CENTER FOR COMMUNITY HEALTH AND EVALUATION

KAISER PERMANENTE
COMMUNITY HEALTH INITIATIVE
Interim Report

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The Group Health Center for Community Health and Evaluation (CCHE) designs and provides evaluation services for health-related programs and initiatives throughout the United States. CCHE is part of the Group Health Center for Health Studies. This report was funded by Kaiser Permanente.
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EXECUTIVE SUMMARY

I. Introduction/Initiative Overview

The Kaiser Permanente (KP) Community Health Initiative (CHI) is a programwide strategy for achieving a significant and measurable impact on the health of communities served by KP. The thematic focus is on “Healthy Eating, Active Living” (HEAL)—promoting improvements in nutrition and physical activity and reductions in overweight/obesity. CHI is designed to promote population-level improvements in intermediate outcomes (e.g., levels of physical activity and proportions of the population eating a healthy diet) as well as longer-term improvements in related health outcomes (e.g., chronic illness outcomes).

KP’s Framework for Community Health Initiatives identifies several core design principles that mature CHIs are expected to manifest. These include a place-based focus, an emphasis on change at multiple levels—particularly environmental and policy change—and community engagement and community ownership.

CHI communities received initial funding for up to five years, including support for a planning period. Goals for CHI are to:

- Initiate intensive, community-level interventions in KP regions that are consistent with the CHI Framework and lead to environmental and policy changes, increases in community capacity and population-level increases in healthy eating and active living.

- Support the institutionalization and sustainability of this work by rigorously evaluating the impact of these initiatives and by aligning CHI with other KP strategic initiatives and activities.

A comprehensive, cross-site evaluation is being conducted covering the first five years of CHI implementation (2006-2011). Evaluation methods include baseline and follow-up population-level surveys of youth and adults and documentation of community changes taking place as a result of CHI efforts. This report summarizes the baseline data for the population-level surveys and provides preliminary data on the community change strategies.


II. Progress/Key Findings

Community Selection and Engagement

HEAL-related activities are taking place in all of the eight KP regions. In five of the eight KP regions (Northern California, Colorado, Georgia, Mid-Atlantic States and Ohio), all the CHI design principles have been applied to multi-sector interventions in specific geographic communities. In the other three KP regions (Southern California, Northwest, Hawaii), HEAL interventions that vary in scope and approach but overlap with CHI design principles are being implemented. For example, building community partnerships and using environmental/policy approaches aimed at increasing access to healthy food and safe physical activity.

It should be noted that all of the communities participating in CHI or the other HEAL initiatives have demonstrated a level of readiness sufficient to form a collaborative and to do action planning and proposal writing. Therefore, the CHI experience cannot be generalized to all communities regardless of readiness.

CHI communities have staggered implementation start dates. There are nine CHI communities in the five regions (three each in Northern California and Colorado3 and one each in Georgia, Ohio and Mid-Atlantic States). These nine CHI communities are currently implementing all the cross-site evaluation measures. The six CHI communities in Northern California and Colorado were the first to launch and are two years into their implementation. Additional CHI communities will be added to the cross-site evaluation as they are phased in.

The nine CHI communities are distinct neighborhoods in urban areas or small cities. Their populations range from 7,500 to 52,000. They are all ethnically diverse, low-income communities with high rates of chronic diseases that might be prevented by improvements in HEAL-related behaviors.

There were significant regional differences in the way communities were selected for participation. Approaches ranged from requests for proposals (RFPs) issued to existing collaboratives to the establishment of new collaboratives in communities identified as meeting the explicit need and readiness criteria. Once CHI communities are selected, the next step they take is a community-wide planning process involving a range of community-based organizations, institutions and residents that comprise the community collaborative. The end result of the planning process is a community action plan or CAP that provides a roadmap for intervention activities. Also, in each region, a local evaluator was selected to provide data for the planning process, evaluate local activities in more depth and serve as a liaison to the cross-site evaluation.

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3An additional 21 sites in Colorado that are part of the LiveWell initiative are currently in the process of being incorporated into the cross-site evaluation.
Community Changes

Starting Point: Population-level baseline data. The ultimate goal of CHI is “population-level change,” i.e., a representative (randomly sampled) community resident is eating more fresh produce and becoming more physically active as a result of CHI. Ultimately, as more people adopt and sustain these lifestyle changes, the result will be reductions in the rates of overweight and obesity and the health conditions that result, such as diabetes and hypertension, among an entire population.

Population-level change is being tracked for adults using an automated telephone survey and, for youth, using a school-based survey and Fitnessgram. In addition, the evaluation is using clinical data from KP to provide information about overweight and more distal outcomes such as diabetes and hypertension. The results from the CHI communities will be compared with trends from a variety of state and national surveys, combined with specifically selected control communities in some regions (e.g., for the Northern California youth surveys).

Figure 1 is an example of baseline population-level data from the school survey, showing a variety of potential risk factors for overweight across the seven communities in Northern California, Colorado, Georgia and Ohio where school surveys have been conducted. Of note, nearly 80% of children were eating fast food regularly and just under half (43%) do not feel safe in their own neighborhood.

Figure 1. Youth Survey Baseline Results: Obesity Risk Factors
**Community Change Strategies: Description, Impact to Date.** KP is working through CHI to promote population-level change by making significant, sustainable changes in communities that promote HEAL-related lifestyle changes and create environments supportive of positive lifestyle choices. A key proposition advanced by CHI is that community changes involving environmental and policy changes across multiple sectors (e.g., neighborhoods, schools, worksites) are likely to be sustainable and reach enough people in enough ways to have a community-wide impact. Nutrition-related environmental changes increase availability of healthy food, through supermarkets, farmers’ markets and other venues. Physical environment changes usually involve changes in the built environment: creating more complete sidewalk networks, developing walking trails or using zoning policy to create more compact walkable neighborhoods.

Six communities in Colorado and Northern California are the farthest along in their implementation timeline. These communities were implementing 139 community-change strategies by 2008. Figure 2 shows the distribution of strategies according to the levels of the “ecological” model for health promotion, where the most immediate, proximal influences on individual behavior (e.g., programs, organizational environment) are shown on the inner rings, and the more distal (e.g., public policy, community environment) are shown in the outer rings. Out of the 139 current CHI strategies, 37% are programmatic, while 25% are either public policy (5%) or environmental change (20%). About one-fifth (19%) are focused on building community capacity, which can affect change in all of the other levels.

The following are examples of strategies being pursued at each level in these six communities:

- **Organizational**: Implementing BMI screening in health clinics
- **Community environment**: Creating new community gardens to increase the availability of fresh produce
- **Public policy**: Shaping redevelopment to promote more compact, walkable neighborhoods
- **Programs**: After-school physical activity programs

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Intermediate Outcomes: Intervention Reach and Impact. A key evaluation focus is on intermediate outcomes, such as whether community changes have been implemented, how many people have been touched by the changes and what the impact has been on each person touched. Two groups of people are being counted for each intervention strategy: (1) exposed to the intervention—touched in some way, whether living in an area that has been redeveloped to be more walkable or shopping in a store that has increased the amount of produce it sells; and (2) affected in a significant way by the intervention—among those exposed, the number who have changed their lifestyle or behavior as a result of the intervention (e.g., they now walk to stores that they used to drive to or now purchase and eat more produce).

Preliminary data on exposure to CHI interventions in the neighborhood and school sectors using the three CHI communities in Northern California are shown in Figure 3. The figure shows “penetration”—i.e., the number potentially exposed to the interventions divided by the total population for the neighborhood sectors and total school enrollment for the school sector. For example, in the school sector each community is working to implement district-wide healthy eating policies around vending machines, cafeteria food and food used as a reward. Although few of these policies have yet been implemented, the potential number of children exposed is significant: 85% penetration across all three communities.
Capacity Building. The CHI design principles, including KP’s role as a funder and partner and the focus on policy and environmental change, represent a significant departure from the way KP has worked with communities in the past. As a result, the successful implementation of CHI has required capacity building and support on a large scale and on a number of levels, including:

Overall KP level: Program Office (PO) support for regions. The KP Program Office has created several mechanisms to build the capacity of the regions to implement CHI, including a CHI work group that meets monthly to share lessons, an annual “HEAL Academy” in-person meeting that allows for more in-depth training and discussion and tailored support to regions and individual CHI leaders. In interviews, regional Community Benefit (CB) staff working on CHI said they generally felt well-supported by Program Office. They appreciated the opportunities for networking with other regions and the willingness of PO staff to come to the communities to work on specific problems. There is room for improvement regarding communication in general and budget/resources were a concern in some regions.

Regional level: Regional CB support for communities. Another part of the capacity building effort is technical assistance provided by the KP regions to the
CHI communities. This assistance has ranged from helping build the collaborative to assisting with the design of specific HEAL interventions. In general, CHI community members were positive about the support they have received, viewing KP as a supportive, committed and responsive partner. Areas mentioned where KP could have been more effective included reducing the number of meeting requests and recognizing that communities vary in their need for technical assistance.

**Community level: Capacity building within communities.** The final, and perhaps most important part of capacity building is taking place within the communities themselves. A central component of the CHI capacity building strategy is the requirement that a community collaborative plan and implement the CHI community-change strategies. The intent is for these collaboratives to continue in existence beyond the period of CHI funding and to find other issues to address in the future. In addition, communities are pursuing general capacity building as part of their own action plans. For example, establishing a neighborhood advisory group to advocate for food policy change and doing community organizing and training of residents around HEAL advocacy. In interviews with communities, respondents noted that they are finding ways to increase their capacity to resolve conflict, focus on planning, engage residents and communicate effectively.

**Sustainability.** If the promising efforts underway in all CHI communities are not sustained beyond this initial period of CHI funding, there will be little hope of seeing the long term health improvements and enhanced community capacity that are the ultimate goals of CHI. There are several potential, often mutually reinforcing, strategies for sustaining the CHI community efforts:

- Be creative and collaborative in securing funding streams
- Implement sustainable strategies, for example, policy and environmental change
- Increase community capacity, including community leadership and durable partnerships
- Change organizational cultures to be more HEAL/community oriented
- Solidify support for CHI within KP

**Be creative and collaborative in securing funding streams.** Long-term sustainability requires funding, which can come from a variety of sources. The most effective and sustainable funding approach is to build line items directly into long-term government and institutional budgets. For example, in Colorado, KP funded staff infrastructure in 2004 for the new Office of Health Disparities in the Colorado Department of Public Health and Environment. During this
time the Office became statutory and several positions became partially supported through federal and state funding. However, such long-term solutions are often not available and shorter-term options must be found instead. To date, CHI communities and KP working together have leveraged approximately $43 million in funding from government agencies and other funding sources to multiply efforts in these CHI neighborhoods. Collaboration with other funders is also a promising approach and there is an active effort underway in most regions with a variety of potential partners. For example, in the Mid-Atlantic States region, multiple foundations are contributing to a pooled fund to support the Port Towns CHI effort.

**Implement sustainable strategies.** One rationale for focusing on policy and environmental change as intervention approaches is that they are inherently sustainable. Written policies, regulations and zoning requirements stay on the books until there is an active effort to alter them. Many environmental changes are similarly durable. For example, park facilities enhancement and building new sidewalks represent durable (if not permanent) changes. About one-quarter of all CHI intervention strategies in 6 CHI communities are either public policy (5%) or environmental change (20%) oriented. Another 19% are focused on organizational policy change (e.g., changing school nutrition and physical activity policies), bringing the total proportion of “sustainable” strategies to about one-third (34%).

**Increase community capacity.** For long-term sustainability, it is essential to build community capacity so that the efforts can be maintained after KP funding ends. A central reason for including a community collaborative as one of the CHI design principles was to promote sustainability. Strong, durable collaboratives can maintain the HEAL efforts even if funding levels decline and they can work on other community issues as they arise. In the interviews with community informants, there was a clear division in the view of their own collaborative’s sustainability between...
collaboratives that existed prior to CHI and those that were created *de novo* as part of CHI. Existing collaborates were generally confident that they would remain active continue to work together. This confidence was based on their ability to remain together and active through previous funding transitions. For the newer collaboratives, there was less confidence expressed that they could sustain themselves. In some cases, sustainability had been discussed, but few concrete steps had been taken to prepare a sustainability plan or define what elements such a strategy would include.

**Change organizational cultures to be more HEAL/community oriented.** There is a need to ensure that the focus is not only on building the collaborative body itself, but also on nurturing change within each of the respective organizations that are part of the collaborative. The change in each of these organizations takes the form of doing business differently in the service of community transformation. Concretely, this is reflected in the alignment of the organizations’ strategic plans, budgets, job descriptions and policies with the community vision for change. For example, in Commerce City, Colorado, inserting a health element into the General Plan required the local health and planning departments to work together. That experience changed the way both of those units see their respective roles—the planning department sees that they have a responsibility to assess the health impacts of their planning work and the health department sees that they have a responsibility to inform the work of the planning department.

**Solidify support for CHI within KP.** For KP to remain a driving force in maintaining CHI, support must be built internally, both to maintain CHI funding and to increase the connections between CHI and other parts of the organization. In interviews, most KP informants felt that they hadn’t done enough so far to promote sustainability. Key areas where more needed to be done included increased resources, improved communication and greater leadership awareness and support. Also, results of CHI need to be demonstrated and communicated to all parts of the organization.

