


Partnering4Health

NATIONAL ORGANIZATIONS EMPOWERING COMMUNITIES TO IMPROVE POPULATION HEALTH

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EXECUTIVE SUMMARY

For the past two decades, the U.S. Centers for Disease Control and Prevention (CDC) has funded communities throughout the United States via a competitive process to promote healthy lifestyles and decrease morbidity and mortality due to costly chronic diseases. The aim of each funding initiative was to stimulate communities' adoption of policies, systems, and environments (PSE) that would make communities healthier and promote individuals' healthy choices. From 2014 to 2017, CDC provided five national organizations a total of $30 million to work with local communities and build their capacity for implementing sustainable changes that support healthy communities and lifestyles. The overall goal of CDC's funding was to implement, evaluate, and disseminate evidence- and practice-based community health activities that promote health equity and eventually lead to a five percent reduction in the rate of death and disability due to tobacco use, a three percent reduction in the prevalence of obesity, and a three percent reduction in the rates of death and disability due to diabetes, heart disease, and stroke.

Through a competitive process, CDC's **Division of Community Health** selected three national organizations to work with their existing regional or local affiliates, chapters, or members: **American Heart Association** (AHA), **American Planning Association** (APA), and **National WIC Association** (NWA). These national organizations provided 97 funding awards to 94 communities in **two cohorts**. The funding supported communities' work toward PSE changes that would increase access to smoke-free environments, healthier foods and beverages, and physical activity opportunities, as well as overall chronic disease prevention and risk reduction or management initiatives. In addition to funding these three organizations, CDC funded two other national organizations to provide training, communication support, and technical assistance to the project: the **Directors of Health Promotion and Education** (DHPE) and the **Society for Public Health Education** (SOPHE).

The expectation was that the national organizations could leverage their existing networks, resources, and expertise to reach more communities—especially smaller communities unlikely to compete successfully for direct federal awards—to yield a positive return on the federal investment. National organizations would further the project's reach by sharing lessons and expertise gained from this project with affiliates, chapters, and members in non-funded communities. To ensure this project functioned as a single entity, the five national organizations formed a national coalition to share decision-making, coordinate resources, and communicate lessons learned with each other. They named the project **Partnering4Health**.

Through their own competitive processes, AHA, APA, and NWA selected two cohorts of diverse urban, rural, and tribal communities for 13 to 15 months of funding support. With modest funding, the 94 funded communities made remarkable strides in improving access to healthier opportunities where people live, work, and play. As a result of the project, more than 20 million people in communities throughout the United States now have more access to nutritious foods, physical activity, smoke-free environments, and/or clinical preventive services. Residents of 74 communities now have more access to healthy food and beverage options sold at corner stores, vending machines, mobile food trucks, farmers' markets, or by planting new community gardens. More farmers' markets and other sources of fresh produce in those communities now accept food stamps and WIC vouchers, making healthy food more available and affordable to those with low incomes. Residents of 36 communities have more opportunities for physical activity through the creation of bike- and walker-friendly spaces, strengthening of school physical education, addition of worksite wellness sites, and/or new shared use agreements that allow the public access to unused facilities such as

after-hours school gymnasiums or tracks. Those in six communities have more smoke-free parks, housing, or other environments. Mothers of young children in 29 communities can take advantage of breastfeeding-friendly environments and better links to health care professionals and community resources that promote healthy lifestyles. These remarkable achievements were disseminated in more than 39,000 media placements that reached over 177 million people and over 70,000 partners.

These impressive results in a short time frame were made possible by the funded national organizations' existing chapters, affiliates, and other connections to states and local communities. The combination of national, respected reputations of each organization; nimble infrastructure; existing partnerships; and chronic disease expertise within the national organizations allowed them to leverage federal funds and expedite results. As a result of participating in this project, each national organization also strengthened its own commitment and resolve to foster community-based changes using PSE approaches for reducing chronic diseases and promoting health equity.

During this three-year project, diverse partners rolled up their sleeves and invested thousands of hours so that adults, children, and adolescents could have expanded opportunities to live longer, healthier lives. Without access to healthy foods, safe places to play or exercise, smoke-free environments, or breastfeeding-supportive policies, people's opportunities to avoid chronic diseases are hampered. The 94 communities each contributed in their own ways to advancing the evidence-based practices that will help others create healthier communities. Each national organization has changed in structural, conceptual, or policy ways that will continue past the funding and advance the healthy communities movement.

This report documents accomplishments of the Partnering4Health project at the community and national levels. It also suggests factors that contributed to success and ways of improving future projects that use a similar national organization model to make community-level changes.

INTRODUCTION

With 13 to 15 months of modest funding (approximately $170,000 each), **94 communities throughout the United States** provided over 20 million people with more opportunities to access healthy foods, physical activity, smoke free environments, and/or clinical preventive services. Five national organizations provided expertise, resources, and financial support to the communities using the federal funding they received from the U.S. Centers for Disease Control and Prevention (CDC). In addition to the accomplishments of these 94 communities, the national organizations leveraged the federal funding they received to affect additional communities by incorporating what they learned through this project into their ongoing work and future plans.

TABLE 1: PRIORITY AREAS OF COMMUNITIES SELECTED BY NATIONAL ORGANIZATION

STRATEGY	AHA	APA	NWA	TOTAL
Healthy Foods and Beverages—in public places such as corner stores, vending machines, cafeterias, mobile markets, farmers' markets, new community gardens, innovative financing, and breastfeeding support	22	21	31	74
Physical Activity—more bike and walker-friendly spaces, physical education and physical activity in schools and worksites, and new shared use agreements	9	27	0	36
Smoke-free Environments	6	0	0	6
Clinical Linkages—more access to physicians and community providers interested in systemic approaches to reducing chronic disease risks, especially by promoting breastfeeding	0	0	29	29

Extending its decades-long commitment to funding community-level work for promoting health, CDC, through its **Division of Community Health**, used a competitive process to select three national organizations to work with their existing regional or local affiliates, chapters, or members across the United States: **American Heart Association**, **American Planning Association**, and **National WIC Association**. In addition, CDC provided funding to two other national organizations for training, communication support, and technical assistance to the other three national organizations and their 94 communities: the **Directors of Health Promotion and Education** and the **Society for Public Health Education**.

