Health Promotion and Chronic Disease Prevention

Healthy Communities: Building Capacity Based on Local Tobacco Control Efforts

2011 Report

Oregon Health Authority
PUBLIC HEALTH DIVISION

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I. Introduction

Healthy Communities: Building Capacity Based on Local Tobacco Control Efforts is an initiative to plan local, population-based approaches to reduce the burden of chronic diseases 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, and 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. This approach helps develop capacity and infrastructure for chronic disease prevention, early detection and self-management.

This report describes the process for developing the ***Healthy Communities: Building Capacity*** (HCBC) program conducted in Oregon from 2008 through 2011, and the results of the capacity-building phase. As a companion to this written report, stories have been gathered from local programs throughout Oregon working towards creating healthier communities. These stories will be available as videos on the HPCDP website www.healthoregon.org/hpcdp/.

Since its formation in 1993, the Health Promotion and Chronic Disease Prevention Section (HPCDP) of the Oregon Public Health Division has fostered collaborative approaches to chronic disease prevention and health promotion, including the development of public-private partner networks and coalitions, and the creation of statewide plans for chronic diseases and risk factors, including arthritis, asthma, cancer, diabetes, heart disease and stroke, physical activity, nutrition and obesity, and tobacco. To increase the efficiency and effectiveness of efforts to achieve policy goals and health outcomes that address risk factors related to multiple health conditions, HPCDP integrated its chronic disease programs in 2009. HPCDP created an overarching vision and mission statement aligned with the goals of each categorical disease and risk factor program and developed ***Healthy Places, Healthy People: A Framework for Oregon*** (the Framework)[1], which honed the categorical program work to a focus on best and promising practices for prevention, early detection and self-management of chronic diseases. The Framework described the statewide, community, school, worksite and health system conditions necessary to improve the health of Oregon's children and adults. It is the direction from the Framework that prioritized the required areas of focus for the ***Healthy Communities: Building Capacity*** process.

Historically, HPCDP provided small grants to a few counties for special projects such as disease- specific coalition meetings, conferences and trainings. Only the state Tobacco Prevention and Education Program had sufficient funds to provide grants to all county health departments and federally-recognized tribes in Oregon. To build statewide infrastructure, combining chronic disease categorical program funds from the Centers for Disease Prevention and Control (CDC) was necessary to support chronic disease prevention, early detection and self-management as defined in the Framework. This approach formed the basis for the ***Healthy Communities: Building Capacity Training Institute*** — a new initiative for HPCDP, its grantees and partners.

1 Healthy Places, Healthy People: A Framework for Oregon. Health Promotion and Chronic Disease Prevention Program Framework and Best Practices Report - December 2008. www.healthoregon.org/hpcdp/

II. Building Capacity Process

By leveraging resources among the arthritis, asthma, cancer, diabetes, heart disease and stroke, physical activity and nutrition, and tobacco prevention and education programs, HPCDP was able to provide funding for participation in ***Healthy Communities: Building Capacity*** to 32 local public health authorities, representing 34 counties and seven tribal grantees in three cohorts over three-and-a-half years. The first cohort of 12 counties was selected through a competitive RFP process, which gave counties an opportunity to demonstrate support of their public health administration and county leadership for policy, system and environmental (PSE) change strategies to reduce the burden of chronic diseases. Counties also provided evidence that assigned staff members had the skills and knowledge to work on PSE strategies. Successful applicants in the first cohort demonstrated strong local tobacco prevention activities focused on policy, system and environmental changes to reduce tobacco use and promote cessation. Some counties also noted experience in local policy efforts addressing healthy eating and active living, and chronic disease self-management.

HPCDP modeled the capacity-building process on Oregon's Healthy Kid's Learn Better coordinated school health model.[2] This model relied on a commitment of high-level leadership participation in the building-capacity process during the learning institutes, and back in the office. As part of the application, counties had to sign commitment forms for the public health administrator to participate in the first institute.

Cohorts

The first ***Healthy Communities: Building Capacity*** cohort included the 12 counties that scored highest in the competitive grant process. Twenty counties and seven of Oregon's nine federally recognized tribes comprised the second and third cohorts. Grants for the second and third cohorts were not competitive. Two counties and two tribes did not apply for building capacity funds.

Cohort 1 (April 2008-April 2009)	Cohort 2 (August 2010-October 2011)	
Benton County	Baker County	North Central Health District (Wasco, Sherman and Gilliam counties)
Clatsop County	Clackamas County	Polk County
Columbia County	Crook County	Tillamook County
Coos County	Curry County	Umatilla County
Deschutes County	Douglas County	Union County
Jackson County	Harney County	Wallowa County
Jefferson County	Hood River County	Washington County
Klamath County	Josephine County	Wheeler County
Lane County	Lincoln County	
Marion County	Linn County	
Multnomah County	Malheur County	
Yamhill County	Morrow County	

Cohort 3 (April 2010-October 2011)	Did not participate
Burns Paiute Tribe	Confederated Tribes of Grand Ronde
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians	Confederated Tribes of the Umatilla Indian Reservation
Confederated Tribes of Siletz Indians	Grant County
Confederated Tribes of the Warm Springs Indian Reservation	Lake County
Coquille Tribe	
Cow Creek Band of Umpqua Indians	
Klamath Tribes	

2 Healthy Kids Learn Better: http://public.health.oregon.gov/HealthyPeopleFamilies/Youth/HealthSchool/HKLB/Pages/index.aspx

The Healthy Communities program scope of work outlined the required activities for county and tribal public health authorities:

a. Participate in a chronic disease training institute.
b. Collaborate with community partners.
c. Complete a community needs assessment.
    i. Gather and use local data for the community needs assessment.
    ii. Focus the assessment on best practices and population-based approaches to prevention, early detection and management of chronic diseases in settings where people live, work, play, learn and receive health care.
d. Develop an implementation plan to reduce the burden of chronic diseases in the community.
e. Promote the Oregon Tobacco Quit Line and other evidence-based chronic disease self-management programs.

La Grande Community Garden, Union County

Participating county and tribal public health authorities each received a one-time annual grant of $32,500 to be primarily used for program staffing and coordination.

To ensure that the scope of work was feasible for the tribes, HPCDP staff convened an advisory group that included a member of each of Oregon's nine federally-recognized tribes to design the tribal Healthy Communities program. The advisory group informed the number of learning institutes for tribal grantees, the type of individuals recommended for participation on the institute team, and the over-arching content of the community assessment and action plan outline for their cohort. HPCDP funded tribal grantees by supplementing existing tribal tobacco prevention and education grants.

Learning Institutes, Training and Technical Assistance

Cohort 1 participated in five training institutes; cohorts 2 and 3 participated in three institutes. The first institute attended by Cohorts 2 and 3 was separated by grantee type (tribes and counties); Cohorts 2 and 3 participated in the second and third institutes together.

The institutes were a series of trainings on best-practice interventions that address tobacco use and health promotion strategies known to decrease the burden of chronic diseases. During the institutes, participants reviewed current policy and environmental changes that best support chronic disease prevention, early detection and self-management where people live, work, play, learn and receive health care. At the conclusion of the institutes, county and tribal public health authorities were expected to have the knowledge and skills required to assess and evaluate their community's needs and health outcomes, and to provide leadership for integrating chronic disease prevention, early detection and self-management into community planning.

Regardless of which cohort counties and tribes participated in, the learning objectives were intended to build upon each institute, resulting in each county and tribal program's capacity to 1) convene a broad group of

high-level community leaders to address chronic disease prevention, early detection and self-management; 2) complete a community assessment where people live, work, play, learn and receive health care that addresses chronic disease and relating risk factors; and 3) complete a three-year community action plan addressing priority areas in each setting. Appendix A provides a detailed list of learning objectives for the three cohorts' institutes.

HPCDP required administrators from local public health authorities to participate in the first institute for each cohort. Local public health staff members — usually the Healthy Communities coordinator and the tobacco prevention and education coordinator — and up to five community partners attended the first and each subsequent institute. Tribal health administrators were invited to the Tribal Healthy Communities Institute (the first institute for Cohort 3), and offered the opportunity to provide specific input during discussion sessions and keynotes.