**Organizational Practice Change within KP**

The primary focus of CHI is on making changes in the CHI communities. However, the initiative is also committed to promoting change within KP—increasing strategic alignments within the organization to promote HEAL and implementing some of the same HEAL-related organizational changes that are being asked of communities.
Strategic Alignment within KP. CHI helped draw together and promote connections among a range of KP units, work streams and initiatives. Examples of increased strategic alignment within KP around HEAL include:

THRIVE. KP’s THRIVE campaign and CHI were developed at different times for different purposes, but there are many synergies between them and they are becoming more closely aligned over time. THRIVE now includes more HEAL-related content and a greater focus on community policy and environmental changes.

Public Relations. There has been increasing collaboration between Community Benefits and Public Relations staff, including work on a program-wide Safe Routes to School campaign, the feature of HEAL-related stories on a syndicated television program and collaboration on the Incredible Adventures of the Amazing Food Detective.

Environmental Stewardship. CB staff have worked closely with Environmental Stewardship to inject land use, transportation and sustainable food into the Environmental Stewardship strategic plan. There is also an explicit strategy around climate change to help reduce the carbon footprint of the communities served by KP.

CHI has also helped bring about strategic changes within CB. These include both a general approach, e.g., working with communities in new ways, more strategic grantmaking, aligning Safety Net and CHI work streams, and specific programs such as the Educational Theater Program. Specific examples include:

Safety Net/CHI alignment. In several regions CB has started conversations to agree on better integration between the CHI and Safety Net Partnerships’ work stream, focusing on strengthening the system of community clinics, hospitals and health departments. For example, in Belvedere, Georgia, KP has funded the DeKalb Board of Health to implement the ALL program and the Oakhurst Community Health Center to support a diabetes education intervention that will involve residents of this community.

Educational Theatre Program. Performances in schools incorporating HEAL messages from KP clinical guidelines have been developed, implemented and are currently being evaluated in several regions. A more intensive performance, Teens Take it On, trained middle and high school students throughout Colorado to assess their own food environment and advocate for changes.
**HEAL-Related Organizational Practice Changes.** There have been a number of instances, particularly around the nutrition environment, where KP is now “walking the talk” making the same environmental and policy changes within the KP organization that it is funding in the CHI communities. These changes have involved the combined efforts of different parts of the organization and credit cannot be assigned to CHI alone. Examples include:

**Local food sourcing.** Kaiser Permanente has implemented food system reforms now emulated by other institutions and businesses throughout the United States. For example, in 2007, more than 60 tons of produce served in KP inpatient meals and cafeterias in Northern California were locally-sourced through the Community Alliance for Family Farmers (CAFF)—up from 24 tons in 2006.

**Farmers’ markets.** Kaiser Permanente launched its first farmers’ market in 2003. By 2007, KP sponsored over two dozen farmers’ markets in hospital lobbies, medical office buildings, parking lots and community settings. In 2007, several regions also started to implement Community Supported Agriculture (CSA) programs in which employees receive weekly delivery of farm boxes on a subscription basis.

**Healthier vending machines.** In 2006, Kaiser Permanente rolled out its Healthy Picks program, which are stringent standards for increasing the percentage of healthy food and beverage items in KP vending machines. All vending machines are now required to have at least 50% of their slots reserved for healthy items. These same standards are now being implemented in KP cafeterias.

**Menu labeling study.** In 2008, CB worked closely with National Nutrition Services to formulate a study that extends the Healthy Picks Program into the cafeteria through provision of point-of-decision calorie information for all cafeteria menu items. The study is expected to inform Nutrition Services’ strategic planning as well as state and local governments that are considering implementing menu labeling.
Building a Broader Movement

State and national policies and cultural norms will have a significant influence on what happens within communities. Recognizing this, the CHI leadership has pursued a number of strategies to contribute to the building of a broader state, regional and national movement, including:

Helping to create Convergence Partnerships around HEAL. KP was a founding partner of the HEAL Convergence Partnership, comprised of several major foundations and the U.S. Centers for Disease Control and Prevention, which share a similar view about how to address the nation’s obesity crisis. In 2007, the Convergence Partnership formalized the partnership and the creation of a shared funding pool, prepared a toolkit for funders of HEAL-focused initiatives and developed a web-based portal for connecting funders and organizations active in this area. Concurrently, a number of KP regions—including Colorado, Northern and Southern California, the Northwest and the Mid-Atlantic States—have advanced the deployment of their own regional or statewide convergence efforts.

Working with other HEAL initiatives. KP has worked closely with other major initiatives to support and expand their efforts, including Steps to a HealthierUS and The California Endowment’s Healthy Eating Active Communities (HEAC) initiative.

Building the evidence base for what works in HEAL interventions. Beyond supporting a rigorous evaluation of its own initiative, KP has been involved in two major projects designed to help build the evidence base and create indicators for success: (1) The Common Community Measures for Obesity Prevention Project is a collaboration among KP, several national foundations and the Centers for Disease Control and Prevention (CDC) working to identify community-level measures that can be used for planning, evaluation and research; and (2) an Institute of Medicine (IOM) effort to address the question of what “evidence-based” should mean in the context of community-based obesity prevention efforts.

III. Conclusions and Recommendations

CHI has had a very productive first two years of implementation with significant progress made on a number of fronts. At the community level, all of the CHI communities have functioning collaboratives and action plans around HEAL policy and environmental change that have a reasonable chance of being implemented.
successfully. KP has played a key catalytic role in the emergence of partnerships with other funders and stakeholders across the nation and in contributing to the evidence base. Finally, KP is implementing internally many of the same HEAL strategies it is promoting in the CHI communities.

Challenges have arisen in several areas. They include maintaining ongoing support for the work given the long time horizon required for policy and environmental change, building collaboratives in communities where none existed before and providing technical assistance and support effectively to communities.

The following are six recommendations for meeting some of the challenges that have arisen in the first two years of CHI implementation:

**Recognize that policy and environmental change is a long-term proposition.** Perhaps even more than anticipated, implementing policy and environmental change is a slow process, particularly for changes to the built environment. Resources and support must be structured so that the effort can be maintained over the long term. If the initial five-year grants are not at least partially renewed, the momentum developed during the first years of funding will be lost.

**Focus on sustainability now.** Planning for sustainability can not begin too early. There are several potential sustainability strategies that are being pursued, to some extent, in various parts of CHI. Peer networks are an effective way to share experiences and promote the spread of promising approaches. Sustainability also needs to be pursued within KP, including building support among KP leadership support and communicating successes and benefits across the organization.

**Work with existing community collaboratives where possible.** In the CHI communities, KP has worked successfully with both existing and new collaboratives of community organizations in developing and implementing community action plans. However, sustainability is much less certain for new collaboratives, whereas existing ones have demonstrated that they can stay together through a variety of funding and other transitions. A caveat is that some communities with the highest need may not have existing collaboratives. Where this is the case, KP needs to provide the minimum level of support required so that local organizations can step forward and take leadership roles.
**Be flexible about intervention approaches.** CHI is emphasizing policy and environmental change strategies because they are cost-effective in reaching large numbers of people and more likely to be sustained. However, policy and environmental change is a somewhat abstract concept and the changes take a long time to implement. Community residents are drawn to programs because they are more concrete and provide immediate benefits to participants. The CHI experience suggests that an approach blending programs and policy/environmental change can maintain community engagement while keeping broader policy and environmental change in the picture.

**Keep the focus on reach and impact.** Population-level change requires reaching sufficient numbers of community residents with interventions of adequate per-person impact. Intervention reach and impact should be reviewed and discussed with communities by technical assistance providers, evaluators and regional CB staff. Evaluators should provide assistance in tracking reach so that the intervention “dose” can be estimated.

**Be modest in providing technical assistance.** Technical assistance providers need to be modest, listen well and fit in, avoiding the impression that they are outside experts who know more than community members. They need to take time to build trust and coordinate with others (e.g., evaluators, KP regional staff) to avoid overloading communities with outsiders. They should focus on simple, concrete solutions: tools, organizational help or practical skills are better than abstract advice.

In summary, CHI is at a critical point in its evolution. Considerable progress has been made in building community collaboratives that are moving forward with promising environmental and policy change strategies that have the potential to produce long-term population-level change. At the same time, these changes will take a long time to fully implement—longer than the current funding horizons in most CHI communities. Some combination of sustained resources, organizational change and community capacity building must be put in place to allow the process that has begun to reach its full potential.
SUMMARY REPORT

I. Introduction/Initiative Overview

The Kaiser Permanente (KP) Community Health Initiative (CHI) is a program-wide strategy for achieving a significant and measurable impact on the health of communities served by KP. The thematic focus is on “Healthy Eating, Active Living” (HEAL)—promoting improvements in nutrition and physical activity and reductions in overweight/obesity. CHI is designed to promote population-level improvements in intermediate outcomes (e.g., levels of physical activity and proportions of the population eating a healthy diet) as well as longer-term improvements in related health outcomes (e.g., chronic disease outcomes).

KP’s Framework for Community Health Initiatives identifies several core design principles that mature CHIs are expected to manifest. These include:

- A place-based focus, with the target population larger than a few blocks and smaller than a county (i.e., a neighborhood)
- An emphasis on change at multiple levels, particularly environmental and policy change
- Multi-sectoral collaboration that involves multiple sectors in addition to health care
- Community engagement and community ownership
- Leveraging the assets and strengths of KP and of its communities
- A long-term commitment to these efforts, with an emphasis on sustainability and community capacity building
- An evidence-informed public health approach
- A commitment to learning and evaluation that drives improvement as well as accountability
- A focus on and commitment to reducing racial and ethnic health disparities

The CHI framework provides a long-term vision for a “CHI community.” Residents of CHI communities will eat more healthfully and be more active, and in so doing, have reduced levels of overweight and associated illnesses. These behaviors will be supported by community and institutional environments that make it easier for

people to eat better and move more. Environmental and policy change will come about through a collaborative process that increases community capacity for making future health-promoting changes. This work will support KP’s transformation into a “total community health organization” that identifies and seizes upon the critical levers of health that reside in KP communities in the service of both KP’s members and the organization’s social mission.

The KP Logic Model for CHI (see Figure 1) provides more detail on the inputs, intervention strategies, and outcome chains that are expected to result in the twin long-term goals of improved population-level health and thriving, empowered communities.

Figure 1. CHI Logic Model
Vision/Goals

CHI communities received initial funding for up to five years, including support for a planning period. Goals for CHI are to:

- Initiate intensive, community-level interventions in KP regions that are consistent with the CHI Framework and lead to environmental and policy changes, increases in community capacity and population-level increases in healthy eating and active living.

- Support the institutionalization and sustainability of this work by rigorously evaluating the impact of these initiatives and by aligning CHI with other KP strategic initiatives and activities.

Evaluation Overview

A comprehensive, cross-site evaluation is being conducted covering the first five years of CHI implementation (2006-2011). The National Evaluation Strategy has three overall evaluation goals: promoting program improvement, assessing impact and sharing lessons learned within KP and externally with practitioners and evaluators. The evaluation strategy also is expected to build the capacity of KP and its community partners to conduct community-based evaluations. The evaluation strategy involves:

- A cross-site evaluator to coordinate data collection, synthesize results and promote cross-site learning

- Regional- and site-level evaluations of intensive community-level interventions, using common metrics and an evaluation plan template developed by the cross-site evaluator

- Local community representatives who will work with the cross-site and regional evaluation staff to inform the development of evaluation questions, ensure that appropriate data are collected and assist in the interpretation of evaluation results

The multi-level evaluation of the CHI effort includes a cross-site evaluation led by the Center for Community Health and Evaluation at Group Health Cooperative (CCHE) and local evaluations in each of the five participating KP regions. The three cross-site evaluation partners are CCHE, the Center for Weight and Health at University of California, Berkeley and the Kansas University Work Group.

See http://info.kp.org/communitybenefit/pdfs/CHINationalEvaluation.doc for a more complete description of the cross-site evaluation.
The evaluation’s specific components are described in more detail in the following sections. Evaluation methods include baseline and follow-up population-level surveys of youth and adults and documentation of community changes taking place as a result of CHI efforts. This report summarizes the baseline data for the population-level surveys and provides preliminary data on the community change strategies.

The focus of the report is on nine CHI sites where KP is the principal sponsor, and in particular on six communities in Northern California and Colorado (three in each region) where implementation activities have begun. An additional 30 sites are under the CHI umbrella—i.e., they have adopted CHI design principles and have at least KP sponsorship/involvement. These include 21 LiveWell3 communities in Colorado that are now being integrated into the cross-site evaluation, 3 communities in the Northwest, and 6 communities in California that are part of The California Endowment’s Healthy Eating Active Communities (HEAC)4 initiative. The map (Figure 2) shows the location of all 39 communities.

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3See http://www.livewellcolorado.com
4See http://www.healthyeatingactivecommunities.org
II. Progress/Key Findings

A. Community Selection and Engagement

This section summarizes the early part of the CHI process: selecting communities to be the geographic area of focus and initiating a community-driven planning process to identify the intervention strategies to be pursued.

Community selection process

HEAL-related activities are taking place in all of the eight KP regions. In five of the eight regions, all the CHI design principles have been applied to multi-sector interventions in specific geographic communities: Northern California, Colorado, Georgia, Mid-Atlantic States and Ohio. In the other three regions (Southern California, Northwest, Hawaii), HEAL interventions that vary in scope and approach but overlap with CHI design principles are being implemented. These efforts often are supported through partnerships with other funders; for example, The California Endowment and the Healthy Eating Active Communities (HEAC) in Northern and Southern California, and the Alliance for the Promotion of Physical Activity and Nutrition (APPAN) in the Northwest.