The overall goal of CDC's funding was to implement, evaluate, and disseminate evidence- and practice-based community health activities for strengthening local-level capacity and implementing population-based strategies. Anticipated outcomes were a five percent reduction in the rate of death and disability due to tobacco use, a three percent reduction in the prevalence of obesity, and a three percent reduction in the rates of death and disability due to diabetes, heart disease, and stroke.

This report documents accomplishments of the project at the community and national levels and demonstrates how the work advances the healthy communities movement. It also suggests factors that contributed to successful implementation of policy, systems, or environmental (PSE) change strategies and recommends ways to shape future work in collaboration with national organizations.

THE FUNDED ORGANIZATIONS

The funded national organizations supported communities by providing training and technical assistance, consultation, resources and tools, and communication support, in addition to funding. This support not only resulted in specific PSE changes that made communities healthier, but also gave community leaders experience with new ways of doing their work and created new partnerships that will continue long after the funding ends. The national organizations themselves also created structural, conceptual, or policy changes that will continue past the funding and will advance the healthy communities movement.

The **American Heart Association's Accelerating National Community Health Outcomes through Reinforcing** (ANCHOR) Partnerships project worked with 30 regional communities on clearing the air of secondhand smoke, improving access to healthy food and beverages, and/or increasing opportunities for physical activity. The **American Planning Association's Plan4Health** project brought APA chapter members together with members of the **American Public Health Association** (APHA) as part of 33 community coalitions that addressed nutrition and/or physical activity. The **National WIC Association's Community Partnerships for Healthy Mothers and Children** (CPHMC) project empowered local WIC agency staff in 31 communities to improve access to nutritious foods and beverages, including breast milk for infants and improved linkages between communities and clinicians—especially those who were members of NWA's project partner, the **American College of Obstetricians and Gynecologists** (ACOG).

The two training and technical assistance-funded national organizations drew on their experience, networks, resources, and members to supplement the other funded national organizations and their community partners. The Association of State and Territorial Directors of Health Promotion and Public Health Education, which does business as the **Directors of Health Promotion and Education**, and the **Society for Public Health Education** jointly developed and launched technology-based tools and resources, provided training, led national communication efforts, and facilitated community and partner national meetings.

To sustain changes and make the best use of federal funding, this project employed PSE approaches and strategies that previous healthy community work had identified as evidence-based or best practices for chronic disease reduction. The initiative increased collaboration between national and community partners; increased the capacity at the community and national levels for implementing and sustaining PSE improvements; and disseminated messages on the importance of PSE change approaches to improving the public's health. For more information on the value of using PSE approaches, see Pullout: **Policy, Systems, and Environmental Change (PSE) as an Approach to Improved Population Health and Reduced Chronic Disease Burden**.

For more information on the specific approaches each national organization used, see Pullout: **Ways the American Heart Association supported its 30 Communities,** Pullout: **Ways the American Planning Association supported its 35 Communities**, Pullout: **Ways the National WIC Association Supported its 32 Communities**, and Pullout: **The Contributions of the Training and Technical Assistance National Organizations: DHPE and SOPHE**. In total, the national organizations made 97 funding awards to 94 communities.

PART I

STRATEGIES USED

Core Strategies

Whether organizations chose to work on improving access to healthier food and beverage options, physical activity opportunities, smoke-free environments, or clinical linkages, all the national organizations and the funded communities employed core approaches that included assessing community needs, working collaboratively through coalitions, and focusing on vulnerable and underserved populations in order to achieve more equitable health outcomes. The following section documents recommendations based on the experiences from this project. Links included in each section provide more information about specific approaches used. Each section ends with a selection of the lessons learned from this project as reported by program participants from funded communities.

Although each coalition implemented the core strategies, each also kept a community-centered approach that met communities where they were. Each community had its strengths and unique challenges, its history, and its culture. No one ideal model fit all communities. As coalitions engaged in the work, they often adjusted to new circumstances or partnerships. Thus, flexibility was a key to success.

COMMUNITY NEEDS ASSESSMENT

To provide the support that communities needed for success, the national organizations assessed their needs formally and informally throughout the project. Those needs evolved, as did the type of support provided.

At the local level, each community coalition either found an existing assessment of its community or gathered information about the community to help identify needs and strategies. They focused especially on working with at-risk populations who identified their priorities for improving their health. For more information on the assessments communities conducted, see Pullout: **Assessing the Needs of Communities**.

In the process of conducting their community needs assessments, the community coalitions gained insights that they will be able to apply to their future efforts. Some insights are well known to public health researchers, but might be less known at the grassroots level. A selection of the insights follows:

- Use both quantitative and qualitative data for determining community assets, existing programs, needs, and acceptable solutions. Include interviews with key stakeholders and community members.
- Decide in advance the plans for using any information gathered. Identify already available information and gaps in information needed, and then gather information to fill gaps.
- Use readability scales for designing questionnaires or surveys. Consider the needs of those with limited English proficiency. Determine which tools potential respondents are comfortable using, and pilot test surveys with members of the community of interest.
- Engage members of the community in planning and implementation from the beginning. Listen to concerns, seek win-wins, and fulfill commitments to build trust.

LOCAL COALITION BUILDING

Local communities developed or enhanced an existing multi-sectoral coalition that was capable of implementing sustainable PSE strategies during and after the project period. Each coalition had a multi-sectoral leadership team of at least three people who were responsible for guiding the coalition's work and representing the coalition at required meetings.

In some communities, an existing coalition applied for the funding and agreed to incorporate the project into its work. Other communities, however, had no relevant and willing coalition, so the national organization's chapter or affiliate created a coalition from the ground up. Having a paid staff person to support the coalition's work, especially in the initial stages, helped jump-start the coalition's formation. Each situation presented opportunities and learnings. Below are some lessons that community leadership teams reported. See Pullout: **Coalition Building** for more information about the coalition work and the types of partners involved.