In addition to these in-person meetings, HPCDP required grantees to participate in monthly (county health departments) or quarterly (tribal programs) training calls and technical assistance calls. Training calls focused on sharing resources, grantee experiences and successes in overcoming challenges in programs. Technical assistance calls focused on statewide updates, sharing local successes and strategies for completing the building-capacity activities.

Building the Community Health Action and Response Team (CHART)

All building-capacity cohorts received guidance and training on collaboration with community partners. HPCDP encouraged grantees to identify and reach out to community organizations representing the settings identified in the assessment, including the places where people live, work, play, learn and receive health care. Additionally, counties were asked to include organizations that support various population groups in adopting and maintaining tobacco-free lifestyles, increasing physical activity, healthy eating, early detection and self-management of risk factors and chronic diseases, and self-management. HPCDP strongly encouraged counties and tribes to construct their CHARTs using high-level leadership representation to ensure community buy-in and organizational accountability for implementing the community plan.

Community Assessment

In 2008, HPCDP created a community assessment for Cohort 1 based on existing tools for community assessment, the experiences of the tobacco control movement (both national and statewide), and HPCDP's focus on policy, system and environmental change. This tool included demographic data as well as policy and system assessment questions for the community, schools, worksites and health systems. It also included a section on identifying champions for policy, system and environmental change. HPCDP contracted with an evaluator to review the experience of Cohort 1, including the use of the community assessment tool. The full report is available from HPCDP.

Between 2009, when Cohort 1 completed the capacity-building process, and 2010, when cohorts 2 and 3 started the capacity-building process, the Centers for Disease Control and Prevention finalized and made available the Community Health Assessment and Group Evaluation (CHANGE) tool. Cohorts 2 and 3 used the CHANGE tool in lieu of the HPCDP-developed community assessment tool.

Stewart Park Playground, Douglas County

The CHANGE[3] tool is a data-collection and planning resource for community members wanting to make their community a healthier place to live, work, play, and learn. It allows communities to have a conversation about their health-supporting policies, systems and environments in a variety of sectors: community-at-large, community institutions and organizations, the health care sector, at schools; and in worksites. Within each of these sectors, CHANGE assesses leadership, chronic disease management, demographics, physical activity, tobacco and nutrition.

Community Action Plan

The final deliverable of the building-capacity process is a three-year community action plan (CAP), completed based on information collected during the assessment. Plans were expected to prioritize evidence-based and best-practice policy, system and environmental changes that support tobacco-free lifestyles, increase physical activity, increase access to nutritious food, and support early detection and self-management of chronic diseases.

Cohort 1 wrote community plans in a template HPCDP provided. The template required communities to identify priorities that reflected the policy priorities in HPCDP's Framework. Cohorts 2 and 3 wrote their community plans using the Centers for Disease Control and Prevention's Action Communities for Health, Innovation and Environmental Change (ACHIEVE) Community Action Plan template (Appendix B). This template explicitly links community priorities to community vision, mission and health improvement metrics.

3 Centers for Disease Control and Prevention. Community Health Assessment and Group Evaluation (CHANGE) Action Guide: Building a Foundation of Knowledge to Prioritize Community Needs. Atlanta: U.S. Department of Health and Human Services, 2010. http://www.cdc.gov/healthycommunitiesprogram/tools/change/pdf/changeactionguide.pdf

III. Analysis of Community Action Plans

HPCDP required cohorts 1 and 2 to submit their CAP as the final deliverable of the capacity-building process. Ten of the 12 communities that participated in the first cohort turned in CAPs in 2009. Lane County submitted a one-year plan in response to an HPCDP funding opportunity for Healthy Communities Implementation grants; Lane County has not yet submitted a three-year CAP. Clatsop County completed its CAP in 2011, so for the purpose of this analysis is listed in Cohort 2 in the table below.

Because cohorts 1 and 2 used different templates for their community action plans, communities have been regrouped in the following table for analysis:

Cohort 1 - CAPs submitted in 2009	Cohort 2 - CAPs submitted in 2011	
Benton County	Baker County	Linn County
Columbia County	Clatsop County	Malheur County
Coos County	Clackamas County	Morrow County
Deschutes County	Crook County	Polk County
Jackson County	Curry County	Tillamook County
Jefferson County	Douglas County	Umatilla County
Klamath County	Harney County	Union County
Marion County	Hood River County	Wallowa County
Multnomah County	Josephine County	Washington County
Yamhill County	Lincoln County	Wheeler County

One additional participant from Cohort 2 (North Central Health District) has not yet completed the planning process with its community health advisory council; its CAP is not included in this analysis.

While counties may have revised their CAPs or completed additional assessment or community planning processes after completing their Building Capacity deliverables, this analysis only includes CAPs submitted to HPCDP as the final building-capacity deliverable.

Cohort 1

The first cohort was expected to submit a community action plan structured around the HPCDP Framework. All communities focused on four settings: community, schools, worksites and health systems. Each community was to identify two to three objectives in each setting, selecting objectives from best practices outlined in the Framework report. While settings and objectives included in the community action plan were directed by the Framework and required for communities to address, counties were instructed to develop strategies for the selected objectives based on assessment results that would be appropriate for their communities.

Because objectives were required for each setting, CAPs from Cohort 1 contain more objectives than Cohort 2 CAPs.

Total CAP Objectives	
Cohort 1 (10 counties)	212
Cohort 2 (20 counties)	169

CAP objectives were reviewed by setting and also by content area: physical activity, nutrition, tobacco, self-management, and “other,” a catch-all category for objectives related to developing advocates or community leadership, and building or sustaining Community Health Advisory Councils, as well as any objectives that did not align with the Framework, such as improving community access to fluoride. CAP

objectives were also reviewed for alignment with best practices and public health strategies outlined in the Framework.

When examined by setting, most objectives were written for the community setting (83 objectives total). To some extent, the emphasis on the community setting reflects the broad range of policy objectives available in the Framework report. Community objectives in the Framework include tobacco-free policies at community colleges, multi-unit housing, or parks and recreational areas, all built environment policies, land use planning and other infrastructure improvements, and nutrition policies, including establishing community gardens and farmers markets, and all farm-to-institution efforts.

Cohort 1 CAP Objectives by Setting

Community	83
Worksites	49
Schools	36
Health System	44

When examined by content area, most objectives were written for tobacco (63 objectives), followed closely by self-management (51 objectives). The emphasis on tobacco-related objectives was expected, as Building Capacity program coordinators were encouraged to work closely with TPEP coordinators to develop the CAPs, and given county familiarity with tobacco policy work.

Cohort 1 CAP Objectives by Content Area

Tobacco	63
Physical Activity	22*
Nutrition	33*
Self-Management	51
Other	40

* Four counties submitted objectives that included nutrition, physical activity, and/or tobacco. For example: "X County will adopt policies to support nutrition and physical activity among employees." These four objectives are included in the total number of objectives and objectives by setting, but are not listed in the objectives by content area table. A more complete breakdown of CAP objectives by content area and by county is available in Appendix C.

In each setting, there were several objectives that were more frequently prioritized by the community and appeared in multiple action plans across the cohort.

Popular Objectives by Setting

Community: Increasing the number of community gardens (6 objectives). Tobacco-free multi-unit housing policies (6). Increasing the number of local organizations offering Chronic Disease Self-Management Programs (CDSMP) (6). Regional coordination of CDSMP (5). Tobacco-free parks and outside events policies (5). Passing or implementing healthy food/nutrition policies (5). Land use planning (5).	Health Systems: Tobacco-free hospital campus policies (13 objectives). Improving benefits and referral systems for tobacco cessation (10). Improving referral systems for self-management programs (7).
Worksites: Tobacco-free county and government buildings/campus policies (6 objectives). Improving health plan benefits for tobacco cessation (6). Conducting campaigns for self-management programs and activities (5).	Schools: Safe Routes to School (5 objectives).