It should be noted that all of the communities participating in CHI or the other HEAL initiatives have demonstrated a level of readiness sufficient to form a collaborative and to do action planning and proposal writing. Therefore, the CHI experience cannot be generalized to all communities regardless of readiness.

Table 1 lists the communities selected for intensive CHI interventions along with some demographic information.
### Table 1. CHI Community Descriptions

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<th>Region</th>
<th>Community</th>
<th>Population</th>
<th>Ethnicity</th>
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<td>South Santa Rosa (Santa Rosa)</td>
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<td></td>
<td></td>
<td></td>
<td>46% White</td>
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<td></td>
<td>West Modesto (Modesto)</td>
<td>38,400</td>
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<td></td>
<td>34% White</td>
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<td></td>
<td>Iron Triangle, Parchester Village, North Richmond, portion of City of</td>
<td>52,900</td>
<td>45% Latino</td>
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<td></td>
<td>San Pablo (Richmond)</td>
<td></td>
<td>29% African-American</td>
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<td></td>
<td></td>
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<td>Colorado</td>
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<td></td>
<td>43% White</td>
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<td>Denver Urban Gardens (Denver)</td>
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<td></td>
<td>33% White</td>
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<td>Park Hill (Denver)</td>
<td>26,400</td>
<td>46% African American</td>
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<td>36% White</td>
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<td>14% Latino</td>
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<tr>
<td>Georgia</td>
<td>Belvedere (Atlanta)</td>
<td>5,457</td>
<td>92% African American</td>
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<td></td>
<td>5% White</td>
</tr>
<tr>
<td>Ohio</td>
<td>Lee–Harvard (Cleveland)</td>
<td>18,000</td>
<td>97% African American</td>
</tr>
<tr>
<td>Mid-Atlantic States</td>
<td>Bladensburg, Colmar Manor, Cottage City, Edmonston (Port Towns, MD)</td>
<td>11,000</td>
<td>64% African American</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>21% White</td>
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<td></td>
<td>14% Latino</td>
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As with all other aspects of CHI, there were significant regional differences in the way communities were selected for participation. Approaches ranged from requests for proposals (RFPs) issued to existing collaboratives to the establishment of new collaboratives in communities identified as meeting the explicit need and readiness criteria. Once CHI communities are selected, the next step they take is a community-wide planning process involving a range of community-based organizations, institutions, and residents that comprise the community collaborative. The two early-adopting regions—Colorado and Northern California—both used RFP processes to select their communities. In Colorado, the KP-led Thriving Communities Partnership, now part of LiveWell Colorado,⁵ issued an open invitation to communities for a six-month planning grant. Twelve communities were awarded planning grants, with a Community Action Plan to implement comprehensive community change as the principal deliverable. Based on the quality of the plans and the effectiveness of the collaboratives, three of the communities were selected to move forward with implementation grants. The remaining communities

⁵See [http://www.livewellcolorado.com](http://www.livewellcolorado.com)
were awarded much smaller grants to continue building their capacity to undertake environmental and policy changes.

A more targeted request for proposals (RFP) approach was used in Northern California. Local Northern California Community Benefit managers were asked to invite specific community organizations and existing collaboratives in their areas to respond to a HEAL-CHI RFP that included a nine-month planning phase followed by a four-year implementation phase.

The subsequent wave of CHI communities—Georgia, Ohio and Mid-Atlantic States—did not use an RFP process. Instead, KP gathered input from a variety of sources, including interviews with funding partners and community leaders and then selected the community that met the CHI criteria. The criteria included the presence of significant community need and the potential for successfully implementing environmental and policy change interventions.

What’s the best way to select communities—RFP process or selection by KP?

Regions used different approaches to selecting communities for participation in CHI. Colorado issued an open invitation or request for proposals (RFP) to interested communities. Northern California also used an RFP process but targeted the invitation to specific communities with a functioning collaborative. Did one approach seem to work better?

Some advantages of an open RFP process (e.g., Colorado) are a wide range of communities often apply and applicants may perceive the process as more fair. Some advantages of a more targeted selection process (e.g., Northern California) are assured selection of communities that have high needs or an established collaborative with a proven track record. Past success is often a predictor of future success, particularly when community collaboratives are involved. It often takes years to build the trust required for organizations to share resources and contribute their own time and energy to a collective good.

A limitation of an open RFP process is that communities with new grassroots efforts may lack grantwriting expertise and might not be selected. This could disadvantage communities that are less organized or have fewer resources. An alternative approach, selecting communities directly based on high need and/or with demonstrated interest from community-based organizations and residents, often requires some assistance with collaborative development.

Early information about CHI does not favor one approach over another. Both successful and challenged collaboratives have emerged from an open RFP process and from targeted selection.
Community engagement/planning process

Once CHI communities were selected, the next step was to convene a community-wide planning process that involved a range of community-based organizations, institutions and residents. This process was fairly straightforward in Colorado and Northern California, where the collaboratives selected as part of the RFP process led the planning. In Georgia, Ohio and Mid-Atlantic States, however, community collaboratives were not already in place. KP leaders played a critical role in engaging multiple community stakeholders to develop a coherent and functional collaborative—an “initiating committee”—which then led the planning process. The work of negotiating stakeholder dynamics, cultivating leadership, establishing governance and structure, and nurturing ownership among the collaborative members required intensive involvement by KP leaders and made KP’s role in these sites distinctly different from its role in sites engaged through an RFP process.

In every CHI site, the end result of the planning process was a Community Action Plan (CAP) that provided a roadmap for intervention activities. In the CHI experience to date, a small group of core individuals and organizations typically has organized and led the CAP process. The common element across all regions was that the CAP addressed HEAL, with interventions reaching a significant proportion of community residents through a focus on environmental and policy change. Also, in each region, a local evaluator was selected to provide data for the planning process, evaluate local activities in more depth and serve as a liaison to the cross-site evaluation. Variations of the planning phase resulted in very different processes and outcomes, including how data were gathered and used, the level of guidance provided by KP, the degree of emphasis on evidence-based interventions and whether other non-HEAL issues (e.g., neighborhood safety) would be addressed.

Community stakeholder meeting, Park Hill neighborhood, Denver, Colorado
How much guidance should KP provide to communities around intervention selection?

As a funder, KP has influence over many aspects of the CHI planning and implementation process. One key decision is how structured to make the community planning process—i.e., how much leeway to give communities in selecting their intervention strategies. Options range from a completely community-driven process to a highly structured approach in which communities are required to implement a specified set of evidence-based interventions selected by the funder.

An advantage of a community-driven process is that community engagement and ownership are enhanced when residents choose their own strategies. Also, residents often know best what will work in their own communities. Moreover, evidence-based interventions typically have not been tested across all ethnic and cultural groups.

The advantage of a more structured approach is a potentially greater long-term impact from selecting interventions that are evidence-based and more focused on environmental and policy change. At times, these strategies may seem less attractive to community groups, but over the long run they have the potential to reach more people and be more sustainable.

CHI regions varied considerably in the amount of structure required during the planning process and the degree to which evidence-based interventions were emphasized. Colorado began with a largely unstructured, community-driven process. This resulted in high levels of community engagement, but also in plans focused primarily on individual-level programs with little coordination among them. More recent revisions of the Colorado CAPs have shifted toward policy and environmental change and a more integrated approach.

Northern California placed two important requirements into the planning process. First, collaboratives were asked to select interventions in each of four sectors: neighborhood, schools, worksites and health care. Second, within each of these sectors, collaboratives were asked to choose one intervention from a menu of evidence-based interventions identified by KP. The intent was to find a way to give communities freedom to develop their own plans within a structured evidence-based framework.

It is too soon to say which approach will produce the greatest long-term community impact. A mixed strategy combining some structure and evidence-based guidance with community priorities is the direction in which most CHI communities are heading. Colorado communities are adopting a more sustainable, coordinated approach that emphasizes more evidence-based interventions and policy/environmental change. Some of the greatest energy in the Northern California communities has been around innovative programmatic approaches that they have developed themselves. It is important to evaluate the impact of these innovative approaches so that they can become part of the evidence base, if successful.
Focus on HEAL only or consider other pressing community issues?

Promoting reductions in overweight and obesity is rarely the top priority identified by residents in CHI communities. The CHI focus on reducing disparities has led KP to recruit more disadvantaged communities that have higher rates of poverty and more ethnic minority residents. Issues that may be of greater concern in these neighborhoods include safety, education, economic development, racism and poverty. So how should KP respond when a strong, grassroots community collaborative wants to include work in other areas outside of HEAL?

Issues of violence prevention, economic development and environmental justice have arisen in several CHI communities, yielding different responses and outcomes. For example, in Richmond, California, violence is a persistent problem. Since becoming more physically active requires the ability to move about safely, focusing on violence prevention has become part of an overall approach to promoting HEAL. Similarly, Port Towns, Maryland, a CHI site that is just beginning the planning phase, plans to address violence within the context of HEAL strategies. In the Lee-Harvard, Ohio, neighborhood, environmental justice has been identified as a community priority. The Lee-Harvard organizers felt that environmental justice was outside the boundaries of HEAL, but some residents have been reluctant to participate in HEAL until they feel their primary concerns in this area are addressed.

Several regions are addressing other community priorities through their evolving grantmaking portfolios rather than by incorporating an expanded effort in CHI sites. Recent discussions among the regions, Program Office and technical assistance providers are now exploring how best to address these issues in the future.
B. Community Changes

This section presents baseline data on the population-level outcomes that are the focus of CHI and descriptions of the community change strategies being pursued to bring about these outcomes, community capacity building efforts, and sustainability.

Starting point: population-level data

CHI’s ultimate goal is “population-level change,” i.e., a representative (randomly sampled) community resident is eating more fresh produce and becoming more physically active as a result of CHI. Ultimately, as more people adopt and sustain these lifestyle changes, the result will be reductions in the rates of overweight and obesity and the conditions that result, such as diabetes and hypertension, among an entire population.

Population-level change is difficult to measure accurately. It involves surveys of complex behaviors, which require large sample sizes to make estimates with any degree of precision. Even if changes can be measured accurately, it is difficult to say whether any observed changes were the result of specific CHI intervention activities. The ways people eat and exercise are influenced by many determinants; the changes brought about by CHI are only a small part of the overall picture. For these reasons, we are supplementing the population-level surveys with extensive data collection addressing more intermediate outcomes, such as new programs, policies and environmental changes made as a result of CHI.

Despite the challenges of measuring population-level change and attributing it to CHI, population-level change is a central outcome goal that will be monitored over time. Population-level change is being tracked for adults using an automated telephone survey and, for youth, using a school-based survey and measures of physical fitness called Fitnessgram. The evaluation also is using clinical data from KP to provide additional information, particularly about overweight and more distal outcomes such as diabetes and hypertension. The results from the CHI communities will be compared with trends from a variety of state and national surveys, and compared with with specifically selected control communities in some regions (e.g., for the Northern California youth surveys).

Tracking changes among adults: Interactive Voice Response (IVR) surveys

Interactive Voice Response (IVR) is an automated approach to phone surveying. In IVR surveys, a recorded voice programmed by computer asks the questions instead of a live person. Names and phone numbers are obtained from a commercial list company for everyone with a listed phone number and address. Unlisted numbers
and cell phones are not called. Community members whose numbers have been selected are notified in advance via postcard that they have been selected and may opt out by calling a number on the postcard. They also are eligible to be entered into a drawing for a prize—an incentive to complete the survey.

The main advantage of IVR surveys is that they are much less expensive than surveys administered by an interviewer. Once the programming is completed, a whole list of people can be called at virtually no cost. The method also provides an opportunity to get community-specific, micro-level data and to track it over time. It also allows customization of the survey to include the community’s own questions. The main disadvantage is that people are much less likely to respond to IVR surveys than to a live person. The lower response rates (approximately 15% of those eligible to be interviewed) mean that the people surveyed may be less representative of the entire community.

Figure 3 shows baseline data for selected measures from seven communities in Northern California, Colorado and Georgia where IVR surveys were conducted between 2006 and 2008. The percent obese was 30%, higher than the national average of 26%. The percent not doing recommended exercise (60%) was higher than the national average of 51%, and the percent eating fewer than five servings of fruits and vegetables per day (55%) was substantially lower than the national average of 76%. There was a considerable range across the CHI communities in these and other measures shown in Figures 3 and 5; for example, the percent doing less than the recommended amount of exercise ranged from 50% to 68%, and the percent obese ranged from 27% to 41%.

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6Detailed IVR survey results, by community, are included in Appendix B, Table B-2.
7National comparison figures for the IVR survey from the 2007 Behavioral Risk Factor Surveillance Survey: http://apps.nccd.cdc.gov/brfss/
8The recommended level of exercise is moderate exercise 5/week, 30 minutes/occasion OR vigorous exercise 3 days/week, 20 minutes/occasion.
Clinical measures—KP member data

Another source of information about population-level HEAL trends is clinical data on KP members. In some CHI communities, KP members make up a significant percentage of the population, so tracking changes among members gives a rough estimate of changes going on in the community as a whole. Also, since the KP member data include information on chronic conditions, such as diabetes and heart disease, we can track changes in key long-term HEAL outcomes.