PROCESS LESSONS

- Find facilitators who can harness the strengths of varied personalities and agendas while ensuring everyone has a voice in developing a shared vision.
- Restrict the use of jargon when working across sectors and with people from the community.
- Find common purpose by looking for win-win solutions.
- Make coalition meetings productive: present data, jointly map assets, discuss differences in organizational cultures, establish clear deliverables, develop a work plan, delineate roles and responsibilities, and provide time for participants to share their relevant work.
- Set short-term goals and quickly achievable objectives to keep people motivated and create a feeling of accomplishment.
- Use a consensus process for decision-making to reduce disappointments and feelings of alienation.
- To overcome barriers to participation, consider using audio or video conferencing when transportation or large distances present challenges. Set meeting times that fit with people's work schedules and arrange for child care or interpreters as needed.

CAPACITY-BUILDING LESSONS

- Educate community partners about the benefits of PSE approaches.
- Take advantage of learning opportunities, existing resources, events, and materials from national

organizations, other communities engaged in PSE work, and partners.

- Continually seek new partners by asking, "Who is not here?"
- Determine who will promote or support the goals of this effort.
- Look for non-traditional partners, keeping health equity a priority.
- Engage people from the affected community from the beginning to avoid plans that do not acknowledge their needs or assets.

SUSTAINABILITY LESSONS

- Recognize impact at two levels: the immediate project and the broader movement.
- Establish systems for measuring progress, keeping the project on track, and celebrating success.
- Remain flexible and responsive to windows of opportunity and changing community needs.

NATIONAL COALITION BUILDING

Recognizing that this project had many complementary elements, the national organizations formed their own coalition to coordinate their work and the support they provided to communities. An early task was clarification of strengths, assets, and roles. Through their participation in bi-weekly conference calls, workgroup meetings, and quarterly in-person meetings, the national organizations solidified their relationships and jointly executed the work. Much of the heavy lifting for the national coalition revolved around strategic planning and executing three national meetings for the funded communities. Results of the evaluation of the national coalition and future recommendations are provided in the evaluation section of this report.

COMMUNICATIONS

Communication with various stakeholders is vital in PSE change. Thus, both the national organizations and local community coalitions used various strategies to disseminate information about their work and how tobacco use and exposure, poor nutrition, physical inactivity, and lack of access to chronic disease prevention and risk reduction or management opportunities affect the public's health.

The national organizations worked with CDC to develop a comprehensive communication plan, including key messages and linking project communications to national U.S. Department of Health and Human Services (HHS) monthly health observances. DHPE and SOPHE engaged in and supported national and regional external communication and led the planning for national health observances communications. For more information about communications, see Pullout: **The**

Contributions of the Training and Technical Assistance National Organizations: DHPE and SOPHE. AHA, APA, and NWA communicated successes of the communities they supported with local media and utilized national health observances as media hooks. Each national organization had communication professionals within its national office and leveraged those resources for this project. Local community coalitions used both their own and the national organizations' media assets to disseminate messages, promote and explain their work, celebrate successes, and recruit participation in specific events and opportunities. CDC's success stories template provided a common framework for the communities to use in telling about their achievements. DHPE and SOPHE also facilitated communication among the national organization partners by facilitating conference calls and meetings and disseminating minutes.

At all levels, the organizations used both traditional and social media as well as other communication strategies. The purpose of some communications was to build the public's appreciation for investing in PSE approaches as a way to achieve better health and well-being. Other communications marketed or advertised specific opportunities for participation. For more information about the communication strategies and channels used, see Pullout: **Communication Activities** and Pullout: **The Contributions of the Training and Technical Assistance National Organizations: DHPE and SOPHE**.

Given that coalition leaders had varying backgrounds, at the end of the project they cited some communication insights to share with other communities. Although such pointers are basic to communication experts, they are included here to remind future project leaders to work with communities from the ground up in planning communication campaigns.

- Clearly define the audience, learn about it, and gauge the prior knowledge of audience members.
- Use language, terminology, symbols, and messages appropriate for the audience. Identify and use dissemination vehicles relied upon by audience members and messengers they find credible.
- Select spokespeople who have credibility with the intended audience. An organization's informal leaders often influence opinions and connect people. Turn such champions into celebrities.
- Match the medium with the audience. In small towns and rural areas with limited Internet access, face-to-face meetings were often more effective than social media.
- Time press releases and project announcements for maximum effect; highlight programs that have potential for recruiting future participation.
- Leverage partnerships, established communication vehicles, and existing resources existing resources (e.g., materials developed by CDC and other national organizations) for national health observances.

EQUITY

The preventable causes of morbidity and mortality that CDC aimed to address through this project are more common in populations where environmental conditions and circumstances reinforce unhealthy behaviors. Chronic diseases are often more debilitating, diagnosed later, and associated with worse outcomes in racial/ethnic minorities and low-income individuals, which affects the health of communities overall. Therefore, CDC specified that sites selected for support should strive to reduce health disparities, positioning health equity at the crux of practice—especially at the community level.

All the national organizations had previously engaged in health equity initiatives and brought that experience to the table. Many local community coalitions were aware of the importance of adopting a health equity approach, while others became awakened to inequities in their communities during this project. Recognizing the importance of achieving health equity, many communities obtained organizational commitments to continue applying this focus within their future practices. For more information about the approaches used to work toward health equity, see Pullout: **Addressing Health Equity**. Incorporating health equity in a meaningful way requires ongoing commitment, ideally becoming a practice and more than just a checkbox for a project—a process rather than an end in itself. Important considerations cited by the communities include:

- Start health equity work internally, using bias assessments with staff as well as equity audits that consider both capacity and need at the organizational level. At both the individual and organization levels, recognize that "my experience is my experience" and that "good community work is good self-work."
- Include community influencers and local leaders in the coalition as full participants in discussions and decision-making. Use focus groups to both hear the community voice and garner community champions. Creating community ownership builds trust and supports sustainability.
- Be deliberate about health equity; learn about "legacies of oppression" that affect how a community does or does not make use of available resources and opportunities. True equity is unattainable without addressing what is not visible—events (what happened), patterns (what continues to happen), and structures (what causes patterns to be maintained). Structures include racism, poverty, sexism, and historical injustices.
- To engage community voices and informal community leaders, attend gatherings and events outside normal work hours, lead from behind, meet people where they are (e.g., farms, stores, bus stops, soup kitchens, clinics, public housing, senior centers, rallies, festivals). Engage community

health workers to build trusted bridges to community members. Some communities used grant funds to pay people for their time and for the costs of attending coalition meetings or focus groups.