Overall, with the exception of Safe Routes to Schools programming, objectives related to physical activity and built environment policies were not as evident in CAPs. A possible explanation for this is a lack of familiarity or experience with land use and county planning. Most communities did not have an existing or strong relationship with city or county planning agencies, and several coordinators indicated that built environment jargon was confusing.

Another area with fewer objectives across Cohort 1's CAPs is in the health systems setting: Only one community included objectives related to nutrition in the health care setting, and no communities included objectives related to physical activity in this setting. It is possible that the health system was viewed as a worksite, and nutrition and physical activity activities that would target health system employees were listed under worksite objectives.

When examined for alignment with the Framework, objectives were sorted into three categories: (1) objectives that directly aligned with the policy goals listed by setting in the Framework report; (2) activities that followed public health strategies for establishing policies and environmental change included in the Framework report (e.g., collecting data or mobilizing the community); and (3) objectives that were not based on best practices or public health strategies in the Framework report.

As activities based on public health strategies included in CAPs were not setting or content area dependent, the next section includes several additional objectives related to general leadership and community engagement that were not included in the tables on page 10.

The majority of Cohort 1's CAP objectives (82 percent) were based on best practices outlined in the Framework report. These included objectives for tobacco-free policies, worksite physical activity and nutrition policies, and referrals to evidence-based self-management programs, among others. A further 25 objectives (12 percent) were based on public health strategies included in the Framework and only 12 objectives (just under 6 percent) were not aligned with the Framework.

Cohort 1 CAP Objectives by the Framework

Objective type	Number of objectives	Percentage of all objectives
Framework-aligned Policy Objectives	175	82 %
Public Health Strategy Objectives	25	12 %
Non-Framework Objectives	12	6 %

Objectives that were not aligned with the Framework can be summarized into two broad categories. The first reflects community interests or disparities that surfaced during the community assessment and were prioritized by the community during the planning process and were included in the CAP. Objectives in this category include increasing access to fluoride in the community, in-home health assessments for asthma triggers, and exploring options for BMI notification letters in schools.

This category also includes all objectives related to seeking additional funding, grant writing, or supporting community partners' applications for funding. As HPCDP stressed the importance of seeking external (i.e., non-state) funds to support healthy communities work during the institutes, it is not surprising that communities prioritized looking for additional funding to support this work.

Cohort 2

The second cohort was expected to submit a three-year CAP containing up to five goals with supporting objectives. Due to the more open-ended nature of the CAP template used by the second cohort, the reach and specificity of goals and objectives vary across counties. Several counties used over-arching goals, such as "improve the health of all county residents" with targeted policy objectives, while others proposed goals related to passing or implementing very specific policies. To ensure as much consistency as possible, this analysis looks at the proposed policy or environmental change, whether it is at the goal or the objective level. Goals and objectives are used interchangeably for the rest of this section.

Most counties submitted CAPs with three to five goals and objectives. One county submitted a CAP with only one objective, but three counties submitted CAPs with more than 30 objectives.

Cohort 2's CAPs were only reviewed by content area and for alignment with the Framework. When looked at by content area, the most objectives were written for nutrition (52 objectives), followed by physical activity (36 objectives), tobacco (29 objectives) and self-management (27 objectives).

Cohort 2 CAP Objectives by Content Area

Content Area	Objectives
Tobacco	29
Physical activity	36
Nutrition	52
Self-management	27
Other	25

A more complete breakdown of Community Action Plan objectives by content area and by county is available in Appendix C.

In each content area, there were several objectives that were more frequently prioritized by the community and appeared in multiple action plans across the cohort.

Popular Objectives by Content Area

Nutrition: Establish healthy meeting and healthy vending policies at worksites (10 objectives). Establish healthy food policies and practices at schools (10). Expand or improve school and community gardens (10).	**Physical Activity:** Infrastructure improvements to increase physical activity, or built environment changes (8 objectives).
Tobacco: Establish tobacco-free campus policies at worksites, including county and other government buildings (15 objectives).	**Self-Management:** Increase referrals from health systems and community organizations to self-management programs (10 objectives).

Other popular objectives were related to worksite wellness programs (9), and building supportive leadership and advocates (7).

While the CAP template required descriptions of settings and policy and environmental change strategies for goals and objectives, communities were not directed to use best practices as outlined in the Framework report. Because of this, CAPs for the second cohort have fewer consistencies and more strongly reflect the differing priorities across communities.

Cohort 2 CAP Objectives by the Framework

Objective Type	Number of objectives	Percentage of all objectives
Framework-aligned Policy Objectives	114	67%
Public Health Strategy Objectives	27	16%
Non-Framework Objectives	27	16%

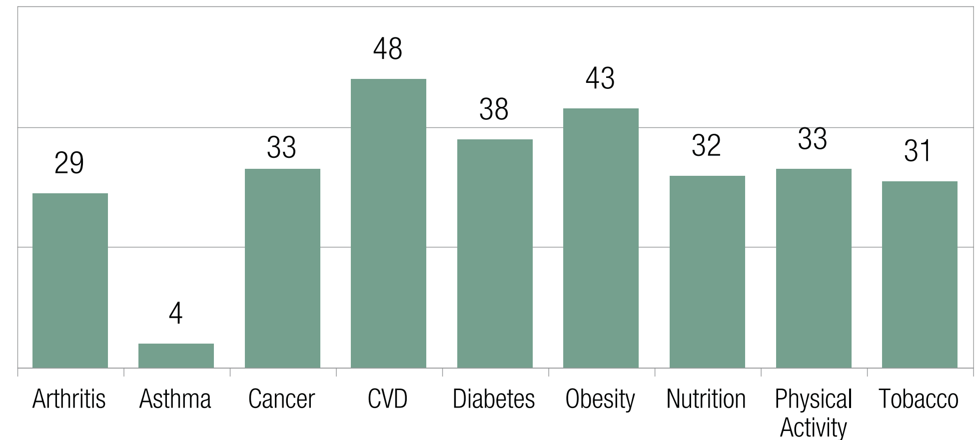
Non-Framework objectives across the second cohort can also be broadly grouped into two categories. The first includes all objectives that are related to improving health and preventing chronic diseases, but are not policy specific and therefore, alignment with the Framework cannot be fully determined. This category includes objectives such as "decrease the number of pregnant women who use tobacco" and "increase the number of parents who report allowing their students to walk/bike to school by 20%." For this objective to be aligned with the Framework, it needed a policy focus, such as "adopt Safe Routes to School policy at two school districts" or "include sidewalks in city plan."

The second category reflects community interests or disparities that surfaced during the community assessment and were prioritized by the community during the planning process and were included in the CAP. Objectives in this category range from enrolling community members in a local cooking class, to working with schools to reinforce healthy behaviors outside of school, to supporting substance abuse programs.

Overall, these CAPs represent a broad range of policy and practice areas, and are well aligned with current TPEP and Healthy Community best practice objectives. Areas not included are more specific to individual counties, especially those counties with very few objectives in their CAP, or those that have no proposed objective across the four content areas (e.g., Baker County's CAP does not include any nutrition or tobacco objectives; Union County's CAP only includes a self-management objective).

When creating the CAP, the second cohort used a template provided by the ACHIEVE. (Appendix B). This CAP template required the grantees to identify priority areas each objective addresses. These priority areas were comprised of nutrition, physical activity, tobacco, obesity, arthritis, cancer, cardiovascular disease (CVD) and diabetes. Asthma was not specifically called out; however, tobacco prevention, chronic disease self-management, and nutrition objectives benefit people living with asthma. When examined by identified priority area, most objectives were connected with cardiovascular disease (48), followed by obesity (43).

Community Action Plan Objectives by Priority Area



A more comprehensive breakdown of county-specific Community Action Plan objectives and their links to specific chronic diseases is available in Appendix D.

IV. Implications for the Future

Lessons Learned

Evaluation is essential for process improvement

HPCDP contracted with Program Design and Evaluation Services to conduct focus groups with county coordinators from the first cohort of Healthy Communities: Building Capacity and members of their CHART teams in June 2009. The report generated from these focus groups included suggestions for improvement that HPCDP was able to act upon to improve the second cohort structure and experience. Participants in the first year spoke of the need for clearer guidelines up front, including standardized materials and due dates, as well as realistic expectations related to the CHART. HPCDP worked to improve these areas for the institutes beginning in 2010.