Another advantage of using the KP member data is that we can also get comparison data on KP members living in the same county, but outside the CHI community boundaries. By selecting comparison neighborhoods that have similar demographics (e.g., ethnicity and income), we have a better chance of separating out the effect of CHI on health status and behavior.
Figure 4 presents data on obesity for the three CHI communities in Northern California. Rates were high, ranging from 37% in Santa Rosa to 46% in Modesto (compared to the national average of 26% noted above). The comparison communities were reasonably well-matched, with rates comparable to the CHI communities. Similar data are being obtained in other communities with high KP penetration rates, including seven CHI/LiveWell communities in the Denver area.

**Figure 4. Northern California KP Adult Member Data Baseline Results: Percent Obese**

![Bar chart showing obesity rates in Modesto, Richmond, and Santa Rosa.](image)

**Tracking changes among youth: school surveys and Fitnessgram**

CHI outcomes among youth are being measured using a self-administered survey conducted in middle and high schools. Survey questions ask about youth attitudes and behavior regarding nutrition and physical activity in schools and in their communities. Baseline surveys were conducted in 2007 and 2008; follow-up surveys will be conducted near the end of CHI funding.

In Northern California, the school surveys are being supplemented with Fitnessgram measurements. Fitnessgram is a statewide program conducted in all high schools and middle schools. It measures three components of health-related physical fitness that have been identified as important to overall health and function: aerobic capacity;

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9More detailed results from the KP member data are included in Appendix B, Table B-5.
body composition; and muscular strength, endurance and flexibility. In Northern California, matched comparison communities have been selected where school survey and Fitnessgram data also are being collected.

Figure 5 shows a variety of risk factors for obesity across the seven communities in Northern California, Colorado, Georgia and Ohio where school surveys have been conducted. Of note, nearly 80% of children were eating fast food regularly and just under half (43%) did not feel safe in their own neighborhoods. The percent eating fewer than five servings of fruits and vegetables per day was high (69%), but well below the national average of 82%.

**Figure 5. Youth Survey Baseline Results: Obesity Risk Factors**

- % who ate fast food in the past week: 79%
- % eating less than five fruits and vegetables per day: 69%
- % not exercising vigorously 20 minutes per day: 50%
- % not taking PE year around: 44%
- % who don’t feel safe in their neighborhood: 43%

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10 Detailed youth survey and Fitnessgram results, by community, are included in Appendix B, Tables B-3 and B-4.

Figure 6 shows rates of obesity among children (BMI-for-age greater than the 95th percentile) and overweight (greater than 85th percentile) for the three Northern California communities for which Fitnessgram results were available. About a third of students were obese across all three grades, while over half were overweight or obese. The estimate of 27% to 28% obese for the sample of seventh and ninth graders was substantially higher than a national estimate of 17% for 12 to 19-year-olds.\textsuperscript{12}

![Figure 6. Northern California 2006-2007 Fitnessgram Baseline Results: Obese and Overweight or Obese](image)

**Community change strategies: description, impact to date**

If the ultimate CHI goal is population-level change, how is it achieved? The short answer is by making significant, sustainable changes in communities that promote HEAL-related lifestyle changes and create environments supportive of positive lifestyle choices. These community changes can include new programs, greater availability of healthier food and a physical environment that promotes physical activity as part of everyday life.

A key proposition advanced by CHI is that community environmental and policy changes across multiple sectors (e.g., neighborhoods, schools, worksites) are likely to be sustainable and reach enough people in enough ways to have a community-wide impact. Environmental changes are changes in the physical, social or economic

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environment in a community that can influence HEAL-related lifestyles. Nutrition-related environmental changes increase availability of healthy food, through supermarkets, farmers’ markets and other venues. Physical environment changes usually involve changes in the built environment: creating more complete sidewalk networks, developing walking trails or using zoning policy to create more compact, walkable neighborhoods.

Policy changes are permanent, written rules that shape HEAL-related environments and programs and are put in place by public and private organizations. Policy changes can take place on a number of levels, including organizational (e.g., removing vending machines from a worksite) and at various levels of government (e.g., making zoning changes that affect the walkability of an entire city).

The CHI evaluation is tracking intervention strategies using the Documentation of Community Change (DOCC), a database that tracks each CAP strategy over time, including implementation status and number or people reached by each strategy. In the six communities in Colorado and Northern California that are implementing their CAPs, 139 strategies are in the process of being implemented.13

Figure 7 shows the distribution of strategies according to the levels of the “ecological” model for health promotion,14 where the most immediate, proximal influences on individual behavior (e.g., programs, organizational environment) are shown on the inner rings and the more distal (e.g., public policy, community environment) are shown in the outer rings. While it is important to intervene at all levels of the spectrum, CHI’s focus is on the “outer rings” of policy15 and environmental changes that have the potential for greater impact and sustainability using potentially fewer resources. Out of the 139 current CHI strategies, 37% are

13More detailed descriptions of the community change strategies, by community, are included in Appendix A, Tables A-2 and A-5.
15Note that “Public Policy” and “Community Environment” often are not mutually exclusive, in particular when policies are designed to modify the community environment (e.g., zoning changes).
programmatic, while 25% are either public policy (5%) or environmental change (20%). About one-fifth (19%) are focused on building community capacity, which can affect change in all of the other levels.

The following are examples of programmatic, policy and environmental change strategies being pursued in the CHI communities:

**Organizational**
- Implementing BMI screening in health clinics
- Changing vending machine and cafeteria practices in schools to promote healthy eating

**Community environment**
- Creating a “Bike Depot” to promote bicycling
- Creating new community gardens to increase the availability of fresh produce

**Public policy**
- Shaping redevelopment to promote more compact, walkable neighborhoods

**Programs**
- Youth gardening education programs
- After-school physical activity programs
Community Change: Stories of Success

Program: Building on Gardens in Denver Urban Gardens
Denver Urban Gardens developed a dense network of 13 small gardens in inner-city lots in the Denver neighborhoods of Baker, La Alma/Lincoln Park and Sun Valley. They developed youth and adult garden programs, healthy cooking demonstrations, and biking/walking “garden tour” maps to initially engage residents and use gardens as a tool for building community and strengthening neighborhood connections. Then they broadened their scope and created a more integrated approach that now includes a mobile youth farmers markets and a centralized, refrigerated storage unit to improve access to fresh produce for neighborhood schools and food banks.

Organizational Change: Supporting Clinical Practice Change in Santa Rosa
Santa Rosa, one of three CHI sites in Northern California, has institutionalized BMI screening in its community health centers. Supported in large part by advocacy and intensive technical assistance provided by KP physicians, clinics have adopted routine BMI screening and questions about diet and physical activity for both adults and kids. At one participating clinic, clinicians went a step further, challenging one another to lose weight and improve their own diets so that they could serve as role models to their patients.

Built Environment: Redevelopment in Commerce City
The CHI collaborative in Commerce City played a key role in developing a master plan for the Derby neighborhood (the commercial zone of historic Commerce City). Guidelines and zoning rules have been included that make the area a more pedestrian friendly place and increase physical activity. The collaborative brought in an expert on walkable communities, trained students in advocacy and enlisted them in the process.

Nutrition Environment: Farmers’ Market and Corner Stores in Modesto
Through trial and error, Modesto found a way to establish a farmers’ market and supply produce to neighborhood corner stores at the same time. They first trained 40 women to grow backyard produce. These neighborhood residents were certified as producers and a license was obtained to offer a farmer’s market in the park. While there were some sales of plums, chili peppers, peaches, tomatoes, and cherries, getting to scale posed a problem. Some resident growers admitted they weren’t able to bring their crops to the market because their children kept eating their produce! Then a new opportunity developed with Heifer International to provide training and growing land to a youth group. The youth now plan to sell plants, flowers, and produce in the farmers’ market. Heifer also provided excess produce at no cost to local neighborhood stores on a delivery schedule that coincides with most residents’ pay day to avoid spoilage, providing even greater access to healthy produce for West Modesto residents.

Community Capacity: Increased Collaboration in Richmond
Prior to CHI, only a few of the 20 current partners in Richmond’s West County collaborative had worked together before. They also differed in the degree to which obesity prevention was tied to their respective missions. Somehow, their varied but shared interests did the trick. Working together on the HEAL Initiative helped the West County collaborative’s members overcome previous differences and become a true collaborating organization, in which everyone contributes different strengths and the whole becomes much more than the sum of individual parts. As the former project coordinator puts it, “It took us a long time to say ‘we.’ Now that they are saying ‘we,’ the group is making progress on several policy fronts, working to make the city General Plan more health friendly.”
Distribution and evolution of strategies across regions

The strategy data from the DOCC can be used to review and discuss the mix of strategy types: policy, environmental change, programs and capacity building. Comparisons can be made across sites or over time within a given site. Figure 8 makes one such comparison, highlighting differences across the regions in the mix of strategies being pursued. The Colorado communities started with more programmatic strategies, reflecting a less structured, community-driven process and a greater interest among community members and residents in concrete, education-oriented programs rather than policy and environmental changes. Northern California’s process required communities to choose at least one policy and environmental change strategy in each of four sectors: neighborhood, schools, worksites and health care. This resulted in a greater number of policy and environmental change strategies initially in Northern California (53%) than in Colorado (34%) and fewer programmatic strategies (28%, versus 48% in Colorado). Both regions are midway through their project period and the Colorado communities are leveraging the grassroots engagement gained through their programs to build momentum and shift the focus to policy and environmental strategies.

Figure 8. Baseline Strategy Mix, by Region
Intermediate outcomes: intervention reach and impact

For reasons noted earlier, it is very challenging to measure the population-level impact of community initiatives such as CHI. Therefore, it is critical to capture more intermediate outcomes, such as whether community changes have been implemented, how many people have been touched by the changes and what the impact has been on each person touched.

Every CHI intervention affects people to different degrees. Some make major changes in their lifestyles by increasing the amount they exercise and by eating healthier foods. Others do not make major lifestyle changes, but may make changes in knowledge, attitudes, awareness or readiness to change. Some people will not be affected at all.

The CHI evaluation is identifying two groups of people for each intervention strategy:

1. Exposed to the intervention—touched in some way, whether living in an area that has been redeveloped to be more walkable or shopping in a store that has increased the amount of produce it sells.
2. Affected in a significant way by the intervention—among those exposed, the number who have changed their lifestyles or behaviors as a result of the intervention. For example, they now walk to stores that they used to drive to or now purchase and eat more produce.

The number exposed requires estimating the number of people who may encounter an environmental change on a regular basis—for example, the number of people who live in a neighborhood affected by redevelopment. The number affected requires some data gathering—for example, counting the number of pedestrians in a shopping district, shoppers at a grocery store or walkers on a walking trail. The initial priority is to collect data on those exposed; the number affected will need to wait for the environmental and policy changes to be implemented and will require more intensive evaluation efforts. Local evaluators in each region will play a major role in gathering information to estimate affected reach, selecting those strategies where realistic evaluation designs can be implemented.

Preliminary data on exposure to CHI interventions in the neighborhood and school sectors in Northern California are shown in Figure 9. The figure shows “penetration,” i.e., the number potentially exposed to the interventions divided by the total population for the neighborhood sectors and total school enrollment for the school sector. For example, in the school sector each community is working to implement district-wide healthy eating policies around vending machines, cafeteria food and food used as a

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16 More detailed results for intervention penetration by strategy type are shown in Appendix A, Tables A-6 and A-7.
reward. Although few of these policies have yet been implemented, the potential number of children exposed is significant: 85% penetration across all three communities.

Penetration in the neighborhood sector is more limited. Unlike the schools, which have a more “captive” population, reaching everyone in the target neighborhood requires multiple overlapping strategies. The highest reach is in the physical activity environment where built environment changes—including street improvements to enhance walkability, new parks and bike trails—have the potential to reach just over a third (34%) of the population. Finally, programs have limited reach either in schools or the neighborhood: only 1% in the neighborhood and 9% in schools.

Figure 9. CHI Intervention Penetration, Northern California

Figure 10 shows comparable penetration figures for the three CHI communities in Colorado. School penetration figures are not shown, since most of the Colorado communities have been focusing primarily on the neighborhood sector. A number of built environment interventions, including a major redevelopment effort in Commerce City, have resulted in a high potential reach for the physical activity environment—just over 60%. The programmatic reach, although four times higher than in Northern California, is low. However, many of those programs are relatively intensive multi-session programs that can be expected to affect the behavior of many participants.
How to move from programs to policy?

Programs are appealing because they are education-oriented, visible and provide immediate concrete benefits. Environmental and policy changes are more abstract, take longer to implement and produce their benefits over a longer period of time. However, as seen above in Figures 9 and 10, program reach is typically more limited, with far fewer people touched by programs than by environmental changes.

One idea that has emerged within CHI is the use of programs as an “on-ramp” to policy change. In this scenario, communities start with programs and then, over time, are encouraged to move to policy change. This shift from programs to policy has occurred in Colorado CHI communities, for example:

- In Denver Urban Gardens, participants are beginning to move from building new gardens and offering educational programs to working on food systems as a whole.
- In Park Hill, the Bike Depot led to increased interest in making the community more bikeable, which in turn led to street-scale built environment changes: bike lanes and reduced traffic lanes.

In both of these cases, the impetus for moving from programs to policy came from the communities themselves as they began to recognize the need to create conditions that supported long-term behavior change and would reach more people in a sustainable way. This was reinforced by technical assistance provided by KP and LiveWell Colorado.
Built environment—change takes time, but results are lasting

Neighborhood and housing characteristics, land-use planning and zoning, transportation choices and community architectural decisions are all factors that can have profound influences on aspects of everyday life, such as eating and physical activity patterns. The resulting “built environment”—buildings, streets, parks and shopping districts—can either promote or discourage mobility and physical activity.