- Educated professionals, people from the majority culture, and people with power often need to be educated about inequities and how issues and conditions interrelate. Approaches to education included use of data, storytelling, and internships.

Intervention Strategies

Funded communities could work on multiple areas within the four priority topics (e.g., nutrition, physical activity). What follows are descriptions of strategies that communities used to address each priority with specific examples, successes, and challenges faced and overcome. Regardless of the specific strategies and topic areas, two factors were keys to success: project management and community champions. When key project personnel or champions left the project, the communities often experienced setbacks. Building on community assets and expanding existing work accelerated progress faster than starting from the beginning. Strategies and tactics that worked in urban environments often did not apply in rural or tribal communities. Those wishing to engage in similar work should consider their communities' strengths, assets, and needs before embarking on a PSE approach. As previously shown in Table 1 (page 5), communities selected a variety of priority areas and strategies.

IMPROVING ACCESS TO HEALTHIER FOODS AND BEVERAGES

To improve access to healthier foods and beverages, strategies often required assuring proprietors that healthier food options could be profitable, overcoming regulatory impediments, and identifying reliable sources of water for gardens and fresh produce in quantities consistent with rates of product turnover. Many initiatives succeeded when the selected communities helped with the marketing of sites offering more nutritious options; provided education on ways to use fresh produce or other healthier options; and enacted policy changes. Click on each strategy in Table 2 (page 15), for specific examples.

TABLE 2: HEALTHY FOOD AND BEVERAGE ACCESS STRATEGIES COMMUNITIES SELECTED BY THE NATIONAL ORGANIZATIONS

STRATEGY	AHA	APA	NWA
Retail/Corner Stores	0	8	26
Procurement	18	1	0
Farmers' and Mobile Markets	11	4	9
Food Financing/Systems	7	8	2
Community Gardens	0	3	4

SUCCESS STORY

As part of the National WIC Association project, Wichita Falls-Wichita County Public Health District Texas started a new farmers' market at the local health department/WIC office to increase use of the farmers' market nutrition program for WIC clients. The project resulted in the distribution of 700 booklets worth $30, an additional $16,800 worth of fruits and vegetables in benefits for WIC clients over the age of one, and a 25 percent increase in voucher redemption rates for 2015.

SUCCESS STORY

To illustrate mobility and access issues that create barriers to walking and biking, one American Planning Association project provided 25 community leaders with wheelchairs to use for running errands. Making places wheelchair-friendly also makes them stroller- and walker-friendly. To illustrate issues related to bicycling, the coalition invited community leaders to ride bikes alongside bicycling advocates.

PHYSICAL ACTIVITY

Many AHA and APA communities worked on increasing access to physical activity opportunities to improve community health. Among AHA's nine communities working on this priority, three used shared use agreements as strategies, six worked to strengthen **physical education in schools**, and two strove to **increase walkability or bikeablity** in the community at large. Of APA's 27 communities that worked to increase physical activity opportunities, 25 worked on changes to make the community more walkable or bikeable, three used shared use agreements, and two sought to increase worksite physical activity initiatives.

SUCCESS STORY

The American Heart Association project in Beaverton, Oregon succeeded in getting all 33 elementary schools to implement 10 minutes of physical activity throughout the day.

COMMUNITY AND CLINICAL LINKAGES

Twenty-nine of NWA's communities worked to improve community/clinical linkages. The local coalitions drew on WIC's existing work in support of **breastfeeding** and **service referrals** to establish strong referral networks; create lactation rooms; make "prescriptions" for non-pharmaceutical interventions; train healthcare providers and community partners on WIC benefits, breastfeeding, and cultural competency; and share tools and resources through resource guides and a resource navigator program. The American College of Obstetricians and Gynecologists (ACOG) helped recruit and engage OB/GYNs and other healthcare providers to participate in WIC's community/clinical linkage work. ACOG successfully included NWA's Project in the American Board of Obstetrics and Gynecology's Maintenance of Certification Process, by authorizing credits toward recertification for participation in the project.

SUCCESS STORY

Richmond City Health District (Virginia) developed three WIC 101 trainings specifically tailored for pediatricians, OB-GYNs, and community-based organizations. The project staff trained a total of 517 care providers. They shared the training materials with other funded communities on a Partnering4Health webinar and provided technical assistance to non-funded local WIC agencies in Virginia and throughout the county. A WIC infrastructure grant allowed them to sustain their work by conducting WIC 101s and liaison outreach at neighboring health districts in Virginia.

SUCCESS STORY

SOPHE partnered with NWA to develop a community/clinical linkage toolkit for local WIC agencies that is available for download at **http://www.sophe.org/resources/integrating-services-community-health/**.

SMOKE-FREE ENVIRONMENTS

The six communities that tackled reducing exposure to second-hand smoke were led by the AHA. Most communities working on this issue focused on ground-softening activities to set the stage for population-level policy adoption. They educated the public about the harmful effects of second-hand smoke exposure, engaged new organizations and champions, promoted smoke-free community events and celebrations, and recruited business owner champions (such as owners of restaurants or bars as worksites). Seizing opportunities to align priorities resulted in building support in diverse settings such as a college campus, trails, and beaches as well as engaging new partners. When a local chapter of the National Association for the Advancement of Colored People (NAACP) adopted the cause, it offered its substantial community contacts as champions and helped build trust among and engage local leaders. One community created the opportunity for new smoke-free signage in public parks, trails, and beaches. In another community, education about existing policies, workers' rights, and the importance of comprehensive smoke-free policies created change.

SUCCESS STORY

"The MLK Jr. event in Arlington became officially smoke-free this year, and it is one way the Smoke-Free Arlington Coalition is raising awareness about the harms of secondhand smoke." — Barbara Odom-Wesley, American Heart Association (AHA) partner and Health Chair of the Arlington, Virginia Chapter of the NAACP

Because the PSE strategies used were evidence-based, the national organizations could guide a community's focus toward approaches that benefitted from the experiences of others.