At the first institute for Cohort 2 in August 2010, a presentation on CHARTs included training on how to facilitate a CHART meeting, stages of group development and a breakout session on power mapping (a policy strategy to identify influential people and entities to influence a desired policy objective). Due dates and the process were clearly defined at the beginning of the series of institutes and posted to TPEP Connection, a location on TPEP's website for county and tribal coordinators to access tools and resources, and information for their day-to-day work. During the second institute in October 2010, participants were guided through the CHANGE tool by its lead author from the CDC, and, over the course of the two-day institutes, learned to plan and facilitate the implementation of the assessment tool in their communities. HPCDP provided clear information about deadlines and descriptions of roles, purpose and objectives of the building-capacity process at the beginning and throughout the year-long grant period.

Advantages of using a nationally endorsed and available assessment tool (CHANGE tool)

HPCDP created a community assessment tool for the first cohort of Healthy Communities: Building Capacity because there was not a comprehensive community assessment tool already available that looked at community conditions specific to chronic disease prevention, early detection and self-management. HPCDP's Framework was a useful tool for defining what conditions were necessary in a community to promote health, and it provided an outline for the community assessment. During the time that Oregon's first cohort was participating in Healthy Communities: Building Capacity, the CDC, in collaboration with national partners, was developing a community assessment tool focusing on multiple community settings and considering the policy, system and environmental changes that would result in community conditions to prevent chronic diseases, and provide access to early detection and self-management resources. The assessment process for cohorts 2 and 3 was greatly improved because, by then, the CDC CHANGE tool was available for public use. Additionally, the CDC provided trainers and materials to support use of the CHANGE among Oregon's Healthy Communities: Building Capacity participants.

Assessment is an opportunity to mobilize people for change

Through the community engagement process of completing assessments, local program staff and partners reported learning of shortcomings in different sectors that may not have been evident prior to being surveyed. When assessment results showed weaknesses in policy, systems and environments, leaders were often motivated to work on improving community conditions through PSE. Many grantees reported progress in access to leadership and greater support for policy change after sharing their assessment results with an organization.

Rural environments are unique

Rural counties and tribes view themselves as having more challenges in garnering political will for policy strategies that change community conditions to improve health outcomes. However, communities differ in where the barrier exists. For some counties and tribes, internal capacity and volunteer resources may be limited. Other grantees lacked county-level administrative support to work on PSE strategies. Regardless, some rural counties have shown tremendous success in engaging community partners and garnering local involvement; this influences community norms and, ultimately, community leadership, both appointed and elected. Several county health department participants have found that the building-capacity process helped them gain new partnerships and enhance existing ones.

Charles Gardener Park, Douglas County

Community involvement is important

HPCDP emphasized the importance of having community organizations participating in the assessment process, as this led to more comprehensive findings and increased buy-in throughout the local community. This engagement resulted in strengthened or new policies among participating organizations. It was also important to have multiple individuals involved in the CAP process. Coordinators were advised to communicate with CHARTs that assessments and CAPs are to be community-owned and guided, to get the best results. Further, the CAP cannot rely upon one individual to do the work; goals are to be derived from assessment results, ideally focusing on the highest identified community health needs.

Community-led process, buy-in and ownership

Some participants reported their ability to complete assessments varied depending on how well the overall process was communicated to partners and the community. Messages such as "We want to assess your business" resulted in non-responsiveness—such messages appeared as if the local public health authority would be grading the business or institution. This was not appealing to those entities. A softer message (focused on improving the entities' state of health and the need for member involvement in the process) would more effectively ensure products are relevant and tailored to the organization. Another effective approach reported by one county participant was to identify what's working to promote health and where barriers to health exist, with an emphasis on the sector the entity represented, rather than the individual entity, resulting in a more global CAP.

Clearly define staff roles and expectations

It is critical to be clear from the beginning about expectations of local program staffing, leadership participation, and focus on PSE strategies rather than service delivery program efforts. For example, one county health department hired a public health nurse to serve as the program coordinator. This person reported that, in her current role, which included her role as the Healthy Communities coordinator along with her nursing responsibilities, she had little control over her time because she had to respond as service delivery cases came in. This resulted in competing priorities within her position. Some local program staff who either hold a concurrent position or who have a direct service background

either hold a concurrent position or who have a direct service background expressed that they do not feel skilled to do the community organizing the Healthy Communities coordinator role requires. In contrast, another local program staff was reported to be familiar and comfortable with the community-organizing aspects of this work. There may also be other skill sets beyond public health that could be valuable to these efforts, such as community organizing, or urban or land use planning. The staff in the engagement, assessment, and strategic planning roles needs to be skilled in facilitating a group through an assessment and planning process, engaging diverse entities, and motivating them to take action to improve the health of their community.

It is important for the state PHD to convene a state-level CHART addressing chronic disease prevention, early detection and self-management

The first cohort identified a need to partner with other governmental agencies responsible for the physical characteristics of communities. These included planning, zoning, transportation, and parks and recreation departments. HPCDP historically had relationships with the state agency equivalent to the identified local government agencies. However, with the loss of the CDC physical activity and nutrition program, HPCDP was limited in staff capacity to maintain regular communication and interaction with these state agencies.

Between the first and second cohort, HPCDP staffed the development of Oregon's Health Improvement Plan, which required a CHART-like leadership team, representing multiple settings. The HIP committee laid the foundation for HPCDP to establish a Prevention Partnership Leadership Team, a CHART-like group that would include representatives from multiple state agencies, private partners, and public health advocates. Similar to a CHART, a state-level leadership team would provide guidance, setting and topic-specific technical assistance, community buy-in, and provide an opportunity to garner political will for statewide policy initiatives.

Clatskanie Elementary School Walking Path, Columbia County

Recommendations

Provide a state road map, like a Framework or strategic plan

Providing a prioritized list of evidence-based policy options, with an emphasis on comprehensive approaches is critical. Without clear direction, and options for communities to focus on PSE strategies, based on the greatest evidence to improve community conditions, participants may neglect certain elements, and gravitate toward traditional health care delivery efforts or policy initiatives that are not grounded in evidence to improve health outcomes for community populations.

Focus on building the capacity of the entire team, not just individuals

Emphasis should be placed throughout the process on building and leveraging skills of the entire CHART and local program staff. This is

to ensure that the building-capacity process doesn't depend upon one person, but rather the larger group. In an effort to maintain a balance of work among CHART members, and to ensure the appropriate use of locally elected officials and high-level community leaders, some CHARTs decided to establish smaller sub-committees with a specific focus that was based on skills and interest.

Engage a broad network of partners in the work

While nearly all grantees either conducted assessment or brought together CHARTs with representatives from health systems, community sectors, schools and worksites, additional outreach can be valuable. Health, particularly poor health, is often a result of community and social norms. The places where people live, work, play, learn and receive health care can ensure healthy options are the default and readily available, or they can create barriers to healthful options. Ensuring broad representation of community partners, particularly new and non-traditional public health partners, is important. Other partners that local programs may consider include local farmers, elected officials, land use planning and transportation, economic development, and neighborhood associations. CHART organizers have the skills to facilitate inclusion of partners, while maintaining the integrity of the Healthy Communities program. This can be done by including CHART members in a leadership role, and providing the space for them to be seen in their community as a leader in the Healthy Communities movement.

La Grande Gleaning Day, Union County

Most counties brought a varying range of partners and sectors to the institutes. Further guidance on which partners are best suited for attending the institutes would be helpful, particularly to ensure that institute participants are able to translate the information gathered and learned through the institute to action back home. Strategic invitations to the institutes may also be necessary to help establish political will. The time commitment for an institute can be a barrier, but as demonstrated in all three cohorts, the counties and tribes who engaged a broad group of stakeholders and had involvement from their public health administrator resulted in a greater level of community engagement in the assessment and planning process.

