29,250	2015-2016 HC Implementation
Lane County	July 2015-June 2016	2015-2016	$73,125	2015-2016 HC Implementation
Linn County	July 2015-June 2016	2015-2016	$58,500	2015-2016 HC Implementation
Multnomah County	July 2015-June 2016	2015-2016	$73,125	2015-2016 HC Implementation
Polk County	July 2015-June 2016	2015-2016	$73,125	2015-2016 HC Implementation

Brief Survey of Non-Healthy Communities Program (2012-2016) County Health Departments

1. Has your county health department received funds from county general funds or external sources (such as charitable foundations, CCO's, or CDC) other than OHA for obesity prevention, self-management, cancer screening, or tobacco prevention work during the time period July 2012-pressent?

2. If yes, please complete provide the following information about funding received:

Item 1
Fund/Grant Title:
Source:
Total Amount:
Year Funding was Awarded:

Item 2
Fund/Grant Title:
Source:
Total Amount:
Year Funding was Awarded:

Item 3
Fund/Grant Title:
Source:
Total Amount:
Year Funding was Awarded:

OR

2. If yes, please estimate the total amount of funding secured for obesity prevention, self-management, cancer screening, or tobacco prevention work from July 2012- to April 2016

Local Program Coordinator Interview Guide:

Prior to the interview send a "Preparing for the interview" email with:

- PSE list
- Implementation Scale
- Instructions to select 2 PSE items that made the most difference or progress toward achieving the healthy communities program objectives.
- Instructions to select 1-2 PSE items that programs attempted to enact but were not successful

Intro:

Thank you so much for participating on this call today. The purpose of the call is to collect information from local program coordinators about policy, systems and environmental change that happened as a part of the Healthy Communities Program from 2013 to 2016.

This call is being recorded. Responses will be analyzed for themes and none of the information you provide today will be tied back to you in reporting unless we receive your permission to do so.

This call should be approximately 45 minutes. Because we want to stay within the time limit, I may ask that we move onto the next question once I feel like we have adequate information on a particular topic. This is not meant to be rude but rather to stay on track and make sure we get to all the questions. Also, I might interrupt you to clarify a point or ask a follow-up question.

** For Deschutes and Linn only – Because this is the first interview in this phase of data collection, this interview will also serve as a test of this interview tool and format. Based on our experience here today, the interview guide and format may be adjusted.

Do you have any questions before we begin?

1. Let's start with talking about the 2 PSE items you selected to talk about today.

Which items did you select?

List here

Let's talk about the first one:

Appendix G: Local Program Coordinator Survey Interview Guide

1.a. What changed in the physical environment, worksite culture or clinical practices as a result of this policy/system/environmental change? For example, what is different now because of this change?

> Probe for number of people affected. For example, how many people now have access to lactation facilities who didn't before? Or, how many people were exposed to vending machines that were filled with soda and candy but now are not?

1.b. Tell me about key partnerships you developed or utilized in creating this change.

1.c. In your opinion what key factors (1 to 3) led to this policy change effort being successful?

Now, let's talk about the second PSE item you chose.

1.d. What changed in the physical environment, worksite culture or clinical practices as a result of this policy/system/environmental change? For example, what is different now because of this change?

> Probe for number of people affected. For example, how many people now have access to lactation facilities who didn't before? Or, how many people were exposed to vending machines that were filled with soda and candy but now are not?

1.e. Tell me about key partnerships you developed or utilized in creating this change.

1.f. In your opinion what key factors (1 to 3) led to this policy change effort being successful?

2. Now, I'd like you to think about healthy communities policy, systems, and environmental changes you had in your plan or that you wanted to achieve but were not able to achieve. Do you have 1 or 2 examples of policy, systems, or environmental changes efforts that were not successful?

List here:

Let's talk about the first one you listed:

2.a. In your opinion, what key factors (1 to 3 things) led to a lack of progress or success in making this change?

Let's talk about the second one you listed:

2.b. In your opinion, what key factors (1 to 3 things) led to a lack of progress or success in making this change?

Now we are going to switch gears a bit and talk about champions that you have developed or worked with as a part of the healthy communities program. For our purposes today, we are defining a champion as a **person or organization with political or social influence who joins your efforts and uses their influence** to support your issue(s).

3. Using this definition of a champion do you feel you've developed any champions in this program? If so, who?

List here: up to 3

For each person named ask:

3.a. In what ways is this person influential?

3.b. How did you develop them as a champion?

3.c. In what ways did they apply their influence to create change related to program outcomes of the healthy communities program?

3.d. Do you think this individual will continue to champion healthy communities work? If so, in what ways?

4. In the preparation email, we sent your list of PSE changes and an implementation scale. Are there any of your changes for which implementation status would be described as E, F or G on the scale? If so, which ones:

List here

Close:

Thank you so much for your time and attention today. Is there anything you would like to add at this time?