PART II

PROGRAM DESIGN STRATEGIES: RELATIONSHIPS

DHPE's and SOPHE's responsibilities fell into several categories over the course of the project:

1. Coordinating the planning, implementation, evaluation, and logistics for three national meetings of the funded communities, national organizations, and CDC.
2. Coordinating multiple calls and meetings among the national organizations and their work groups.
3. Collecting and disseminating project-wide information and relevant resources.
4. Developing newsletters, online courses, and toolkits, and coordinating this summative white paper.
5. Providing webinars, trainings and technical support.
6. Conducting a national public communications campaign and providing communications resources to partners and communities.
7. Making presentations at professional meetings.

The other three national organizations (AHA, APA, NWA) worked through their affiliates or chapters. In each case, the primary contact in a community resided in the local entity where the chapter, affiliate, or member of the national organization was based. Both APA and NWA built strong partnerships with another national organization. Those partner national organizations (APHA for APA and ACOG for NWA) created relationships with their members who were part of the local community coalitions and further enhanced opportunities for sustainability.

In all, there were 97 funding awards made in two cohorts to 94 communities. Three communities were funded in both cohorts one and two. The first 50 communities received support from mid-2015 through the spring of 2016. The second cohort of 47 communities received support from the spring of 2016 through early summer of 2017. For each cohort, AHA, APA, and NWA solicited and reviewed applications; selected and oriented the communities; provided coaching and guidance on creating their Community Action Plans (CAPs); provided training and technical assistance throughout the funding period; and served in a grant monitoring role. The actual timeline varied by national organization due to differences in each national organization's internal processes and its relationship with the communities, but the average time each community received financial support was 13 months. Some selected communities were implementation-ready but others were at a capacity-building stage and needed more time to organize internally. As part of the selection process, future projects might consider communities' level of readiness when proposing timelines.

AHA, APA, and NWA staff functioned as project officers for their communities, which resulted in close and positive working relationships between national organizations and their community partners. Each national organization also contributed non-grant funded staff resources and expertise. A brief description of each national organization's project structure follows.

- The AHA's ANCHOR Partnerships Program selected its communities from its affiliates and local offices. AHA and its affiliates are one 501(c)3 organization, not separate legal entities. The AHA's national office served as the central program management base.

  The ANCHOR national core program management team included a principal investigator who was an AHA Vice-President, a senior program manager, a training and technical assistance specialist, operations and finance specialists, and a performance monitoring and improvement specialist. Each local ANCHOR project had a dedicated project manager or regional campaign manager (RCM) who was part of the affiliate's health strategic team. Three RCMs served in an elevated role as team leads with responsibility for implementing a community-level project

as well as for coaching and consulting with four other RCMs. RCMs brought knowledge of cardiovascular disease burden and prevention as well as running campaigns promoting healthy eating, physical activity, and/or smoke free environments. Scientists from the Texas A&M University were hired as project evaluators.

- The APA's Plan4Health grantees were coalitions of planning and public health professionals anchored by members of APA chapters and APHA affiliates. The coalitions included planning and public health professionals from an array of settings: local, regional, and state governments; nonprofit organizations; and the private sector. APA and APHA members brought expertise in both planning and public health to their coalitions.

  Plan4Health was supported by APA's research department team, with the managing director of Research and Advisory Services serving as the principal investigator. APA's Planning and Community Health Center manager and project associate oversaw the project, providing ongoing support to coalitions. Staff from APHA's Affiliate Affairs department led the evaluation component of Plan4Health. At times, staff members worked on specific portfolios within the project (e.g., communications); at other times, staff worked collaboratively on all aspects of the project. This balance ebbed and flowed depending on other demands of staff time and the phase of the project.

- The NWA's Community Partnerships for Healthy Mothers and Children (CPHMC) grantees were legally independent local WIC agencies. They hired their own staff and each agency had its own governance. Some were governmental agencies, while others were nonprofit organizations. WIC providers, who traditionally work one-on-one with clients who are women, infants, and children in poverty and in under-resourced communities, brought knowledge of nutrition, physical activity, and healthcare referrals. Each coalition included a local WIC agency staff member, a WIC client, and a healthcare provider recruited with assistance from the ACOG.

  NWA's national team evolved over time from a project director, two program managers who provided technical assistance to the funded communities, and a program associate focused on communications, training, and reporting. NWA later hired a fiscal consultant and an operations management consultant who handled logistics, and a reporting assistant to help with reporting and communications. Altarum Institute was hired as the project's independent evaluator.

PART III

PROGRAM DESIGN STRATEGIES: PROCESSES

Training, Tools, and Technical Assistance

During the Partnering4Health project, the national organizations used training modalities to orient and support the selected communities. Such modalities included national conferences, national and/or regional meetings, pre-conference sessions attached to national conferences, webinars, eLearning, and communities of practice.

While some group trainings, tools, and resources were available to all communities, such efforts had to be supplemented, given that each community started in a different place, had distinct objectives, and had varying challenges. Such focused technical assistance was provided at varying levels of intensity during site visits and face-to-face planning meetings, one-on-one conference calls, and coaching and consultation.

As communities found new ways of doing things and with new partners, they often met similar challenges. Sharing successes, challenges, insights, discoveries, and solutions across projects validated communities' experiences, accelerated their progress, and provided assurance. Each national organization facilitated peer-to-peer sharing within a cohort and between cohort one and two communities. Peer-to-peer learning between communities funded by AHA, APA, and NWA occurred mostly at the national meetings convened by DHPE and SOPHE.

Table 3 shows the types of trainings, tools, and technical assistance the national organizations provided. AHA, APA, and NWA provided such support to its communities, and DHPE and SOPHE complimented their efforts and coordinated the Partnering4Health coalition. For specifics on what each national organization did, click on its link: **AHA**, **APA**, **NWA**, **DHPE & SOPHE**.