Statewide Strategic Planning

As statewide strategic planning related to health promotion and chronic disease prevention moves forward, the lessons learned and findings from local assessments and action plans will prove useful. Issues identified by county health departments and tribes as being of greatest need or importance to their local communities should be considered throughout the statewide planning process.

Appendix A– Institute Learning Objectives

Cohort 1	Learning Objectives
Institute 1	1. Attendees will understand and be able to present the Health Promotion and Chronic Disease Prevention Section Framework to their Community Health Action and Response Team (CHART) before the May institute. 2. Attendees will be able to establish a CHART and sponsor their first CHART meeting prior to the May institute.
Institute 2	1. Participants will be able to demonstrate their understanding of the public health approach to addressing the prevention, early detection, and management of chronic diseases by: • Identifying at least two best practice strategies for prevention, early detection, and self-management of chronic diseases and sharing them with their CHART. • Identifying at least one best practice strategy for the prevention, early detection, and self-management of chronic diseases, in the community, schools, worksites, and health systems, and sharing them with their CHART. 2. Participants will demonstrate they know how to engage community partners in a needs assessment by contacting at least one person associated with an organization linked to each setting prior to the June institute.
Institute 3	1. Participants will be able to plan and facilitate the implementation of the Tobacco-Related and Other Chronic Disease (TROCD) Community Assessment prior to Institute 5 in September. 2. Participants will be able to describe the purpose and value of data collection and community assessments in prioritizing areas of focus for their TROCD implementation plan.

Cohort 1	Learning Objectives
Institute 4	1. Participants will celebrate completion of the assessment. 2. Participants will understand how to use the community assessment to: • Cultivate new champions and CHART members. • Prioritize populations facing disparities. • Identify community priorities that directly related to the HPCDP Framework. 3. Participants will identify skills, resources, and tools necessary to cultivate champions, communicate results and promote the community assessment, and prioritize areas of focus in relation to the HPCDP Framework.
Institute 5	1. Participants will celebrate their work over the past year. 2. Given the Healthy Communities RFA work plan, the HPCPD Framework and Best Practices Report, and results from the community assessment, participants will be able to: • Verbally articulate the difference between the local public heath authority Healthy Communities work plan, other community grant work plans (e.g., ACHIEVE), and the three-year community plan. • Write a three-year Healthy Communities plan addressing the opportunities identified in the community assessment by June 30, 2009. • Identify lead organizations (community partners) for objectives in the community plan. • Identify three to five community leaders to participate on their CHART to ensure implementation of their community plan. • Write three statements that will be used to recruit or retain CHART members in implementation. 3. Participants will be able to write three next steps to ensure sustainability of their Healthy Communities program and support of their three-year community plan. 4. Participants will be able to list five components to building a self-management infrastructure through the local public health authority using their Healthy Communities Implementation funding.

Cohort 2	Learning Objectives
Institute 1	1. Given the Health Promotion and Chronic Disease Prevention Section's Framework, Health Improvement Plan goals, Community Health Assessment and Group Evaluation (CHANGE) tool and other background information, the participant will understand and be able to develop three messages about healthy communities. 2. Given the purpose, structure, roles, and responsibilities of a CHART, the learner will be able to establish a CHART and sponsor the first CHART meeting prior to the October institute.
Institute 2	1. Participants will be able to plan and facilitate the implementation of the CHANGE tool prior to Institute 3 in March 2011.
Institute 3	1. Participants will be able to create a three-year community plan focused on policy, system, and environmental change strategies to address chronic disease prevention, early detection, and self-management. Counties and tribes will be able to use the results from the CHANGE tool assessment to inform their plan.

Cohort 3	Learning Objectives
Institute 1	1. Examined what has made policy change processes successful in the past. 2. Described their role in proposing policy change to tribal organizations, enterprises and tribal council. 3. "Interviewed" HPCDP's Framework. 4. Reached consensus on the content of a policy inventory to complete during the 2010-2011 grant year. 5. Individualized a plan for how they will use people, the policy inventory and their experience to generate a community plan including policy priorities.
Institute 2	1. Participants will be able to plan and facilitate the implementation of the CHANGE tool prior to Institute 3 in March 2011.
Institute 3	1. Participants will be able to create a three-year community plan focused on policy, systems and environmental change strategies to address chronic disease prevention, early detection and self-management. Counties and tribes will be able to use the results from the CHANGE tool assessment to inform their plan.

Appendix B: Community Action Plan Template

Healthy Communities-Building Capacity: Community Action Plan

Introduction

The Community Action Plan (CAP) is intended to be completed in sections as your CHART progresses through the assessment and planning phases.

These phases are:

1. Commitment
2. Assessment
3. Planning
4. Implementation
5. Evaluation

Each section of this plan gathers information relevant to a phase which, when complete, will provide a comprehensive plan and summary of your activities.

Each section should be completed as relevant activities are completed. Communities have the option of submitting sections of the CAP as they are completed or submitting the entire CAP all at once, on May 27, 2011. CAPs must be submitted to your liaison via email.

CAPs are due no later than May 27, 2011.

Commitment

[ENTER YOUR COMMUNITY NAME HERE]

CHART Membership

CHART Member Name	Organization Name	Organization Role	Organization Type (choose from drop-down or List A)	Sector (choose from drop-down or List B

List A

- Academia/Education
- Advocacy Group
- An Individual
- Business/For Profit/Consultant
- Civic Organization
- Coalition/Alliance
- Community Based Organization
- Community Health Center
- Cultural/Ethnic Organization
- Elected/Appointed Official
- Environmental Organization
- Faith-based Organization
- Foundations/Philanthropic
- Government Organization
- Health Care Organization
- Health Insurance Company
- Nonprofit organization
- Organization representing priority population
- Professional Association
- Public Health Organization
- Public Relations/Media
- Other (specify)

List B

- Community-at-large
- Community Institution/Organization
- Health Care
- School
- Work Site

Vision

Your vision statement is your inspiration, the framework that describes your strategic planning. It highlights what will be achieved when the activity is successful. It describes a healthier future and answers the question, "Where do we want to be in a few years?" Example: "All citizens of Any Town, USA will, on a daily basis, consume a nutritionally-balanced diet, acquire the minimum recommended daily physical activity, and refrain from using tobacco products." The vision is what will be achieved by your efforts. [Enter text below]

Mission

The mission statement informs what impact your CHART will make and describes why it is important to achieve the vision. Example: "The CHART of Any Town, USA will work with top-level leaders in all community sectors to implement policy and environmental strategies to facilitate for residents better diets, increased physical activity, and the cessation and abstinence of tobacco products." The mission includes efforts your CHART will undertake to achieve the vision. [Enter text below]

Community Description

Demographic information, target population, socio-economic and health data, community size. [Enter text below]

Intervention Area Map [This is optional]

Existing Efforts

Describe existing efforts and experience with the identified sectors, populations, risk factors, and chronic disease areas that may support or be a barrier to the implementation of policy, systems, and environmental change strategies. Also describe existing coalitions and efforts that have been made and that will be leveraged to advance Healthy Communities. [Enter text below]

CHART

Summarize the structures and processes developed for decision making within the CHART. [Enter text below]

Describe the structures and processes that have been put in place to ensure that CHART member involvement matches their skills, interests, and resources. [Enter text below]

Summarize structures and processes for communication within the CHART. [Enter text below]

Describe how the CHART prioritized strategies within the CAP. [Enter text below]

Assessment

CHANGE Tool Information

Describe key findings of CHANGE and how the data will be used to inform the CAP. [Enter text below]

Community Assessment Information

Enter any assessments conducted in addition to CHANGE. If no other assessments have been conducted, leave this section blank. Add additional rows as needed.

Name of Assessment	Date Assessment Completed	Description of Assessment	How Assessment Data Informed the CAP

Planning, Implementation and Evaluation

Workplan Instructions:

Goals (list up to 5)

Goals are broad statements that establish the overall direction for and focus of your project, describe your project's overall purpose, and serve as a framework for developing your objectives. For purposes of this workplan, your goals should span the entire project period. Use the following format for developing your goals:

- By [date], [increase, decrease, or maintain] [#, %, or rate] [what will be measured] from [baseline] to [target].
- Example: By September 2012, increase the percent of total miles of physical infrastructure for walking from 35 to 65.