CHI collaboratives set about making changes in their own neighborhood environments. Ideas included renovating parks, adding sidewalks and bike lanes, developing walking paths, suggesting transit routes and revitalizing commercial zones. Several grantees noted that attending KP-sponsored Smart Growth conferences helped them by raising awareness about the need for changes to the environment and providing an opportunity to learn about approaches underway in other communities.

Early successes set the stage for change to the built environment in CHI neighborhoods:

• In Commerce City, the health and city planning departments teamed up to produce a Health Impact Assessment in conjunction with a commercial district redevelopment effort. Called the Derby Redevelopment Project, the team was able to build pedestrian safety and traffic calming elements into the planning and design guidelines in order to make streets safer for walking and biking.

• In Santa Rosa, the CHI collaborative applied for Safe Routes to School funding, which is administered by the state Department of Transportation. They plan to upgrade stop signs, crosswalks and street striping to make walking to school easier and safer. They were selected as the first of 10 pilot sites across the nation to develop and evaluate the Safe Routes to School program in a low-income neighborhood.

• In Richmond, the CHI collaborative realized there was a unique and timely opportunity to add public health elements to the City of Richmond’s General Plan. CHI collaborative partner organizations provided regular input and influenced the process. They recommended that the draft of the Richmond General Plan incorporate sustainable health concepts such as natural resource conservation, transit-oriented development, access to many modes of transportation, green building incentives and public health into the planning framework.
Photovoice as a powerful tool for policy and advocacy

One major early CHI success has been the use of Photovoice—both in mobilizing community residents and in contributing to successful policy advocacy. Photovoice is a community-based approach to documentary photography that provides community-based organizations and residents with training on the use of photography to generate critical discussion. Photovoice can also be used as an advocacy tool to engage policymakers and other stakeholders around policy and environmental change. The goals of Photovoice are: 1) to enable people to record and reflect their community’s strengths and concerns, 2) to promote critical dialogue and knowledge about important issues through group discussions of photographs and 3) to reach policymakers to make changes that enhance the community.

Between summer 2006 and winter 2008, more than 115 participants took photos of barriers to healthy eating and active living throughout 12 distinct neighborhoods in five KP regions across the nation as part of CHI. The products of Photovoice—pictures with captions—have been presented to many different groups, including neighborhood associations, real estate developers, police staff, schools, grocery retailers, city planners and policymakers (see Figure 11 for an example). Photovoice themes have included increasing access to fresh, healthy and affordable food in schools and neighborhoods; reducing the impact of crime, gang and drug activity; enhancing the safety and cleanliness of parks and recreational areas; and advocating for safe and complete streets.

Photovoice efforts have made significant contributions to improving parks, walkability and bikability, demolishing unsafe buildings and improving access to healthy food, including the promotion of youth markets.

- In Park Hill, Colorado, Photovoice helped improve the built environment in Axum Park, contributing to multi-use paths, increasing lighting for enhanced safety, and making the entrance location more user-friendly. Also in Park Hill, an image of an abandoned, unsightly building contributed to its demolition, which allowed the land to be used for a watershed project.
- In Denver Urban Gardens in Colorado, Photovoice led transit development decisionmakers to agree to include people with disabilities on their advisory committees.
- In Commerce City, Colorado, Photovoice images have been used to support changes to their General Plan and also will be used in conjunction with the neighborhood walkability assessments.
- In Richmond, California, Photovoice was used in collaboration with other efforts to achieve the demolition of a long-standing, crime-ridden liquor store.
- In Portland, Oregon, Latina parents were able to successfully advocate for safe placement of school bike racks. One Portland participant stated, “To see these women—who have not had a lot of opportunities—step forward and be equipped to make change, was inspiring. And I believe this is the beginning of a phase where organizations discover they can work together to change policy.”
- Photos from Santa Rosa, California also were used by one of KP’s physician champions to successfully advocate at the state level for Safe Routes to School.
Figure 11. Example of Photovoice from Santa Rosa, California

Because of a lack of sidewalks and an adequate bike lane, the residents have to put their own signs out for the safety of their families and their children walk in the street with the risk of suffering an accident.

Por la falta de banquetas y de un lugar adecuado para circular en bicicleta, los propios habitantes tienen que poner sus letreros para la seguridad de su familia y los niños usan la calle con el peligro de sufrir un accidente.
“I think the Program Office is helpful in that they come to a lot of our meetings and help us think through issues. Also, having the links to other regions, and facilitating the peer network-making. The HEAL academy, which was great. They’re great at identifying where we’re all struggling and showing us how to work with that. They’re great at bringing people together.”

**Capacity building**

CHI represents a significant change in the way KP works with the communities it serves. The CHI design principles, including KP’s role as a funder and partner and the focus on policy and environmental change, are departures from past KP practice. As a result, community capacity building to support such a large scale initiative has been key to the successful implementation of CHI on a number of levels, including:

- **Overall KP level: Program Office (PO) support for regions**—building capacity of regional CB staff to work collaboratively with communities around HEAL policy and environmental change.
- **Regional level: Regional Community Benefit (CB) support for communities**—individual regions providing support to partnerships to help them plan and implement their HEAL strategies.
- **Community level: Capacity building within communities**—carrying out strategies to strengthen collaboratives, build community leadership and in general increase capacity to do HEAL-related work.

This section describes these capacity building efforts, their success to date and suggestions for improvement based on interviews with KP regional leaders and community collaborative members.

**Overall KP level: PO support for regions.** The PO has created several mechanisms to build the capacity of the regions to implement CHI. These include a CHI work group with representation from all regions that holds monthly calls to share lessons and hear presentations on a diversity of topics; an annual “HEAL Academy” in-person meeting for more in-depth training and discussion, and tailored support to regions and individual CHI leaders. In interviews, regional CB staff working on CHI said they felt well supported by PO. They appreciated the opportunities for networking with other regions and the willingness of PO staff to come to the communities to work on specific problems. An annual online survey showed similar levels of satisfaction with the support. For example, 90% of respondents rated the PO support around CHI strategy development a 9 or 10 on a 1-10 scale.

There is room for improvement regarding communication in general, as well as role clarification around budgets and evaluation. Budgetary and resource concerns were the primary concerns in some regions. The following areas for improvement were mentioned:
“I think the major challenges have been resources—the time and energy it really takes to ramp up for such an ambitious initiative. I think that’s put a strain on the Regions and Program Offices.”

“Having a private meeting with them at the kickoff was great—just being able to let our guard down... They listened to the collaborative, heard what we were saying for real, and we didn’t have to worry about what we were saying.”

“KP has been pretty involved, would help with making connections with hierarchy in organizations like schools, mayors, board of supervisors. KP should say we are here to stay, and this is not just here, but statewide, national.”

**Staffing and resources.** While almost all interview respondents would have preferred to have more staffing and time to fully implement CHI, they also felt that they were able to get the work done with the resources they had.

**Planning.** CHI staff suggested that there would be benefit to having more time up front for planning, both internally with KP colleagues and with community partners.

**Communication.** Respondents were consistent in their responses that it is important to do a better job of telling the CHI story, both within KP and externally in the community, as well as developing better communication with the communities with whom they partner directly.

**Leadership.** While respondents felt that there was definite support in various sectors of the organization for CHI, some felt that support could be improved, especially among some regional and local medical office leadership.

**Regional level: regional CB support for communities.** Another part of the capacity building effort is technical assistance provided by the KP regions to CHI community collaboratives. This assistance typically is provided by a consultant under contract with KP’s CB Program and Regional Offices or by the CB staff themselves. Assistance has been provided around general capacity building (e.g., building the collaborative, developing leadership skills) and in specific HEAL intervention areas (e.g., advocacy training for medical providers and physician leaders from community clinics and sharing best practice strategies for policy changes in BMI screening and breastfeeding promotion in the health care sector).

Interviews were conducted with collaborative members in Northern California, Colorado and Georgia between Spring 2007 and Summer 2008 to assess the support and technical assistance provided by KP regions. In general, community collaborative members were positive about the support they have received from KP. Respondents found KP to be flexible in responding to changing circumstances, a source of guidance around the overall picture and a supportive, committed, and responsive partner.

Areas where KP could have been more effective included cutting down on the number of meetings, and recognizing that communities had assets and, in many cases, did not need assistance. Suggestions for improvement included creating more peer learning opportunities for communities to learn from each other, being clearer on expectations, connecting them to key political figures and making a long-term commitment to stay engaged with the communities.
Community level: capacity building within communities. The final and perhaps most important part of capacity building is taking place within the communities themselves. A central component of the CHI capacity building strategy was the requirement that a community collaborative plan and implement the CAP strategies. Some communities had existing collaboratives already in place that adopted or modified their missions to include HEAL (e.g., Modesto, Richmond). Other collaboratives were formed specifically for CHI, either as part of an RFP process (e.g., Denver Urban Gardens in Colorado) or through a KP-led initiating committee process (e.g., Georgia, Mid-Atlantic States). In putting together the collaboratives, the goal was to include a broad cross-section of community stakeholders, including community residents, and not just organizations focused on HEAL. The intent was for these broad-based collaboratives to continue to exist beyond the CHI funding period and for them to find other issues to address in the future. An example of a successful collaborative-building effort in Richmond is shown in the box on page 33.

A second part of the capacity building effort was a set of strategies pursued by the communities as part of their CAPs that focused on general capacity building as opposed to capacity specifically related to HEAL. General capacity building strategies have included:

- Photovoice for community assessment and mobilization (all communities)
- Hiring, training and providing organizational support and focus to efforts by Latino outreach workers to engage the community and spread the word about the CHI project (Commerce City)
- Establishing a neighborhood advisory group to advocate for food policy change (Modesto)
- Doing community organizing and training to train residents in HEAL advocacy (Santa Rosa)
What is KP’s role — funder, partner or combination of the two?

KP is attempting to create a new model for working with communities, acting as a funder as well as an ongoing partner. Resources KP brings as a partner include clinical expertise, physician champions, research units to assist with needs assessment and evaluation, health education and a population-based, “public health” approach to health care delivery. For example, KP physician champions actively participate in collaborative efforts across the nation, including advocacy efforts such as writing letters to school boards to address the importance of physical activity and training clinical staff to deliver obesity counseling. KP research units are partnering with sites by acting as local evaluators and also are providing KP member data to track long-term health outcomes. Other KP units involved in CHI efforts include worksite wellness, government relations, health education, weight management, educational theatre, food service, community relations, media relations and facilities (for farmers’ markets).

However, there are potential disadvantages to KP’s dual role. Community grantees are not used to this dual role and may be reluctant to be candid, fearing that surfacing problems will affect future funding. Also, too much KP involvement may cause community partners to assume less ownership or take less of a leadership role, as has occurred to some degree in some regions.
How to provide useful technical assistance to communities?

The purpose of providing assistance to CHI collaboratives is to improve their capacity and effectiveness in meeting project goals. Technical assistance providers have offered group trainings and coaching about implementing and evaluating specific strategies, linkages with other resources and sharing of information across CHI sites.

CHI collaboratives vary considerably in their leadership and collaborative makeup—with differing backgrounds, experience and affiliations. As a result, some collaboratives welcomed assistance and others found it unnecessary and/or burdensome. At times during the initial stages, offers of assistance created tension and were criticized for not recognizing the assets already in the CHI collaborative or respecting the capacity to manage the process within the team.

Technical assistance providers faced many challenges. Learning about the CHI collaborative and understanding their plans required contact and meeting time that was sometimes viewed as an impediment to actually getting the implementation work accomplished. In Northern California, CHI sites had multiple technical assistance providers—for evaluation, implementation and communications—creating an overload of requests for meeting times with the CHI collaboratives. This problem was addressed when providers started meeting regularly to coordinate and streamline the timing of their contact with communities.

Evaluation technical assistance posed unique challenges. Implementing consistent cross-site measures in all CHI communities required the presence of a local evaluator in each community, a similar set of skills and the need to coordinate with a national cross-site team. Contracting relationships directly with local KP regions versus the national cross-site evaluation team created communication complexities and accountability challenges. Local evaluators also faced challenges in gathering succinct and useful information for community development of their first community action plans and gathering adequate information for the cross-site evaluation without placing undue burden on the collaboratives.

One evaluation lesson was that oral progress reports could be effective. Annual site visits that reviewed past year accomplishments and plans for the year ahead were less burdensome on communities than written progress reports—and gave more insights about progress and challenges to KP staff and the evaluators.

Opportunities were created for CHI collaboratives to learn from one another through linkages and meeting forums attended by the technical assistance providers. For example, several Colorado CHI collaborative members attended a meeting for the three CHI collaboratives in Northern California and engaged in peer-to-peer learning and support to solve common problems and concerns. Finally, to promote peer learning among the local evaluators, regular conference calls and an annual meeting have been instituted.
Sustainability

If the promising efforts underway in all CHI communities are not sustained beyond this initial period of CHI funding, there will be little hope of seeing the long-term health improvements and enhanced community capacity that are CHI’s ultimate goal. Several mutually reinforcing strategies for sustaining the CHI community efforts have potential. They include:

- Being creative and collaborative in securing funding streams
- Implementing sustainable strategies (such as policy and environmental change)
- Increasing community capacity, including community leadership and durable partnerships
- Changing organizational cultures to be more HEAL and/or community-oriented
- Solidifying support for CHI within KP

This section reviews the current status of CHI sustainability efforts in each of these areas.