TABLE 3: TYPES OF TRAININGS, TOOLS, AND TECHNICAL ASSISTANCE NATIONAL ORGANIZATIONS PROVIDED

TRAININGS	TOOLS	TECHNICAL ASSISTANCE
Webinars – All National Organizations	Online courses – DHPE, SOPHE Infographics, Customizable Ads – SOPHE Needs Assessments – SOPHE, DHPE	Call agendas – All National Organizations
Ask-the-Expert Calls – DHPE, SOPHE	Toolkits – All National Organizations	Tailored resources – All National Organizations
Peer calls – AHA, APA, NWA	Group Websites – All National Organizations	Site Visits – AHA, APA, NWA
Meetings with organization staff and for Community Leaders – AHA, NWA, APA	Resource Directory – DHPE, SOPHE	Coaching – AHA, APA, NWA

TABLE 3: TYPES OF TRAININGS, TOOLS, AND TECHNICAL ASSISTANCE NATIONAL ORGANIZATIONS PROVIDED

TRAININGS	TOOLS	TECHNICAL ASSISTANCE
National Organization Teleconference Calls – Whole group; work groups; AHA,APA, and NWA; DHPE and SOPHE; Leaders	Templates for CAPS, Success Stories, etc. – CDC, AHA, APA, NWA	Regular monitoring and check-in calls – AHA, APA, NWA
National Organization planning meetings	Newsletters – DHPE, SOPHE	
	E-mail blasts – AHA, APA, NWA	

Throughout this project, the national organizations learned lessons about working collaboratively across organizations as well as about working with affiliates, chapters, or members. Some of those insights include:

- **Working collaboratively:** Take time in the beginning to learn about each national organization's respective strengths and assets. Build a joint plan to meet the needs of both the national organizations as a national coalition and the individual national organizations. Clarify respective roles. Prioritize training on cross-cutting topics for all communities.
- **Scheduling:** Use a master calendar where all national organizations can post training opportunities to minimize scheduling conflicts.
- **Planning:** Create a plan for training that includes different approaches at different times, tailored to audiences' needs: webinars, peer calls, face-to-face meetings, and team lead model. As the project progresses, include community members as trainers for their peers. Make use of any relevant trainings, conferences, webinars, and calls that the organization hosts for all its constituents/members/affiliates, not just those funded through the project.
- **Training:** Create formal training opportunities for the project. Determine which are mandatory for all and which are optional, depending on project focus and needs. Schedule both formal group trainings and individual project technical assistance. Determine what types of assistance/information are generic enough for a formal group event versus unique to one situation and requiring more tailored technical assistance, coaching, or consultation. Remain flexible, nimble, and responsive to adapt plans as needs evolve.

- **Technical assistance:** Establish regular check-in opportunities in addition to reporting mechanisms to keep abreast of project efforts and to identify challenges or obstacles early. Develop open lines of communication between national organizations and their funded communities. Be accessible and responsive to local needs as they arise.
- **Internal coordination:** Develop systems for tracking and monitoring progress that are consistent with the organization's, in addition to those provided/required by the funding agency. Maintain regular communications with each organization's permanent operations structure.
- **Grant monitoring:** Establish monthly, quarterly or bi-annual reporting timelines that meet the needs of the funder without creating a burden for awardees. Provide templates and appropriate guidance to ensure reporting compliance and to capture the tasks required of national organizations in the funding announcement.

Evaluation

As part of their evaluation plans, AHA, APA, and NWA were responsible for measuring the short-term and intermediate-term outcomes for the communities they supported. DHPE and SOPHE had responsibility for evaluating joint activities such as webinars and national meetings as well as the processes that supported the Partnering4Health national coalition. CDC provided specific online monitoring templates that each national organization completed to measure the reach of implementation and communications. In addition, following the requirement in the funding announcement, each national organization hired an evaluator to create and implement an evaluation plan for assessing the national organization's work and that of the communities. By monitoring progress on intermediate outcomes, the national organizations adjusted their training and technical assistance strategies based on community needs and contributed to long-term project outcomes. The specific approach used by each national organization follows:

American Heart Association engaged its Texas A&M University evaluators from the proposal development concept phase. Texas A&M University developed a comprehensive evaluation plan that included a variety of surveys and tools tailored for each local project that were adjusted as new opportunities arose. The evaluation focused on:

1. Documenting changes in collaboration and capacity of AHA affiliates to implement PSE interventions for chronic disease risk factors.
2. Documenting activities related to PSE interventions.
3. Documenting PSE changes resulting from PSE intervention activities.

To address the first focus, the evaluation team used interviews with partners, an organizational support survey, and an interorganizational network survey. The interviews and surveys were designed to measure coalition characteristics, satisfaction with the training and technical assistance from AHA national office, and the relationships among coalition organizations. For the second and third evaluation foci, the evaluators used multiple instruments and created an activity-reporting database in which regional campaign managers recorded monthly summaries of their progress and activities. The database tracked stakeholder perceptions as well as intervention outcomes measured both by the number of setting units/sites impacted and the potential population reach. The evaluators created monthly snapshot reports that the core team used during the check-in calls with regional campaign managers to consider next steps for meeting goals.

American Planning Association in partnership with APHA and the APA Policy and Research Group, APA developed evaluation reports for each cohort. Together they developed the following three evaluation questions:

1. To what extent did the Plan4Health project increase collaboration between national and community partners?
2. To what extent did the Plan4Health project increase messaging on the importance of PSE improvements?
3. To what extent did the Plan4Health project increase community capacity to implement PSE improvements?

For each question, APA's Policy and Research Group articulated the purpose of the project and what it aimed to achieve; then, the group developed monitoring and evaluation indicators for all objectives. Instruments and data collection tools included a national organization technical assistance tracking form, subrecipient monthly reporting form, subrecipient survey, media impressions worksheet, and Basecamp website. The Policy and Research Group also conducted interviews with members of the capacity-building coalitions in cohort two and developed two memos describing the progress of the five capacity building sites. A significant finding was that over 90 percent of Plan4Health respondents said they increased their understanding of the health impacts of planning decisions. APA's evaluation reports are available at **www.plan4health.us/evaluation**.