For each goal, select which priority area(s) the goal addresses and explain how the goal impacts them. Include background, history, and a rationale for the goal. Finally, include information on how the goal will be measured (i.e. source(s) of data). For the CAP resubmission, you will be asked to describe the progress and challenges to meeting the goal. For each goal, copy the template on page 7 and paste onto a new page. Number goals as 1.0, 2.0, etc.

Objectives (minimum of 1 objective per goal)

For purposes of this workplan, the objective should span a one-year period and use the following format:

- By [date], [increase, decrease, or maintain] [#, %, or rate] [what will be measured] from [baseline] to [target].
- Example: By September 2011, increase the percent of new developments with paved sidewalks from 10 to 100.

For each objective, select the setting/sector and policy/environmental change strategy it addresses. Also describe the evidence- (e.g., The Community Guide, American Heart Association national recommendations, Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure) or practice-base (e.g., expert opinion, pilot project results) for the objective. Include the number of people reached through this objective (e.g. number of residents in a neighborhood, number of students in a school district). Describe how the objective impacts the problem. Then list up to 10 action steps needed to accomplish the objective, including the lead person/organization responsible for each action step and the timeframe. Finally, include information on how the objective will be measured (i.e. source(s) of data). For the CAP resubmission, you will be asked to describe the progress and challenges to meeting the objective. For each objective, copy the template on pages 8-9 and paste onto new pages. Number objectives as 1.1, 1.2 (for Goal 1), 2.1, 2.2 (for Goal 2), etc.

[ENTER YOUR COMMUNITY NAME HERE] WORK PLAN

Project Goal 1.0 (list up to 5)

Goal:

State your goal here using the following format: By [date], [increase, decrease, or maintain] [#, %, or rate] [what will be measured] from [baseline] to [target].

Priority area(s) the goal addresses:

Chronic diseases: ☐ arthritis ☐ cancer ☐ cardiovascular disease ☐ diabetes ☐ obesity

Related risk factors: ☐ nutrition ☐ physical activity ☐ tobacco

How the goal impacts the priority area(s): [Enter text below]

Measuring progress:

Primary Data Source:

Secondary Data Source:

Describe the progress:

Describe barriers or issues and plans to overcome them:

Annual Objective 1.1 (minimum of 1 objective per goal)

Setting/Sector:

☐ Community at large ☐ Community institution/organization ☐ Health care ☐ School ☐ Work site

Policy/environmental change strategy to achieve this objective: [Identify the selected sector's corresponding focus area and strategy from list found in Appendix A, e.g. physical activity: mixed land use]

Evidence/practice base for the strategy: [Enter text below]

Target number of people that will be reached:

How the objective impacts the problem: [Enter text below]

Objective: State your objective here using the following format: By [date], [increase, decrease, or maintain] [#, %, or rate] [what will be measured] from [baseline] to [target].

Measuring progress:

Primary Data Source:

Secondary Data Source:

Describe the progress:

Describe barriers or issues and plans to overcome them:

Action Steps (list up to 10):

Action Steps	Specific Person(s)/Organization(s) Responsible	Timeframe

Sustainability Plan

Describe the plan to maintain the CHART and/or associated activities beyond the national funding commitments. Elements of sustainability include CHART infrastructure, maintenance, and development of local capacity, identification of additional funding sources, or policy implementation that may continue beyond the life of this funding. [Enter text below]

Communications Plan

Describe any plans your CHART has to communicate this plan or your work to your greater community or stakeholders. [Enter text below]

Resources

Describe what additional resources (e.g., funding, equipment, media, human resources, in-kind) that have been committed, and by whom, to leverage resources. [Enter text below]

Date completed

Date revised

Date revised

Appendix to Community Action Plan Template

Community-At-Large Sector

Focus Area: Physical Activity

PSE change strategies

1. Sidewalks
2. Land use plan
3. Bike facilities
4. Complete streets plan
5. Walking route maintenance
6. Biking route maintenance
7. Park maintenance
8. Parks, shared-use paths and trails, or open spaces
9. Mixed land use
10. Sidewalk compliance with the Americans with Disabilities Act
11. Public parks and recreation facilities compliance with the Americans with Disabilities Act
12. Public recreation programs and activities (e.g., walking, biking, or other physical activity opportunities) for all
13. Public transportation within reasonable walking distance
14. Street traffic calming measures
15. Personal safety strategies
16. Other (specify)

Focus Area: Nutrition

PSE change strategies

1. Healthy food and beverage option retail strategies
2. Healthy food and beverage options at local restaurants and food venues
3. Healthy food and beverage options at public parks and recreation facilities
4. Community gardens
5. Public transportation to supermarkets and grocery stores
6. Farmers' markets
7. WIC and food stamp vouchers or food stamp benefits at farmers' markets
8. Locally grown foods
9. Fruit and vegetable promotion
10. Nutritional labeling
11. Smaller portion sizes
12. Trans fat ban
13. Recruitment of supermarkets and large grocery stores in underserved areas
14. Private spaces for nursing or pumping
15. Right to breastfeed in public places
16. Pricing strategies
17. Safe, unflavored, cool drinking water at no cost at public parks and recreation facilities
18. Other (specify)

Focus Area: Tobacco

PSE change strategies

1. Smoke-free policy 24/7 for indoor public places
2. Tobacco-free policy 24/7 for indoor public places
3. Smoke-free policy 24/7 for outdoor public places
4. Tobacco-free policy 24/7 for outdoor public places
5. Tobacco advertisement ban
6. Tobacco promotions, promotional offers, and prizes ban
7. Tobacco retail outlets regulation
8. Tobacco vending machine restriction
9. Single cigarette sale ban
10. Tobacco product price increase
11. Tobacco cessation referral system
12. Other (specify)

Focus Area: Chronic Disease Management

PSE change strategies

1. Chronic disease self-management programs
2. Obesity prevention strategies
3. High blood pressure control strategies
4. Cholesterol control strategies
5. Blood sugar or insulin level control strategies
6. Heart attack and stroke symptom strategies
7. Preventive care strategies
8. Emergency medical services
9. Chronic disease health disparities strategies
10. Other (specify)

Focus Area: Leadership

PSE change strategies

1. Chronic disease community coalitions and partnerships
2. Public policy process to address chronic diseases and related risk factors
3. Financing shared-use paths or trails
4. Financing public recreation facilities
5. Financing public parks or greenways
6. Financing public sports facilities
7. Financing pedestrian enhancements
8. Financing bicycle enhancements
9. Physical activity a priority in operating budget
10. Mixed land use promotion through regulation or other incentives
11. Management program to improve transportation system safety
12. Staff for overseeing community-wide healthy living opportunities
13. Marketing of community-wide healthy living strategies
14. Other (specify)

Community Institution/Organization Sector

Focus Area: Physical Activity

PSE change strategies

1. Stairwell use
2. Safe area outside to walk or be active
3. Walking path
4. Non-motorized commutes
5. Public transportation within reasonable walking distance
6. Onsite fitness center or classes
7. Changing room or locker room with showers
8. Bicycle parking
9. Access to competitive and noncompetitive physical activities
10. Opportunity for unstructured play or leisure-time physical activity
11. Physical activity as punishment prohibition
12. Screen time restriction
13. Direct support for community-wide physical activity opportunities
14. Other (specify)

Focus Area: Nutrition

PSE change strategies

1. Healthy food and beverage options in vending machines
2. Healthy food and beverage options at meetings and events
3. Healthy food and beverage options in onsite cafeteria and food venues
4. Healthy food purchasing
5. Healthy food preparation practices
6. Pricing strategies
7. Marketing ban of less than healthy foods and beverages
8. Smaller portion sizes
9. Nutritional labeling

10. Safe, unflavored, cool drinking water
11. Food as a reward or punishment
12. Direct support for community-wide nutrition opportunities
13. Private space for nursing or pumping
14. Other (specify)