Be creative and collaborative in securing funding streams. Long-term sustainability requires funding, which can come from a variety of sources. The most effective and sustainable funding approach is to build line items directly into long-term government and institutional budgets. For example, in Colorado, KP funded staff infrastructure in 2004 for the new Office of Health Disparities in the Colorado Department of Public Health and Environment. During this time the Office became statutory and several positions became partially supported through federal and state funding.

However, such long-term solutions often are not available and shorter-term options must be found instead. To date, CHI communities and KP working together have leveraged approximately $43 million in funding from government agencies and other funding sources to multiply efforts in these CHI neighborhoods. Collaboration with other funders is a promising approach and there is an active effort underway in most regions with a variety of potential partners, including the Robert Wood Johnson Foundation, W.K. Kellogg Foundation, federal and state Safe Routes to School programs, The California Endowment and the Centers for Disease Control and Prevention’s Steps to a HealthierUS Initiative.\(^{17}\) The work with Robert Wood Johnson and Kellogg Foundations is discussed further on page 61. Examples of funder collaborations include:

\(^{17}\)http://www.healthierus.gov STEPS
• In 2004, the Centers for Disease Control and Prevention issued an RFP for its Steps to a HealthierUS program, which featured many elements of CHI. KP collaborated with local public health departments and community partners on 11 proposals, only one of which was funded. Over the next 12 months, KP continued to support these partnerships with KP Steps Sustainment Grants ranging from $40,000 to $100,000 per community. When the federal government announced Round II awards, 3 of the 5 winning communities were KP-sponsored collaboratives.

• In the Mid-Atlantic States region, multiple foundations contributed to a pooled fund to support the Port Towns, Maryland CHI effort.

• In the Northwest, KP partnered with the Northwest Health Foundation to create a donor-restricted fund for the Alliance for Promoting Physical Activity and Nutrition (APPAN). The advisory council members for this fund included Pacific Source Charitable Foundation, Providence Health and Services, CareOregon, Oregon Department of Humans Services and Multnomah County Health Services. Kaiser Permanente's seed funding attracted other contributions from other regional health care organizations to support the HEAL initiatives in Oregon and Southwest Washington.

• In Northern California, the Santa Rosa CHI collaborative applied for and secured state funding and $1.1 million in federal funding for Safe Routes to Schools work that will continue beyond the current KP CHI funding period.

**Implement sustainable strategies.** One rationale for focusing on policy and environmental change as intervention approaches is that they are inherently sustainable. Written policies, regulations and zoning requirements stay on the books until there is an active effort to alter them. And many environmental changes are similarly durable; for example, park facilities enhancements and new sidewalks represent durable (if not permanent) changes. As noted above (Figure 7, page 32), about one-quarter of all CHI intervention strategies are either public policy oriented (5%) or environmental change (20%). Another 19% are focused on organizational policy change (e.g., changing school nutrition and physical activity policies), bringing the total proportion of "sustainable" strategies to about one-third (34%). Challenges to implementing policy and environmental change are that they take longer to implement and often require the sustained effort of multiple partners. In addition, once adopted, policy changes at the organizational or local government level must be implemented which in turn requires resources and monitoring.
**Increase community capacity.** For long-term sustainability, it is essential to build community capacity so that efforts can be maintained after KP funding ends. The capacity is needed both to maintain existing policies and programs and to create and take advantage of new opportunities, both within HEAL and in other areas (e.g., violence prevention). A central reason for including a community collaborative as one of the CHI design principles was to promote sustainability. Strong, durable collaboratives can maintain the HEAL efforts even if funding levels decline; they also can work on other community issues as they arise.

The interviews with community informants revealed differences in how they viewed their own collaborative’s sustainability. Collaboratives that had existed prior to CHI (e.g., in Northern California) differed from those that were created *de novo* as part of CHI. Existing collaboratives generally were confident they would remain active and continue to work together. This confidence was based in their ability to remain together and stay active through previous funding transitions. The newer collaboratives expressed confidence that they could sustain themselves. In some cases, sustainability had been discussed, but few concrete steps had been taken to prepare a sustainability plan or to define which elements such a strategy would include.

In addition to building strong collaboratives, it is important to cultivate and support community leaders at multiple levels in order to develop skills that can be applied to address the current work as well as other (future) community issues and/or needs. For example, members of neighborhood groups and 13 Richmond area youth interns recruited through RichmondWORKS (a summer youth employment program) surveyed conditions at 57 public parks in Richmond and San Pablo, in partnership with the Pacific Institute. The Richmond CHI community plans to engage youth in advocacy activities to convince city officials and neighborhood groups to reinvest time and money into parks in Fall 2008.

In Colorado, 33 Adams City High School teens participating in KP’s Educational Theatre Program decided to focus on promoting walking and biking to school. They conducted a survey of 672 of their peers, determined that only 16% of the students walked/biked to school and then made a video to document the barriers
“The collaborative will continue because it was in existence before the grant, for so long. Money is powerful but it doesn’t drive the passion we have.”

The collaborative will continue because it was in existence before the grant, for so long. Money is powerful but it doesn’t drive the passion we have.

they personally faced while walking to school. They presented the video to their parents and City staff to encourage changes to make it safe to walk and bike to school in historic Commerce City. In addition, the video was used in a Health Impact Assessment that has been presented to the City Council to influence land use decisions during a redevelopment process in this area.

Change organizational cultures. While building the collaborative body itself is important, it is also important to nurture change within each of the respective organizations that form the collaborative. Change in each of these organizations can take the form of doing business differently in the service of community and organizational transformation. Concretely, this is reflected in the alignment of the organizations’ strategic plans, budgets, job descriptions and policies with the community vision for change. For example, in Commerce City, Colorado, inserting a health element into the General Plan required the local health and planning departments to work together. That experience changed the way both of those units saw their respective roles. The planning department now sees that it has a responsibility to assess the health impacts of its planning work and the health department sees that it has a responsibility to inform the planning department’s work. The positive experience of working on a common project helped change the cultures of each of their respective units and what the departments consider their respective roles to be in future work.

Solidify support for CHI within KP. For CHI to be sustained over the 7-10 year period identified in the CHI Framework and as described in internal and external communications, more internal support for the initiative must be cultivated, both
“Budget is a major issue—just making sure we have the funds . . . and that they’re earmarked appropriately. This gets back to the importance of communication, telling the story, keeping up support through those means.”

“The next big step is showing results. The idea has inspired people, and progress is obvious, the momentum there, but the issue now is that we show results. People will want results before they’re reasonable to expect, so we need to condition those expectations.”

to maintain CHI funding and to increase the connections between CHI and other parts of the organization. In interviews, most KP informants felt that they hadn’t done enough so far to promote sustainability. Key areas where more needed to be done included increased resources, improved communication and greater leadership awareness/support. Also, CHI results need to be demonstrated and communicated to all parts of the organization.

In summary, sustainability efforts have been mixed thus far. There are examples of regions and communities taking steps toward sustainability, including securing additional funding sources, strengthening their collaboratives and changing organizational cultures. These efforts need to be spread widely throughout CHI using peer networks and other means. The CHI leadership has emphasized policy and environmental change strategies and this message has taken hold. However, the sustainability effort for CHI within KP needs to be strengthened if the ongoing commitment to communities is to be maintained.
“CHI’s not just about talking the talk but walking the walk. I think that it’s changed nutrition, what’s in our vending machines, what’s served in our hospitals, how we build our facilities, the farmers’ market promulgation and the food that we serve at meetings. The employees who work on CHI, they’ll ask you to do a meeting while walking around the lake. They’re really walking the walk. They’re change agents and it’s having a ripple effect in the organization.”

“So the THRIVE commercials are just brilliant and they help reinforce what we’re doing in the communities. We can point to it, there’s a synergy there. I think there’s a potential for a lot of magic there.”

C. Organizational Practice Change within KP

The primary focus of CHI is on making changes in the CHI communities. However, the initiative is also committed to promoting change within KP—increasing strategic alignments within the organization to promote HEAL and implementing some of the same HEAL-related organizational changes that are being asked of communities. To capture some of these organizational changes within KP, in-depth interviews were conducted with fifty KP executive, program and regional office staff in summer and fall 2007. Similar interviews were conducted in 2005. Additional information about KP organizational changes came from documents and informal conversations with KP staff.

Strategic alignment within KP

An overwhelming sentiment among those interviewed was that CHI was a significant, concrete expression of the KP mission to improve community health. CHI helped draw together and promote connections among a range of KP units, work streams and initiatives. It is important to note that in many, if not most, cases the changes that have occurred involve the combined efforts of different parts of the organization; credit cannot be assigned to CHI alone. Rather, CHI is part of a convergence of interest around HEAL that has been building within KP over the last several years.

The following are specific examples of increased strategic alignment within KP around HEAL:

**THRIVE.** KP’s THRIVE campaign and CHI were launched at similar times for different purposes, but there are many synergies between them and they are becoming more closely aligned over time. THRIVE now includes more HEAL-related content and a greater focus on community policy and environmental changes. An early THRIVE commercial—Power to Change—was one of the first commercials to be influenced by KP’s HEAL work. Interactions between CB and brand staff
resulted in “Kid Wisdom,” a commercial and website, which focused the THRIVE campaign on childhood obesity. Most recently, conversations between CB and the brand department led to commercials, radio spots, billboards and print media that reflected an effort focused on “spreading health.” The message is that health is not something that only happens in a doctor’s office; it is also influenced by the environments in which people live.

**Public Relations.** Stakeholders identified increasing collaboration between Community Benefits and Public Relations (PR) staff, including work on a program-wide Safe Routes to School campaign, the feature of HEAL-related stories on a syndicated television program and collaboration on the Incredible Adventures of the Amazing Food Detective. The Amazing Food Detective, an innovative and award winning video game, was an attempt by the PR unit to leverage the HEAL program in support of the KP brand while broadening the exposure of people to HEAL messages. The Care Management Institute and CB staff worked closely with PR to insure that the game and related products incorporated evidence-based HEAL messages, including reductions in screen time.

**Environmental Stewardship.** CB staff have worked closely with Environmental Stewardship to inject land use, transportation and sustainable food into the Environmental Stewardship strategic plan. In 2008, the KP Board of Directors approved an organizational statement on climate change that commits the organization to “reduce the carbon footprint of the communities we serve by: a) supporting land use and transportation decisions that encourage the use of public transportation and promote walking and biking instead of driving; and b) supporting the development, where appropriate, of local food systems that feature locally grown, sustainably farmed food.” These land use planning and climate change strategies, in turn, promote chronic disease prevention by increasing walking, biking and public transit and reducing dependence on car travel. This work by KP is influencing the thought leaders and the industry at large, for instance, through KP’s involvement in the redraft of the Green Guide for Healthcare, which established standards for green hospitals.

**Care Management Institute (CMI).** A number of CMI efforts have helped bridge the gap between the clinical side of KP and the CHI communities. CMI clinical leaders have been actively involved in the Safe Routes to Schools work as well as built environment and policy change efforts in the Northwest. CMI and CB now do joint strategic planning around health and weight management.

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“We now have a long-term, multi-faceted approach, with an emphasis on evaluation and a focus on permanent change... Community Benefit now has more broad thinking than in the past.”

“We’ve always said in our mission statement that we’re not just serving our members but the broader community. Until now, we’ve been hard pressed to show that, so CHI is taking that head on.”

**Regional Research Units.** KP Research Units have become active partners in the CHI evaluation. Both the Division of Research in Northern California and the Institute for Health Research (IHR) in Colorado are using KP clinical data to generate community-level indicators of key CHI outcomes, including obesity rates. IHR developed the capacity to do automated household surveys (Interactive Voice Response or IVR), that are the source of the population-level information about adults. IHR also serves as the local evaluation team for over 20 LiveWell communities in Colorado.

CHI has also helped bring about strategic changes within CB. These include both a general approach—e.g., working with communities in new ways, more strategic grantmaking, and aligning Safety Net and CHI workstreams—and specific links such as the ETP. Specific examples include:

**Safety Net and CHI alignment.** In several regions, CB has started conversations to agree on better integration between the CHI and Safety Net Partnerships’ work stream, focusing on strengthening the system of community clinics, hospitals and health departments. For example, in Belvedere, Georgia, KP has funded the Dekalb Board of Health to implement the ALL program and the Oakhurst Community Health Center to support a diabetes education intervention that will involve residents of this CHI community.

**Educational Theatre Program.** HEAL performances incorporating messages from KP clinical guidelines have been developed, implemented and are currently being evaluated in several regions. A more intensive ETP program, Teens Take it On, trained teenagers throughout Colorado to develop peer-to-peer HEAL initiatives for middle and high school students and to assess their own food environment. At Aurora High School, these youth advocates successfully persuaded school officials to offer fresh fruits and vegetables daily in the cafeteria.

![Amazing Food Detective, Educational Theatre Program, Cleveland, Ohio](image-url)
Grantmaking and conference sponsorship. Over the last several years, KP CB grantmaking has become more focused on environmental and policy change and multi-year efforts. It has also sought to integrate work streams and increase the program’s emphasis on evaluation to guide ongoing improvements and contribute to the evidence.

An example of focused grantmaking that complements more intensive place-based CHI grants, is the Campaign for California cities. The goal of this grant is to develop and disseminate information, tools and personalized assistance to city officials throughout the state to establish local policies to promote healthy eating and physical activity. Another grant supports the Safe Routes to School (SRTS) State Network Partnership, an effort designed to build both Safe Routes projects on the ground as well as an advocacy infrastructure to influence the 2009 federal highway reauthorization to increase federal funding for such initiatives.