National WIC Association projects charted new territory for the organization. Its main evaluation goal was to determine whether PSE change projects were, in fact, a good fit for local WIC agency staff and client leadership. If successful, the evaluation sought to understand what types of PSE

projects worked best for local WIC agencies and what factors contributed to success that could inform similar work in other local WIC agencies.

NWA chose the Altarum Institute as its evaluation contractor. The Altarum Institute's evaluation and measurement plan focused on four main questions:

1. To what extent did agencies prepare workable and reasonable community action plans (CAPs) with clear and responsible steps to implementation?
2. To what extent were local WIC agencies well prepared to implement the CAPs?
3. To what extent were strong partnerships put in place to develop and implement CAPs?
4. What significant progress was made in implementing CAPs and meeting measurable objectives?

For both cohorts, the Altarum Institute designed a multi-staged, mixed-method evaluation that measured capacity building and achievement towards project objectives for all agencies. They also measured the activities and circumstances that led to the most successful implementation in a subset of agencies. The Altarum Institute abstracted information from CPHMC project applications, the CAPs, monthly and quarterly reports, and site visit reports prepared by the program managers. They also conducted a pre- and post-intervention web survey of each local project's leadership team and conducted qualitative interviews of the leadership team members within the first four months of the intervention and within two months of project completion. For the subset of agencies, the Altarum Institute also conducted interviews and on-site observations. The cohort one evaluation informed changes in project implementation for cohort two to improve efficiency and effectiveness in implementation.

Directors of Health Promotion and Education's evaluator, Elizabeth Traore, was originally on staff and later became a contractor. To answer the following evaluation questions, DHPE's evaluator used web analytics, training evaluations, logs, and document reviews.

1. What type(s) of and how many trainings, technical assistance, communication strategies, and tools and resources did DHPE and its partners provide in support of subrecipients?
2. To whom did DHPE and its partners provide trainings, technical assistance, and messages?
3. To what extent were the goals and objectives of the meetings/webinars met?
4. To what extent did the information provided during capacity-building activities meet the needs of AHA, APA, and NWA and the community initiatives they supported?

Society for Public Health Education. SOPHE's independent evaluator, AFYA, Inc., used a mixed-methods evaluation approach that combined process-oriented formative evaluation with a summative (impact) evaluation. The primary evaluation goals were to:

- Use a process evaluation to support continuous quality improvement of the training and technical assistance activities SOPHE provided.
- Determine the impact of the capacity-building, dissemination, and collaboration activities used to support the overarching Partners4Health objectives.

The AFYA team gathered both quantitative and qualitative needs assessment and training and technical assistance satisfaction data from AHA, APA, and NWA and the community initiatives they supported. They also conducted key informant interviews with community leaders and held discussions with AHA, APA, and NWA about their experiences with the support they received from DHPE and SOPHE. AFYA shared the data relevant to its communities with AHA, APA, and NWA.

AFYA collected and analyzed evaluation data from each national meeting during years one to three. During years one and two, this information informed all the national organizations about the training and technical assistance needs of community leaders. The highest need areas were for locating funding, sustaining program planning, designing a communication plan, developing and monitoring effective communication, engaging stakeholders, and developing and maintaining coalitions. The year three meeting evaluation revealed that some community leaders still desired training about sustainability, which supported SOPHE's and DHPE's plans to develop a final online sustainability course and toolkit. These resources could also help other communities embarking on PSE approaches in the future.

In year three, AFYA conducted qualitative interviews with the principal investigator and primary staff person in each national organization to determine the extent to which the Partnering4Health national organization model was successful and to suggest ways of strengthening similar efforts in the future. The four core interview questions were:

1. Thinking about the national organization model used in the Partnering4Health project, what worked well?
2. What did you see or experience as the primary limitation(s) of the national organization model used by Partnering4Health?
3. What would you do or suggest to work around or overcome the weakness(es) you identified?
4. If you were to envision an ideal model for community health improvement that included a federal organization using national organizations to support local community efforts, how would you establish such a model based on your experiences with this project?

Overall, the interviewees from all of the national organizations felt this was an effective model for improving community health outcomes and addressing health disparities, particularly the diverse strengths, experience, and systems-level approaches to health improvement that the five organizations brought to the project. The structure of having a national organization fund local, community-based subrecipients was regarded as a good way to improve the health in those communities and also facilitated sharing local community leaders' experiences across organizations and across cohorts.

Limitations of the model of working through national organizations for community change included the time the national organizations needed to develop trust and working relationships. Because the time constraints of this project did not allow such time, there was a lack of clarity and common understanding about the respective roles and responsibilities of the two types of funded national organizations (i.e., those working directly with communities and those providing training and technical assistance support), particularly when it came to training and technical assistance. CDC's expectation that the national organizations would generate national media coverage during the first year was unrealistic because the communities were just getting their projects started.

Among the recommendations for funding future projects, the national organizations suggested:

- Define the respective roles of national organizations working directly with community initiatives and those providing support.
- Establish clear coordination procedures and ensure equality across national organizations.
- Fund community initiatives for two or three years to allow more time for relationship building at the community level, collective impact, an expanded scope of work, and more flexibility as projects progress.
- Use a grant funding mechanism rather than a cooperative agreement.
- Plan overall project evaluation early in the project and clarify up front any expectations about joint evaluation efforts/coordination across all participating national organizations.
- Expect national organizations to involve evaluation experts starting with proposal development to ensure that the evaluation plan considers planning and community needs assessments, tools, surveys, and resource requirements; integrates with activities at the community level; supports implementation; and monitors progress.
- Include evaluators in key meetings with communities such as reviews of community action plans (CAPS) and face-to-face trainings.
- Offer one-on-one evaluation planning meetings with communities to build a tailored approach.

PART IV

SUCCESSES, RESULTS, AND MORE RECOMMENDATIONS

Successes and Results

Every funded community achieved at least some PSE change, even if these achievements did not match all they had planned. Many learned the value of working in partnerships and coalitions. Some experienced community engagement and PSE approaches for the first time and intend to continue using PSE approaches whenever possible. Some gained new insights into the realities of working with disenfranchised and marginalized populations and plan to rethink their work and address inequity issues more significantly in the future. For details of what communities accomplished, go to the **Success Stories link**. Each national organization created some structural, conceptual, or policy change that will continue past the funding and will advance the healthy communities movement.