If you have any questions or want to follow-up on anything we talked about today please call or email me.

Implementation Scale For Policy, Systems, and Environmental Changes:

A = We are in the "planning stage" of implementing this policy/system/environmental change. The planning stage might include activities such as preparing educational materials about the policy and planning for any environmental changes (such as removing ashtrays or vending machines) that need to happen prior to implementation.

B = This policy/system/environmental change is in "early stage" implementation: This stage might be about 1 to 4 months long and often includes activities such as responding to questions, complaints, or concerns and possibly making adjustments to implementation plans or materials.

C =This policy/system/environmental change has been "fully" implemented. In this stage most people affected by the policy are aware of it and generally understand expectations for compliance. This does not necessary mean that there is complete compliance but that for the most part the policy is "in place."

D = This policy/system/environmental change is fully implemented and we are (or have) evaluated compliance and impact.

E = This policy/system/environmental change was implemented but implementation has been stopped or rolled back. If you chose this option, please provide a brief narrative explanation.

F= This policy, system or environmental change was passed but never implemented.

G = Other. If you choose this option please provide a narrative explanation.

Local Program Coordinators Interviewed

Grantee	Interviewees	Title
Benton County	Mac Gillespie	Healthy Communities Coordinator
Coquille Indian Tribe	Fauna Larkin	Assistant Health and Human Services Administrator
	Dennita Antonellis-John	Healthy Communities Coordinator
Deschutes County	Sarah Worthington	Healthy Communities Coordinator
Douglas County	Shawna Hormann	Healthy Communities Coordinator
	Robin Stalcup	TPEP Coordinator, Public Health Lead (Adapt)
Jackson & Josephine County	Kate Roberts	Josephine County Healthy Communities Coordinator
	Jane Stevenson	Jackson County Healthy Communities Coordinator
Lane County	Renee Mulligan	Healthy Communities Coordinator
Linn County	Erin Sadlacek	Healthy Communities Coordinator
	Pat Crozier	Public Health Program Manager
	Kacey Urrutia	TPEP Coordinator
	Joscelyn Stangel	Health Educator
Polk County	Alinna Ghavami	Healthy Communities Coordinator
Multnomah County	Elizabeth Barth	Healthy Communities Coordinator

Healthy Communities Evaluation
Partner Interview Guide:

Intro:
Thank you so much for participating on this call today. My name is Alex McFerrin and I am with the Rede Group. We are conducting this assessment of the Oregon Public Health Division. The purpose of the call is to collect information from partners of local Healthy Communities program about policy, systems and environmental change that happened as a part of the Healthy Communities Program from 2013 to 2016.

This call is being recorded. Responses will be analyzed for themes and none of the information you provide today will be tied back to you in reporting unless we receive your permission to do so.

This call should be approximately 20 minutes. Because we want to stay within the time limit, I may ask that we move onto the next question once I feel like we have adequate information on a particular topic. This is not meant to be rude but rather to stay on track and make sure we get to all the questions. Also, I might interrupt you to clarify a point or ask a follow-up question.

Do you have any questions before we begin?

1. Please briefly describe (1 or 2) projects that you've done in collaboration with the XXX county healthy communities project? *(List here)*

2. What effects (if any) have these projects had? What effects (if any) do you think they will have?

3. What key factors made it possible for this change to happen? *(Try to talk about each project categorically)*

4. Has your agency/program benefited from the relationship with the XXX healthy communities program? If so, in what ways?

5. Is there anything else you'd like to add about working with the Healthy Communities Program, or about the work done by the Healthy Communities Program?

Close: Thank you so much for your time and attention today. Is there anything you would like to add at this time?If you have any questions or want to follow-up on anything we talked about today please call or email.

Community Partners Interviewed

Sector	Interviewee	Title	Organization
County or Tribal	Christy Inskip	TPEP Coordinator	Lane County Public Health
	Kylie Menagh-Johnson	Wellness Program Manager	Multnomah County
	Matthew Stevenson	TPEP Coordinator	Polk County Family & Community Outreach
Farms/Agriculture	Bryan Allen	Farm Manager	Zenger Farms
Health Care, Coordinated Care Organizations, and Insurance	Cindy Norona	Executive Coordinator	Umqua Community Health Center
	Dr. Kincade	Physician	Formerly PeaceHealth Hospitals
	Elaine Knobbs	Director of Programs and Development	Mosaic Medical
	Emily McNulty	Health Education Manager	Samaritan Health Services
	Hannah Ancel	Community Engagement Coordinator	Jackson Care Connect
	Jenna Bates	Transformation Manager	Samaritan Health Services
	Kim Prosser	Clinic Manager	Central Health & Wellness Center
	Marilyn Carter	Health Policy & Systems Director	Adapt
Higher Education	Cheryl Kirk	Family & Community Health/SNAP-Ed	Josephine County OSU Extension Service
	Tina Dodge Vera	Family and Community Health	Linn County OSU Extension Service
Parks & Recreation and Transportation	Kim Curley	Community Outreach	Commute Options
	Stephen DeGhetto	Assistant Director	Corvallis Parks and Recreation