KP has also developed relationships with community foundations in KP regions to create and manage a Donor Advised Fund supporting CHI efforts. These community foundations have helped KP with financial and contractual oversight to fund these large initiatives. In some regions, the community foundations also have participated in strategic planning and grantee selection. For example, the HEAL Project leader in Belvedere, Georgia, began his work on the CHI project as a staff member of The Community Foundation of Greater Atlanta. He is now a consultant employed by the Foundation and ensures Foundation involvement at key junctures with CHI.

KP has also sponsored a number of conferences in an attempt to build capacity among community partners and promote an environmental change agenda. For example, KP sponsored conferences specifically held with elected officials and policymakers to support and influence work:

- KP in Southern California sponsored a workshop on Safe Routes to Schools (SRTS) at the 2007 U.S. Conference of Mayors national meeting in Los Angeles, providing mayors and their staffs with an opportunity to hear about promising practices in this area. As a follow-up effort, KP developed a national campaign about SRTS that included physicians writing letters to news outlets and media coverage of physicians and KP employees walking with kids to school.
What’s changed is the inclusion of locally sourced, sustainably farmed foods for our inpatient settings. The farmers’ markets have expanded in number, but they’ve been going on for 4 years. The other change that’s less global is the food box deliveries to the facilities. But the biggest change is inpatient food sourcing. We think locally about sustainability and Kaiser’s purchasing power.”

• KP partnered with the nonprofit Local Government Commission as major sponsors of the 2007 New Partners for Smart Growth Conference for a third consecutive year, working to elevate health considerations on the agendas of elected public officials, city and county planners, developers and others directly affecting the design of America’s communities. A large delegation from KP’s National Facilities Services played an active role in the conference proceedings.

HEAL-related organizational practice changes

There have been a number of instances, particularly around the nutrition environment, where KP is now “walking the talk” of the same environmental and policy change that it is promoting in the CHI communities. As noted earlier, these changes have involved the combined efforts of different parts of the organization; credit cannot be assigned to CHI alone. Examples include:

Local food sourcing. KP has implemented food system reforms now emulated by other institutions and businesses throughout the United States. In 2007, more than 60 tons of produce served in KP inpatient meals and cafeterias in Northern California were locally-sourced through the Community Alliance for Family Farmers (CAFF)—up from 24 tons in 2006. Fifty-two facilities in the greater Bay Area are now buying local produce through the CAFF-Growers’ Collaborative distribution venture. This includes 19 KP hospitals and 33 other facilities, including colleges, hospitals, businesses and school lunch programs. Local sourcing efforts also began in several Southern California medical centers. Fewer “food miles” associated with this shortened supply chain have reduced KP’s carbon footprint and increased the economic viability of small, low-resource farmers in California’s Central Valley.

Farmers’ markets. KP launched its first farmers’ market in 2003. By 2007, KP sponsored over two dozen farmers’ markets in hospital lobbies, medical office buildings, parking lots and community settings. In 2007, several regions also started to implement Community Supported Agriculture (CSA) programs in which employees receive weekly delivery of farm boxes on a subscription basis. These programs provide employees with healthy food and support local farmers with reliable and predictable demand. In many cases, these internal efforts have resulted in KP taking a leadership role in spreading the innovations to CHI communities and nationwide. For example, the KP Farmers’ Market Resource guide has been widely circulated and informs other farmers’ markets across the nation.
“The one most applicable to us is food work for our patients, employees and the community. So for the community there are farmers markets. For employees, there are cafeteria, catering and vending machines changes. For patients, there’s the no-hormone milk, fruit instead of dessert and healthier choices for inpatients. It doesn’t make sense for us to say we’re helping people get healthier in a community, but not for ourselves and our patients.”

**Healthier vending machines.** In 2006, KP rolled out its Healthy Picks program, stringent standards for increasing the percentage of healthy food and beverage items in KP vending machines. All vending machines are now required to have at least 50% of their slots reserved for healthy items.

**Menu labeling study.** In 2008, CB worked closely with National Nutrition Services to formulate a study that extends the Healthy Picks Program into the cafeteria through providing point-of-decision calorie information for all cafeteria menu items. The study is expected to inform Nutrition Services strategic planning as well as state and local governments that are considering implementing menu labeling. The KP menu labeling study is expected to inform state and local government policymakers working to implement menu labeling policies in their own jurisdictions.

**Facility improvements to promote physical activity.** KP medical centers, clinics and offices are often among the largest employers and business facilities in their local communities. In 2007, KP installed several walking paths around the medical office buildings to encourage physical activity and built healing gardens in their hospitals. They have opened up stairwells and promoted their use with signs and posters. These features are becoming the standard for the design of new KP facilities.
KP involvement in public policy

Effecting changes in public policy and organizational practices is a core element of CHI, as reflected in the community action plans developed to date. In addition to supporting advocacy and policy change through the CHI collaboratives, KP is finding opportunities to complement and support community-based efforts through direct advocacy. Examples of this expanded public policy role for KP include:

Supporting HEAL-related legislation in California. Since the launch of CHI, California KP Government Relations leaders have increased their efforts to identify public health legislation that the organization can endorse. On a limited number of occasions, KP has endorsed legislation. Highlights of recent HEAL-related California legislation endorsed by KP include: The Healthy Food Access Act of 2006 (SB 1329) that sets up a grant/loan program to encourage the development and revitalization of grocery stores, small markets and farmers’ markets and The Healthy Purchase Pilot (AB 2384) that creates a pilot program for financial incentives for corner store grocers to make fresh fruit, vegetables and other perishables more accessible in low-income neighborhoods. Other HEAL-related legislation endorsed in California are described in Table 2.

Physician advocates in Colorado. CHI in Colorado has created a community health advocate program that provides physicians with learning and advocacy opportunities in public health, community relations and policy. Colorado Permanente Medical Group physicians will spend one day of their work week, under the supervision of the Director of Prevention, executing strategies that support Community Benefit efforts and statewide goals aimed to promote health eating and active living.

Policy change in the Northwest. In 2007, KP endorsed and helped secure the passage of a landmark bond measure that will raise $227 million for open space, parks and trails in metro Portland. The decision was informed by the production of the Regional Equity Atlas, which was supported by a Kaiser Permanente HEAL grant. The Northwest KP region also supported the Oregon Farm to School and Garden Bill that passed in 2008 and is working collaboratively with other organizations to align food policy in both the health care and school sectors.

Safe Routes to Schools. One of KP’s physician champions used Photovoice pictures from grantees to successfully advocate at the state level for Safe Routes to School, specifically $24 million to support the Metropolitan Transportation Commission plan to incorporate more safe routes and bike trails. In addition, several KP physicians now serve as members or advisers to metropolitan transit commissions and blue ribbon panels seeking to increase safe routes and other programs promoting alternatives to auto-focused transportation.

Institute for Health Policy. KP’s Institute for Health Policy is actively involved in the national HEAL work. They have supported the National Convergence Partnership and its policy efforts from a KP perspective, and more directly are developing a roundtable on agricultural policy and health.
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<tr>
<th>Bill</th>
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<td><strong>2005</strong></td>
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<td>SB 12 School Food Nutrition Standards</td>
<td>Strengthens and implements the competitive food standards for fat and added sugar for foods sold and served in grades K-12, originally described in SB 19 (Escutia, 2001).</td>
<td>Signed by the Governor on September 15, 2005.</td>
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<td>SB 281 Nutrition Program</td>
<td>Creates new program implemented by DHS and Dept of Food &amp; Agriculture to develop programs that encourage schools to provide free fruit and vegetables.</td>
<td>Signed by the Governor on September 15, 2005.</td>
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<tr>
<td>SB 965 Pupil Nutrition: Beverages</td>
<td>Restricts sale of certain beverages in high schools — same standards as elementary and middle schools.</td>
<td>Signed by the Governor on September 15, 2005.</td>
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<tr>
<td>SCR 4 Public Health Awareness</td>
<td>Encourages various government, community, school and workplace activities in support of public health awareness and prevention of diabetes and obesity.</td>
<td>Passed on Senate Floor on April 28, 2005.</td>
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<tr>
<td>SCR 33 California Fitness Month</td>
<td>Proclaims May 2005 as CA Fitness Month and encourages all Californians to get proper exercise and diet.</td>
<td>Passed on Senate Floor. Passed Assembly on April 28, 2005.</td>
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<td><strong>2006</strong></td>
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<tr>
<td>SB 1329 Redevelopment Supermarkets</td>
<td>Authorizes redevelopment agencies to award planning grants and other financial incentives to supermarkets, grocers, small markets to become established in low-income areas.</td>
<td>DEAD – in Assembly Appropriations Committee.</td>
</tr>
<tr>
<td>AB 2384 Healthy Food Purchase Program</td>
<td>“Healthy Food Purchase” pilot to increase sale and purchase of fresh fruits and vegetables in low-income neighborhoods.</td>
<td>Signed by the Governor on September 13, 2006.</td>
</tr>
<tr>
<td>AB 2121 Farm to School Program</td>
<td>Increases linkage between schools and farms through legislative findings and declarations and State encouragement.</td>
<td>DEAD – in Assembly Appropriations Committee.</td>
</tr>
<tr>
<td>SCR 73 Task Force on Youth and Workplace Wellness</td>
<td>Continues existence of California Taskforce on Youth and Workplace Wellness.</td>
<td>Passed on Senate Floor in 2006 and Assembly Floor in 2008.</td>
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<tr>
<td><strong>2007</strong></td>
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<tr>
<td>AB 57 Safe Routes to School</td>
<td>Repeals the sunset clause for authority to use federal transportation funds for construction of bicycle and pedestrian safety and traffic calming projects. Extends program indefinitely.</td>
<td>Signed by the Governor on October 14, 2007.</td>
</tr>
<tr>
<td>AB 898 Nutrition Education</td>
<td>Creates a 3-year pilot grant program for 3-5 school health centers that utilize “Promotores de Salud” model for diet education and obesity prevention.</td>
<td>DEAD – in Assembly Appropriations Committee.</td>
</tr>
<tr>
<td>AB 967 Farm Fresh Schools Program</td>
<td>Increases linkage between schools and farms through legislative findings and declarations and State encouragement.</td>
<td>DEAD – in Assembly Appropriations Committee.</td>
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<tr>
<td><strong>2008</strong></td>
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<tr>
<td>SCR 76 California Fitness Month</td>
<td>Proclaim May 2008 as Fitness Month to encourage proper diet and fitness.</td>
<td>Passed Assembly Floor on April 14, 2008. Passed Senate Floor on April 17, 2008.</td>
</tr>
<tr>
<td>SB 441 Vending Machines in State Buildings</td>
<td>Requires vending machines on state property to offer food and beverages that meet acceptable nutritional guidelines as defined.</td>
<td>Signed by the Governor on September 30, 2008.</td>
</tr>
<tr>
<td>AB 1966 School Breakfast Severe Need</td>
<td>Requires schools that meet qualifications for federal severe need reimbursement to offer a nutritionally adequate breakfast if the Superintendent of Public Instruction determines that there is sufficient funding.</td>
<td>DEAD – stuck in Assembly Appropriations Committee.</td>
</tr>
<tr>
<td>AB 2726 Healthy Food Purchase</td>
<td>Amends existing law that requires the CA Dept of Public Health to develop a “Healthy Food Purchase” pilot program to increase the sale and purchase of fresh fruits and vegetables in low-income communities.</td>
<td>Signed by the Governor on September 27, 2008.</td>
</tr>
<tr>
<td>AB 2989 Outdoor Environmental Education and Recreation Program</td>
<td>Create the Outdoor Environmental Education and Recreation Program in Parks and Rec to increase the ability of underserved and at-risk populations to participate in outdoor recreation and educational experiences by awarding grants to nonprofit organizations.</td>
<td>DEAD – in Senate Appropriations Committee.</td>
</tr>
</tbody>
</table>
“Synergy is beginning to happen between the pieces. You have to have a policy agenda, a social justice policy—and it’s long term. I think we’re looking at how do we make our band-aids stronger and bigger. How do you address fundamental disparities? I think in some ways we don’t have a choice (to do this work).”

D. Building a Broader Movement

The nature of the epidemic of overweight and obesity—including the significant role of social norms, culture and the environment—requires a multi-level, multi-pronged approach. This is recognized explicitly in the strategies pursued in each CHI community, but it also applies at higher levels. State and national policies and cultural norms will have a significant influence on what happens within communities. Recognizing this, CHI’s leadership has pursued a number of strategies to contribute to the building of a broader state, regional and national movement, including:

• Helping to create Convergence Partnerships19 around HEAL that bring together state and national foundations, community partners and government agencies
• Working with other HEAL initiatives to build coalitions and coordinate more effectively
• Building the evidence base for what works in HEAL interventions
• Disseminating successful HEAL practices more widely

The following sections briefly summarize those efforts and the progress made to date.

Building a national and regional convergence around HEAL

By working with a diverse array of coalitions and partnerships, KP’s HEAL effort has brought scale, visibility and impact to the work and has influenced the national dialogue on what it will take to turn around the obesity epidemic. KP was a founding partner of the Healthy Eating Active Living Convergence Partnership. The Partnership is comprised of several major foundations and the U.S. Centers for Disease Control and Prevention (CDC), all of whom share a view of how to address the nation’s obesity crisis. These foundations include The California Endowment, the Robert Wood Johnson Foundation, the W. K. Kellogg Foundation and Nemours Health and Prevention Services. In 2007, the Convergence Partnership formalized the partnership and the creation of a shared funding pool, prepared a toolkit for funders of HEAL initiatives and developed a web-based portal for connecting funders and organizations active in this area.