NWA reoriented WIC staff in funded communities from a direct service model to a systemic approach to nutrition and health care that involved PSE interventions. Having learned a new way of doing business, many local WIC agency staff intend to continue reaching out to their communities and seeking opportunities for using PSE approaches. Several NWA community initiatives expanded to include other communities and influence state programs. Those from funded communities shared this new approach within their agencies and with those in non-funded communities at national NWA conferences. As a result of its partnership with NWA on this project, ACOG adopted a "maintenance of certification" option (CEUs required of physicians to recertify as an OB-GYN) for participation in community health coalitions.

APA's collaboration with APHA created partnerships that both sets of professionals found beneficial; many reported an intention to continue working together in the future. The positive response from APA members to the Plan4Health project announcement made it clear that members were interested in implementing PSE improvements at the local level and in engaging partners and residents in community change strategies at the intersection of health and planning. The final year of the project offered chapters the opportunity to institutionalize health at APA through the **Planners4Health initiative**. With 28 participating chapters, the Planners4Health project disseminated experiences from the first two cohorts of Plan4Health while sustaining the healthy communities conversation within APA. Providing another vehicle for bringing planners and public health professionals together, Planners4Health emphasized the impact of national organizations to shape daily practice by elevating member experiences and amplifying best practices. APA and APHA also supported the growth of a health affinity group within APA called the Healthy Communities Collaborative (HCC). The HCC has become a mechanism for fostering conversations about health across the organization.

AHA introduced its affiliate staff to tools and resources they will continue to use in future work. The positive response that AHA received from its affiliates has led to further interest across the organization on how to "be of the community" when seeking to implement PSE activities. For example, the AHA provided topic training and technical assistance, coaching, and consultation using its subject matter experts. Some of the tools and resources developed have garnered interest across other departments for adoption. Additionally, training conducted on an open source learning management system has created a core of "experts" within AHA who can use the learning management system for future projects.

DHPE and SOPHE strengthened communication efforts and dissemination of resources. In addition to multiple webinars and peer calls that were recorded and available through the project website,

DHPE developed an onboarding orientation course and an online sustainability course. In response to community needs, SOPHE developed three toolkits on healthy eating, community-clinical linkages, and sustainability. From September 2014 through September 2017, SOPHE developed and disseminated more than 700 messages to the public, funded communities, and partners. These communication messages resulted in more than 177 million media impressions to the public and over 70,000 to partner audiences. Infographics and 300 different ads that communities could tailor to their projects also were designed and made available on the project website. In the final stages of the project, SOPHE is developed a searchable microsite that will allow all project resources to continue to be available to the public, along with this white paper.

Overall Recommendations

- Hire full-time staff dedicated to the project as well as staff who are on the project part-time but who can integrate the work with the organization itself. Consider key functions such as project management, evaluation and performance improvement, operations, training and technical assistance, and communications. Build a project team that has the right asset mix to meet the project demands. Project staff do not need to be subject matter experts, but can draw on subject matter experts available within the national organization, its consultants, and/or its professional members. Plan for continuity in cases of staff turnover.
- Include time for planning at both the national and community levels before initiating implementation:
  - National organizations need a minimum of three months for joint coordination and another three months for getting their systems and processes in order to select and then work with communities in a coordinated fashion with other national organizations.
  - Communities also need time for planning, especially if there is no existing coalition working on the priority focus area. Those that are not implementation-ready need at least six months to identify and engage the right partners, identify opportunities, and align priorities before initiating momentum and 12 months for any implementation of PSE improvements. Securing buy-in from within the organization and from partners is essential for building PSE improvements. Within only 13 months of funding, communities had just gotten themselves organized and begun to see momentum for PSE changes when they had to shift to sustainability and closing down.
- When setting criteria for selecting communities, consider the need for achieving quick results versus changing ways of approaching work for the long term.

- National organizations could work with other national groups such as the **Association of State and Territorial Health Officials** (ASTHO) or the **National Association of Chronic Disease Directors** (NACDD). Such groups can facilitate introductions of community leaders and relevant state agency staff. State agency staff could:
  - » Join community coalitions or subscribe to e-mail or newsletter distribution lists to learn about community initiatives.
  - » Share relevant state data and resources with funded communities and coalitions.
  - » Showcase and promote the work of local communities.
  - » Connect coalitions working in overlapping jurisdictions on similar initiatives.
  - » Offer support appropriate for the PSE readiness of involved communities.
  - » Find ways to work across a project's geographic boundaries.
  - » Encourage and support community leaders wanting to work at a regional level.

In summary, thanks to funding allocated by the U.S. Congress through CDC and to the expertise and dedication of staff in five national organizations, their partners, and coalition members, residents of 83 communities have more access to healthy food and beverage options. Those in 38 communities have more opportunities for physical activity. Those in six communities have more smoke free environments. Mothers of young children in 29 communities have more support for breastfeeding and have access to more physicians interested in systemic approaches to reducing the risk of chronic diseases.

Every funded community has moved along on the continuum of the stages of change to a greater level of ability and commitment to use PSE approaches to create healthier places for all who live, work, or play there. Achieving these results in 13 to 15 months per cohort and a total of three years required resources including grant funding that enabled dedicated staff time, established expertise and access to resources at the national level, and passionate community leaders. True to its name, the Partnering4Health project showed that a model of supporting healthier communities by working with and through national organizations is a viable way to leverage resources and build capacity at both the local and national levels. After this promising start, it has great future potential for reaching even more communities than those directly funded as PSE approaches are adopted by more communities and organizations.

APPENDIX

Authorship

Directors of Health Promotion and Education, Society for Public Health Education, American Heart Association, American Planning Association, and National WIC Association.

PREFERRED REFERENCE

Directors of Health Promotion and Education, Society for Public Health Education, American Heart Association, American Planning Association and National WIC Association. (2017). Partnering4Health: National Organizations Empowering Communities to Improve Population Health. Washington, DC: Author.

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