Focus Area: Tobacco

PSE change strategies

1. Smoke-free policy 24/7 for indoor public places
2. Tobacco-free policy 24/7 for indoor public places
3. Smoke-free policy 24/7 for outdoor public places
4. Tobacco-free policy 24/7 for outdoor public places
5. Tobacco vending machine sales ban
6. Tobacco promotions, promotional offers, and prizes ban
7. Tobacco advertisements ban
8. Tobacco cessation referral system
9. Other (specify)

Focus Area: Chronic Disease Management

PSE change strategies

1. Chronic disease self-management programs
2. Onsite nurse
3. Onsite medical clinic
4. Routine screening, follow-up counseling and education
5. Heart attack and stroke curricula adoption
6. 9-1-1 curricula adoption
7. Chronic disease prevention promotion
8. Emergency response plan
9. Other (specify)

Focus Area: Leadership

PSE change strategies

1. Chronic disease prevention incentives
2. Public policy process to address chronic diseases and related risk factors
3. Wellness coordinator
4. Wellness committee
5. Health promotion budget
6. Mission statement including patron health and well-being
7. Needs assessment for health promotion programs
8. Evaluation of health promotion programs
9. Patron feedback about health promotion programs
10. Chronic disease community coalitions and partnerships
11. Other (specify)

Health Care Sector

Focus Area: Physical Activity

PSE change strategies

1. Stairwell use
2. Screening of patients' physical activity habits
3. Regular counseling about physical activity
4. Physical activity referral system
5. Other (specify)

Focus Area: Nutrition

PSE change strategies

1. Breastfeeding initiative
2. Screening of patients' nutritional habits
3. Regular counseling about good nutrition

4. Weight management or nutrition programs
5. Nutrition referral system
6. Healthy food and beverage options in vending machines
7. Healthy food and beverage options served to patients
8. Healthy food and beverage options in the onsite cafeteria and food venues
9. Pricing strategies
10. Healthy food purchasing
11. Healthy food preparation practices
12. Nutritional labeling
13. Marketing ban of less than healthy foods and beverages
14. Smaller portion sizes
15. Other (specify)

Focus Area: Tobacco

PSE change strategies

1. Smoke-free policy 24/7 for indoor public places
2. Tobacco-free policy 24/7 for indoor public places
3. Smoke-free policy 24/7 for outdoor public places
4. Tobacco-free policy 24/7 for outdoor public places
5. Screening of patients' tobacco use
6. Screening of patients' exposure to tobacco smoke
7. Regular counseling about the harm of tobacco use and exposure
8. Tobacco cessation referral system
9. Pharmacological quitting aids
10. Provider-reminder system
11. Other (specify)

Focus Area: Chronic Disease Management

PSE change strategies

1. Chronic disease referral system
2. Routine follow-up counseling and education
3. Screening for chronic diseases
4. BMI measurement
5. Plan to increase patient adherence to chronic disease treatment
6. Systematic approach to diabetes care
7. Emergency heart disease and stroke treatment guidelines
8. Stroke rating scale training
9. Specialized stroke care units
10. Specialized heart disease units
11. Other (specify)

Focus Area: Leadership

PSE change strategies

1. Chronic disease community coalitions and partnerships
2. Public policy process to address chronic diseases and related risk factors
3. Childhood overweight prevention and treatment services
4. Standards of modifiable risk factor practice
5. Standardized treatment and prevention protocols
6. Electronic medical records system and patient data registries
7. Chronic Care Model
8. Provider care team
9. Medical services or access to medical services outside of regular working hours
10. Collaboration between health care professionals
11. Partners to provide chronic disease health screenings, follow-up counseling, and education
12. Cultural competence training
13. Other (specify)

School Sector

Focus Area: District

PSE change strategies

1. Physical education for middle and high school students
2. Physical education for elementary school students
3. Daily recess education for elementary school students
4. Physical education waivers
5. Fruits or vegetables required wherever foods and beverages are sold
6. Sale and distribution of less than healthy foods and beverages eliminated
7. Sugar-sweetened beverages
8. Tobacco-free policy 24/7
9. Tobacco advertising ban
10. Tobacco promotions, promotional offers, and prizes ban
11. Full-time, qualified healthcare provider
12. Case management plan for students with chronic diseases or conditions
13. Access to prescribed medications
14. District health group
15. Designated school health coordinator
16. School compliance with district school wellness policy
17. Public use of school buildings and facilities
18. Physical education curriculum adoption
19. Nutrition education curriculum adoption
20. Tobacco-use prevention curriculum adoption
21. Other (specify)

Focus Area: Physical Activity

PSE change strategies

1. Physical activity as punishment ban
2. Active time during physical education class
3. Competitive and noncompetitive physical activities
4. Walk or bike to school initiative
5. Proper equipment and facilities
6. School location within reasonable walking distance of residential areas
7. Other (specify)

Focus Area: Nutrition

PSE change strategies

1. Healthy food and beverage options beyond the school food services
2. School breakfast and lunch programs
3. Healthy food preparation practices
4. Marketing ban of less than healthy foods and beverages
5. Promotion and marketing only of healthy food and beverage options
6. Adequate time to eat school meals
7. Safe environment to eat school meals
8. Food as a reward or punishment ban
9. Safe, unflavored, cool drinking water
10. School garden and resources
11. Multiple channels to promote healthy eating behaviors
12. Other (specify)

Focus Area: Tobacco

PSE change strategies

1. Tobacco cessation referral system
2. Other (specify)

Focus Area: Chronic Disease Management

PSE change strategies

1. Chronic disease self-management programs
2. Nutritional needs of students with special health care or dietary requirements
3. Heart attack and stroke curricula adoption
4. 9-1-1 curricula adoption
5. CPR curricula adoption
6. Family involvement in the development of school plans
7. Other (specify)

Focus Area: Leadership

PSE change strategies

1. Chronic disease community coalitions and partnerships
2. Public policy process to address chronic diseases and related risk factors
3. School building health group
4. Individual responsible for leading school health activities
5. Health promotion budget
6. Mission or position statement that includes student health and well-being
7. Teachers with appropriate training, education, and background
8. Training and support to food service/relevant staff
9. Professional development or continued education to staff
10. Training for teachers and staff on school physical activity, nutrition, and tobacco prevention policies
11. Health-promoting fund raising efforts
12. Other (specify)

Focus Area: After-School

PSE change strategies

1. Physical activity as punishment ban
2. Food as reward or punishment ban
3. Physical activity programs
4. Active time during after-school programs or events
5. Healthy food and beverage options
6. Sugar-sweetened beverages prohibition
7. Other (specify)

Work Site Sector

Focus Area: Physical Activity

PSE change strategies

1. Stairwell use
2. Flexible work arrangements
3. Non-motorized commutes
4. Public transportation within reasonable walking distance
5. Clubs or groups to encourage physical activity
6. Safe area outside to walk or be active
7. Walking path
8. Onsite fitness center or classes
9. Changing room or locker room with showers
10. Subsidized membership to offsite workout facility
11. Bicycle parking
12. Activity breaks for meetings
13. Direct support for community-wide physical activity opportunities
14. Other (specify)

Focus Area: Nutrition

PSE change strategies

1. Healthy food and beverage options at meetings and events
2. Healthy food and beverage options in vending machines
3. Healthy food and beverage options in onsite cafeteria and food venues
4. Healthy food purchasing practices
5. Healthy food preparation practices
6. Marketing ban of less than healthy foods and beverages
7. Smaller portion sizes
8. Safe, unflavored, cool drinking water
9. Nutritional labeling
10. Pricing strategies
11. Refrigerator access
12. Microwave access
13. Sink with water faucet access
14. Direct support for community-wide nutrition opportunities
15. Breastfeeding support through maternity care practices
16. Other (specify)

Focus Area: Tobacco

PSE change strategies

1. Smoke-free policy 24/7 for indoor public places
2. Tobacco-free policy 24/7 for indoor public places
3. Smoke-free policy 24/7 for outdoor public places
4. Tobacco-free policy 24/7 for outdoor public places
5. Insurance coverage for tobacco cessation services
6. Insurance coverage for tobacco cessation products
7. Tobacco vending machine sales ban
8. Tobacco promotions, promotional offers, and prizes ban
9. Tobacco advertisements ban
10. Tobacco cessation referral system
11. Other (specify)