19http://www.convergencepartnership.org
Concurrent with these national efforts, a number of KP regions—including Colorado, Northern and Southern California, the Northwest and the Mid-Atlantic States—advanced the deployment of regional or statewide convergence efforts. These activities complement the national convergence effort by bringing together local and regional funders and community partners working on place-based obesity prevention initiatives to better coordinate those efforts and to build critical mass for policy and social norms change. For example the California Convergence, led and sponsored by The California Endowment and KP, has brought together seven major obesity prevention initiatives and over 40 separate communities.

KP has played a key role in LiveWell Colorado. The early success of the KP CHI initiative in Colorado led to it becoming a model for the state. In 2007, funding was increased for these sites, new sites were added and comprehensive technical assistance and evaluation efforts were fully implemented. It is now a statewide initiative called “LiveWell Colorado,” officially launched on March 1, 2007, as a partnership among KP, the Colorado Health Foundation and the Colorado State Department of Public Health and Environment.

An example of regional convergence from the Northwest is the Alliance for the Promotion of Physical Activity and Nutrition (APPAN). APPAN was created to promote physical activity and healthy eating in local communities. The coalition is funded with contributions from KP Northwest, CareOregon, PacificSource Charitable Foundation and the Northwest Health Foundation. In October 2006, the APPAN advisory committee awarded grants to seven community coalitions working in six Oregon counties and in Cowlitz County, Washington to promote physical activity and healthy eating locally. The CHI evaluation team has provided technical assistance and support for the Northwest Community Changes evaluation plan being developed by the APPAN collaborative.

**Collaborating with other HEAL initiatives**

Along with the convergence work, KP has worked closely with other major initiatives to support and expand their efforts, including Steps to a HealthierUS and the Healthy Eating Active Communities (HEAC) initiative. In 2004, the Center for Disease Control and Prevention issued an RFP for its Steps to a HealthierUS program that featured a number of CHI design principles. KP collaborated with local public health departments and community partners on 11 proposals, only one of which was successful in Round I awards. Over the next 12 months, KP continued to support these collaboratives with KP Steps Sustainment Grants ranging from $40,000 to $100,000 per community. When the federal government announced Round II awards, 3 of the 5 winning communities were
KP-sponsored collaboratives. In many cases, KP continues to be involved in these efforts as members of the Steps leadership groups and as a provider of technical assistance to the collaboratives.

Healthy Eating Active Communities (HEAC) is an initiative funded by The California Endowment to promote policy and environmental approaches to reducing childhood obesity using a multi-sectoral approach similar to CHI in six California communities. KP is partnering with HEAC to provide expertise and technical assistance to sites, including clinical and patient education materials and train-the-trainer programs for physician advocates and other health care providers. In addition, KP participates as an active member of the community collaboratives in the five communities that are located in KP service areas and supports the program as a whole with grantmaking to the initiative’s technical assistance providers. This experience significantly influenced the design of KP Northern California’s own HEAL-CHI program.

Looking forward, one of the W.K. Kellogg Foundation’s first nine Food and Fitness communities and four of the Robert Wood Johnson Foundation’s lead Healthy Kids/Healthy Communities sites are located in KP communities. In many cases, these initiatives build on KP seed funding and capacity building efforts. These sites will be mentors for future Food and Fitness and Healthy Kids/Health Communities sites that will be funded over the coming years.

**Building the evidence base and creating indicators for success**

Beyond supporting a rigorous evaluation of its own initiative, KP has been involved in two major projects designed to help build the evidence base and create indicators for success: the Common Community Measures for Obesity Prevention Project (COCOMO) and an effort by the Institute of Medicine (IOM) to identify standards of evidence in community-based obesity prevention efforts.

**COCOMO Project.** COCOMO is a collaboration among the Robert Wood Johnson Foundation, W.K. Kellogg Foundation, KP, the Centers for Disease Control and Prevention (CDC) and the CDC Foundation. The project is identifying community-level measures that can be used for planning, evaluation and research. It focuses on community-level policy and environmental strategies that impact obesity, particularly childhood obesity.

The COCOMO Project is identifying a set of core data elements intended for use by communities, program evaluators and researchers to facilitate cross comparisons of different interventions and compilation of results from multiple programs. The use of common measures by organizations that fund community interventions has the
potential to expand the knowledge base of community interventions and simplify data collection by communities. For researchers, the use of common measures also will facilitate research to understand how program variations impact effectiveness. Critical factors can be identified and used to plan and refine program strategies for greater public health impact. Communities may adopt the common measures as a foundation for their own program evaluation efforts and expand the set of measures as needed for particular evaluations.

The proposed common community measures will be pilot tested in at least 20 communities. Those communities will be convened at an in-person meeting to discuss the feasibility of collecting and reporting data on the measures as well as the utility of the collected information to local governments. The measures along with project reports will be reviewed by an external review panel. Final measures will be incorporated into the International City/County Management Association’s (ICMA) Center for Performance Measurement web-based measure management system to enable professional level staff working in local government jurisdictions to collect and report data.

**Institute of Medicine: re-defining the evidence base.** KP is providing major funding to the Institute of Medicine (IOM) to address the question of what “evidence-based” should mean in the context of community-based obesity prevention efforts. It is often difficult to test policy and environmental change strategies using the same experimental methods used for more conventional programmatic interventions. As a result, the evidence base in the scientific literature for the approaches used by CHI is limited. In addition, interventions are often evaluated in more affluent and less diverse communities and may not be effective or appropriate in more ethnically diverse settings.

The IOM project is developing an evidence-informed, decision-making framework focused on policy- and community-level interventions designed to influence food and physical activity environments. It will be guided by a systems approach that explicitly takes into account the social contexts in which decisions are made and the multiple determinants of policy and community action (e.g., projected health and economic impacts, feasibility, acceptability, public demand). While focused on obesity prevention, this framework could guide more general efforts to assess and use scientific evidence in complex, multifactorial public health challenges (e.g., violence, HIV/AIDS, tobacco control).

The project will provide an overview of the current nature of the evidence base, identify the challenges faced in integrating scientific evidence into the broader array of factors that encourage or inhibit social change and then develop a framework for evidence-informed decision-making. The framework will provide practical, action-oriented recommendations for choosing, implementing and evaluating obesity prevention efforts. Innovative assessment and funding strategies for overcoming barriers to funding research and evaluation efforts also should be suggested.
III. Conclusions and Recommendations

CHI has had a very productive first two years of implementation with significant progress made on a number of fronts. Within the CHI communities:

- Functioning community collaboratives have been created or supported in all of the KP regions implementing CHI.
- Community action plans have been developed that incorporate a mix of programs, policy and environmental change and have a reasonable chance of being implemented successfully.
- The potential penetration (lives touched) of the interventions is high, particularly for policy and environmental change in the school sector.
- Communities that began with programs are transitioning toward policy and environmental change as the CHI design principles are increasingly incorporated into the work.
- Capacity is being built within KP to engage communities, promote policy change and conduct useful evaluations.
- Creative strategies are being implemented to promote sustainability, including finding new partners and new funding sources, and implementing organizational and systems change.

There has also been significant progress in implementing changes within KP and building a broader movement around HEAL:

- CHI is helping draw together and promote connections among a range of KP units, work streams and initiatives.
- CHI is helping bring about strategic changes within Community Benefit, including working with communities in new ways, more strategic grantmaking and aligning Safety Net and CHI work streams.
- KP is now “walking the talk” initiating the same environmental and policy changes within the organization that it is funding in the CHI communities, including providing healthier foods within KP facilities and promoting local farmers’ markets.
- KP is playing a key catalytic role in the emergence of partnerships with other funders and stakeholders across the nation and in contributing to the evidence base.
Challenges have arisen in several areas. They include maintaining ongoing support for the work given the long time horizon required for policy and environmental change, building collaboratives in communities where none existed before and effectively providing technical assistance and support to communities. Potential responses to these challenges are discussed in the following recommendations.

The evaluation also has had a mix of successes and challenges. The focus on types of strategies (e.g., environmental change vs. programs) and reach has led to productive conversations with communities about the mix and scope of intervention strategies. The evaluation team has successfully collected population-level data from a variety of sources with relatively minimal resources, although in some cases the quality is uncertain and the numbers small. There is a need to continue to communicate to key stakeholders the difficulty of measuring long-term population level changes in BMI and HEAL behaviors and to emphasize the importance of measuring intermediate outcomes, such as community changes.

**Recommendations**

The following are six recommendations for meeting some of the challenges that have arisen in the first two years of CHI implementation. The first two are related to CHI’s long-term trajectory, specifically how to sustain the work given the need for long-term engagement in order to achieve policy and environmental change. The next four concern the ways in which community efforts can be more effectively supported, both in terms of initial partnership building and action planning, and providing ongoing technical assistance and support.

**Recognize that policy and environmental change is a long-term proposition.**

Perhaps even more than anticipated, implementing policy and environmental change is a slow process, particularly when considering changes to the built environment. Plans must move through lengthy design and review processes and find funding within shrinking local budgets before actual construction can even be considered. In several cases, initial progress in gathering support for walking trails and other redevelopment efforts has stalled because of lack of funding and competing priorities.

This has two implications for CHI. First, resources and support must be structured so that the effort can be maintained over the long term. If the initial five-year grants are not at least partially renewed, the momentum developed during the first years of funding will be lost. Targeted resources must be secured, including staff support within agencies responsible for moving policy and environmental efforts forward. Second, CHI collaboratives must continue to work with other partners to bring about change. Major changes to the built environment will only come about if a wide range of local organizations and institutions is involved.
Focus on sustainability now. Evidence from other initiatives suggests that planning for sustainability can not begin too early. The section on sustainability (page 46) described several potential strategies, all of which are being pursued to some extent in CHI. Peer networks are an effective way to share these experiences and promote the spread of promising practices. Mechanisms need to be found to promote the effort’s sustainability, including both money and other resources. At the same time, continued support should be tied to accountability mechanisms that set clear long-term goals and tie annual funding decisions to progress toward meeting those goals. Sustainability also needs to be pursued within KP, including building support among KP leadership that takes the form of budget and staffing decisions, as well as routinely communicating successes and benefits across the organization.

Work with existing community collaboratives where possible. Building authentic and durable partnerships is an important part of the CHI capacity-building strategy. Working through collaboratives helps ensure that the interventions are community-driven and that the work will continue when CHI funding ends. In the CHI communities, KP has worked successfully with both existing and new collaboratives in developing and implementing community action plans. However, in the newly formed collaboratives, KP often has needed to take a prominent role in moving the work forward, detracting from the ability of the collaborative to develop its own leadership. Further, sustainability is much less certain for new collaboratives; existing ones have demonstrated that they can stay together through a variety of funding and other transitions. A caveat is that some communities with the highest need may not have existing collaboratives. Where this is the case, KP needs to provide the minimum level of support required so that local organizations can step forward and take leadership roles.

Be flexible about intervention approaches. CHI emphasizes policy and environmental change strategies because they are cost-effective in reaching large numbers of people and more likely to be sustained. However, policy and environmental change is a somewhat abstract concept and the changes take a long time to implement. Community residents are drawn to programs because they are more concrete and education-oriented and they provide immediate benefits to participants. The CHI experience suggests that an approach blending programs and policy/environmental change can maintain community engagement, while keeping broader policy and environmental change in the picture. If programs are the first

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interventions to be implemented, they can lead to the adoption of other programs that involve collaboration with larger organizations and institutions (e.g., schools, health care organizations) that can subsequently be enlisted to pursue policy and environmental change. As the programs and partnerships expand in scope, they also extend their reach, impact and sustainability—key ingredients for long-term community impact.

Another challenge related to intervention selection is that many programs that are attractive to the community are not evidence-based. The evidence base should be considered when selecting strategies but should not be a decisive factor. The limitations of the scientific literature that prompted the IOM project (see page 62) are significant; CHI should be open to other promising approaches that have community support. Where possible, evaluations of new approaches should be conducted to help them become part of the evidence base.

**Keep the focus on reach and impact.** As noted earlier, population-level change requires reaching sufficient numbers of community residents with interventions of adequate per-person impact. Intervention reach and impact should be reviewed and discussed with communities by technical assistance providers, evaluators and regional CB staff. Evaluators should provide assistance in tracking reach so that the intervention “dose” can be estimated.

**Be modest in providing technical assistance.** TA providers need to be modest, listen well, and fit in, avoiding the impression that they are outside experts who know more than community members. They need to take time to build trust and coordinate with others (e.g., evaluators, KP regional staff) to avoid overloading communities with outsiders. They should focus on simple, concrete solutions: tools and organizational help or practical skills are better than abstract advice. TA providers need to be flexible in their expectations about how assistance will be used; some communities may use little or none of it. Finally, peer networks are an effective approach to sharing challenges and lessons learned; the HEAL Academy and other meetings that bring together multiple sites for sharing lessons learned have been effective. CHI should continue to look for ways to create peer learning opportunities, especially face-to-face, among communities, KP regional stakeholders, evaluation partners and TA providers, without taking time away from the community work itself.
In summary, CHI is at a critical juncture in its evolution. Considerable progress has been made in building community collaboratives that are moving forward with promising environmental and policy change strategies, which have the potential to produce long-term, population-level change. At the same time, these changes will take a long time to fully implement—longer than the current funding horizons in most CHI communities. Some combination of sustained resources, organizational change and community capacity building must be put in place to allow the process that has begun to reach its full potential.