Grantee	Name of Funding	Type of Funding	Source	Total Amount	Award Year
XXX	Delivery System Transformation to **XXX** County Public Health, Colorectal Cancer Screening Project	Coordinated Care Organization	IHN-CCO	$41,000.00	2015
XXX	CRCS Project	Coordinated Care Organization	IHN-CCO	$40,111.06	2015
XXX	Cancer You Can Prevent Campaign	Coordinated Care Organization	AllCare, Jackson Care Connect, and Primary Health of Josephine	$7,000.00	2013
XXX	Designing Active & Healthy Communities – A local workshop featuring Mark Fenton	Coordinated Care Organization	AllCare and Jackson Care Connect	$1,000.00	2015
XXX	Safe Routes to School	Coordinated Care Organization	AllCare	$50,000 - $75,000	2016
XXX	Strategic Grant to expand Living Well to include DSMP	Foundation/Non-profit	Pacific Source Charitable Foundation	$37, 792.00	2014
XXX	HEAL Grant to City of **XXX**	Foundation/Non-profit	Oregon Public Health Institute	$8,600.00	2015
XXX	Oregon Food Bank	Foundation/Non-profit	Oregon Food Bank	$50,000.00	2012
XXX	Employee Wellness Grant	Foundation/Non-profit	Oregon Education Association Choice Trust	$47,000.00	2014
XXX	Disability and Healthy Communities Project	Foundation/Non-profit	National Association of Chronic Disease Directors (NACDD)	$22,800.00	2016
XXX	Community Food Systems Implementation Grant	Foundation/Non-profit	Meyer Memorial Trust	$375,000.00	2013
XXX	Expand Living Well offerings to include Living Well with Chronic Pain	Foundation/Non-profit	COHC Pain Standards Taskforce	$12,769.00	2016
XXX	Community Partnership Program Grant	Health Care	OHSU Knight Cancer Institute	$24,992.00	2014
XXX	HEAL grant	Health Care	Kaiser Permanente	$179,895.00	2012
XXX	HEAL grant	Health Care	Kaiser Permanente	$250,000.00	2015
XXX	REACH	National Government	CDC	$242,000.00	2013
XXX	CDC Work@Health	National Government	CDC	$5,000.00	2014
XXX	Racial and Equity Approaches to Community Healthy (REACH) grant	National Government	CDC	$2,958,588.00	2014
XXX	Recreational Trails Grant: **XXX**	State Government	Oregon Parks and Recreation Department	$21,520.00	2014
XXX	Sodium Reduction in Communities	State Government	Oregon Health Authority, HPCDP	$102,000.00	2014
XXX	Sodium Reduction in Communities	State Government	Oregon Health Authority, HPCDP	$38,500.00	2014
XXX	Sodium Reduction in Communities	State Government	Oregon Health Authority, HPCDP	$100,000.00	2014

XXX	Sodium Reduction in Communities	State Government	Oregon Health Authority, HPCDP	$102,000.00	2014
XXX	SRCH	State Government	Oregon Health Authority, HPCDP	$51,938.00	2015
XXX	SRCH	State Government	Oregon Health Authority, HPCDP	$147,000.00	2015
XXX	SRCH	State Government	Oregon Health Authority, HPCDP	$11,121.00	2016
XXX	SRCH	State Government	Oregon Health Authority, HPCDP	$59,000.00	2016
XXX	South 3rd HIA	State Government	Oregon Health Authority	$15,000.00	2013
XXX	**XXX** Health Equity Alliance	State Government	Oregon Health Authority	$16,200.00	2013
XXX	SRCH	State Government	Oregon Health Authority	$21,740.00	2015
XXX	**XXX** Health Equity Alliance	State Government	Oregon Health Authority	$9,000.00	2014
XXX	Northwest Portland Area Indian Health Board Public Health Improvement	Tribal Health Care	Northwest Portland Area Indian Health Board (NPAIHB)	$23,369.00	2014
XXX	WEAVE-NW	Tribal Health Care	Northwest Portland Area Indian Health Board (NPAIHB)	$50,000.00	2015
XXX	Northwest Portland Area Indian Health Board Public Health Improvement	Tribal Health Care	Northwest Portland Area Indian Health Board	$18,750.00	2013
XXX	Convergence II Food Systems Fund Program	Tribal Health Care	Northwest Health Foundation – Grant # 16499	$25,000.00	2013
XXX	Tobacco Prevention and Education Program (TPEP)	Tribal Health Care	Health Promotion and Chronic Disease Prevention	$40,573.00	2015