Focus Area: Chronic Disease Management

PSE change strategies

1. Routine screening, follow-up counseling and education
2. Onsite nurse
3. Onsite medical clinic
4. Time off to attend health promotion programs or classes
5. Insurance coverage for preventive services and quality medical care
6. Free or low cost employee health risk appraisal or health screenings
7. Chronic disease self-management programs
8. Heart attack and stroke curricula adoption
9. 9-1-1 curricula adoption
10. Chronic disease prevention promotion
11. Emergency response plan
12. Other (specify)

Focus Area: Leadership

PSE change strategies

1. Reimbursement for preventive health or wellness activities
2. Public policy process to address chronic diseases and related risk factors
3. Wellness coordinator
4. Wellness committee
5. Health promotion budget
6. Mission statement that includes employee health and well-being
7. Employee health and well-being organizational or performance objectives
8. Health insurance plan

9. Office-based incentives for participating in chronic disease prevention measures
10. Needs assessment for health promotion program
11. Evaluation of health promotion programs
12. Employee feedback about health promotion programs
13. Chronic disease community coalitions and partnerships
14. Other (specify)

Appendix C: Community Action Plan Objectives

Note: Cohorts have been slightly regrouped for analysis. Not all counties are included in this analysis, as explained earlier in this report in the analysis section.

Cohort 1

Community Setting

	Physical Activity	Nutrition	Tobacco	Self-Mgmt	Other	Totals
Benton	2	3	3	2	0	10
Columbia	0	2	2	2	0	6
Coos	0	2	2	3	0	7
Deschutes	2	1	3	2	1	9
Jackson	1	1	2	2	0	6
Jefferson	1	3	4	3	2	13
Klamath	1	2	2	2	0	7
Marion	1	2	3	2	0	8
Multnomah	1	4	4	1	1	11
Yamhill	1	1	2	2	0	6
Totals	10	21	27	21	4	83

Schools Setting

	Physical Activity	Nutrition	Tobacco	Self-Mgmt	Other	Totals
Benton	1	1	0	0	2	4
Columbia	0	0	1	0	2	3
Coos	0	0	0	1	1	2
Deschutes	1	0	0	0	1	2
Jackson	0	0	0	0	2	2
Jefferson	2	0	1	0	2	5
Klamath	1	0	0	0	2	3
Marion	0	1	0	0	1	2
Multnomah	3	3	0	1	2	9
Yamhill	1	1	0	0	2	4
Totals	9	6	2	2	17	36

Worksites Setting

	Physical Activity	Nutrition	Tobacco	Self-Mgmt	Other	Totals
Benton	1		1	2	1	5
Columbia	0	1	1	1	2	5
Coos	0	0	1	1	1	3
Deschutes*	1			3	1	5
Jackson	1	1	0	2	1	5
Jefferson*	1		2	2	1	6
Klamath*	1		1	3	1	6
Marion	0	2	1	0	1	4
Multnomah	2	0	0	2	0	4
Yamhill	0	0	1	4	1	6
Totals	3*	4*	8	20	10	49

*Four counties had objectives that included nutrition, physical activity, and/or tobacco. For example: "X County will adopt policies to support nutrition and physical activity among employees." These four objectives are included in the totals, but not in the "Objectives by Content Area" tables.

Health System Setting

	Physical Activity	Nutrition	Tobacco	Self-Mgmt	Other	Totals
Benton	0	0	3	1	1	5
Columbia	0	0	2	0	2	4
Coos	0	0	1	1	0	2
Deschutes	0	0	3	1	0	4
Jackson	0	0	2	2	1	5
Jefferson	0	0	3	0	1	4
Klamath	0	0	3	0	1	4
Marion	0	0	3	1	1	5
Multnomah	0	1	2	2	1	6
Yamhill	0	0	4	0	1	5
Totals	0	1	26	8	9	44

Cohort 2

Objectives by content area

	Physical Activity	Nutrition	Tobacco	Self-Mgmt	Other	Totals
Baker	1	0	0	1	1	3
Clackamas	2	1	0	0	0	3
Clatsop	2	2	1	0	1	6
Crook	7	12	7	6	1	33
Curry	6	10	5	4	5	30
Douglas	6	13	6	9	3	37
Harney	0	0	0	0	1	1
Hood River	1	1	1	0	0	3
Josephine	1	1	1	1	1	5
Lincoln	0	1	1	0	0	2
Linn	0	0	1	1	2	4
Malheur	1	3	1	0	0	5
Morrow	2	0	1	1	1	5
Polk	2	1	1	1	0	5
Tillamook	0	0	2	0	1	3
Umatilla	0	2	0	1	1	4
Union	0	0	0	1	2	3
Wallowa	3	3	0	0	2	8
Washington	1	2	1	0	2	6
Wheeler	1	0	0	1	1	3
Totals	36	52	29	27	25	169

Appendix D: Community Action Plan Objectives by priority area, as defined by each county

The numbers for each county correspond with the CAP objective number that addresses that priority area.

Disease & Risk Factors	Arthritis	Asthma*	Cancer	CVD	Diabetes	Obesity	Nutrition	PA	Tobacco
Baker	1, 2, 3		2, 3	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3
Clackamas	1, 2		1, 2	1, 2, 3	1, 2	1, 2, 3	2	1, 3	
Clatsop	1		2, 3	1, 2, 3	1, 2	1, 2	1, 2	1	3
Crook	Not marked in this manner								
Curry	Not marked in this manner								
Douglas	Not marked in this manner								
Harney						1	1	1	1
Hood River	2		1, 3	1,2,3	1,2	1,2	1	2	3
Josephine	Not marked in this manner								
Lincoln			2	1, 2	1	1	1		2
Linn	1,2,3,4	1,2,3,4	1,2,3,4	1,2,3,4	1,2,3,4	1,2,3,4	2,3,4	2,3,4	1,2,3,4
Malheur			1, 2,4	1, 2, 3,4	1, 2, 3	1, 2, 3	1, 2	1, 3	4
Morrow	1		1,2,3	1,2,3	1,3	1,3	3	1	2
North Central	Not marked in this manner								
Polk	4		3,4	1,3,4,5	4	1,2,4,5	2,4	1,4,5	3,4
Tillamook	1, 3		3	1, 3	1, 3	1, 3	3	1, 3	1, 2, 3
Umatilla	1,2,3,4		1,2,3,4	1,2,3,4	1,2,3,4	1,2,3,4	1,2,3,4	1,3,4	1,3,4

Disease & Risk Factors	Arthritis	Asthma*	Cancer	CVD	Diabetes	Obesity	Nutrition	PA	Tobacco
Union	1,2,3			1,2,3	1,2,3	1,2,3	1,2,3	1,2,3	1,2,3
Wallowa	2,3		3	1,2,3	1,2,3	1,2,3	1,3	2,3	3
Washington	1,2,4		1,2,3,4	1,2,3,4	1,2,4	1,2,4	1,2,4	1,2,4	1,2,3,4
Wheeler	1, 2		1, 2	1, 2, 3	1, 2, 3	1, 2, 3	1, 3	1, 2, 3	1, 3
TOTAL COUNTIES	13	1	14	15	15	16	16	15	15
TOTAL GOALS	29	4	33	48	38	43	32	33	31

*When creating the CAP, the second cohort used the ACHIEVE template, which required grantees to identify the priority areas each objective addresses from the list above, with the exception of asthma. Asthma was not specifically listed in the template, but one community did write it in.

Note: As the second cohort used a more open-ended CAP template, the reach and specificity of goals and objectives vary. As explained earlier in this report, the analysis by content area located in Appendix C looked at both goals and objectives to identify the proposed policies or environmental changes. In this table, priority areas were defined by each county based only on their stated CAP goals. The total number of objectives in Appendix C do not align with the total numbers here.

Healthy communities: Building capacity based on local tobacco control efforts

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