National initiative overview
The Community Health Initiative (CHI) is a Kaiser Permanente (KP) Community Benefit strategy for achieving a significant and measurable impact on the health of communities served by KP. The thematic focus is on healthy eating and active living (HEAL) to improve nutrition and physical activity and reduce overweight/obesity. KP is a relatively decentralized organization and its eight regions around the country have considerable autonomy in how they implement programs such as CHI. However, KP’s Framework for Community Health Initiatives identifies core design principles¹ that have generally been followed in regions where CHI has been implemented. These include a place-based focus; an emphasis on change at multiple levels, particularly environmental and policy change; a multi-sectoral collaboration that involves sectors such as health care, neighborhood, schools, and work sites; and community engagement and community ownership.

KP is the principal sponsor of place-based initiatives that feature all these elements in 30 sites, including 3 in Northern California and 25 in Colorado – the first regions to implement the initiative. In addition, KP is a co-funder of initiatives in another 10 communities, including 6 California Endowment’s Healthy Eating Active Communities (HEAC) sites. In addition to place-based initiatives, KP sponsors other HEAL-related efforts including grant-making to state and national organizations, training of health professionals, advocacy around HEAL-related policies and internal practices changes focused on KP’s own food and physical activity environments.

Evaluation Design
The CHI evaluation uses a logic model approach to assessing impact that combines indicators of intermediate outcomes (e.g., environmental and policy changes implemented in communities) with more conventional pre/post tracking of population-level measures of physical activity, nutrition, and overweight (e.g. surveys of youth and adults). The intermediate and long-term indicators are incorporated into structured case studies that allow us to take a holistic view of each community; for example, assessing how community context and history influence the selection and implementation of the action plan strategies, which in turn influence the trends in the long-term behavioral and health indicators. The CHI logic model (see Figure 1 on page 3) also includes a capacity building pathway that emphasizes the community building aspects of CHI - i.e., that by engaging communities and having them own the process, they will develop the capacity to address other issues outside of HEAL. Community capacity building is being assessed largely through key informant interviews with collaborative members.

The CHI cross-site evaluation is led by the Center for Community Health and Evaluation at Group Health Cooperative (CCHE); other evaluation partners include the Center for Weight and Health at University of California, Berkeley and the Kansas University Work Group. In addition, local evaluators in each region help gather information about strategy implementation and

lessons learned, and work with the community collaboratives to integrate evaluation lessons learned into program improvement.

We are using three principal data sources for assessing CHI impact: (1) Documentation of Community Change (DOCC) database to track the implementation, reach, and impact of intervention strategies; (2) pre/post population-level surveys and (3) KP member data on clinical outcomes. We are also conducting key informant interviews and doing Photovoice projects to get a more qualitative assessment of change.

**Results - Progress to Date**

We are currently tracking 460 strategies across 26 communities in the two KP regions where CHI implementation is underway: Colorado (n=23 communities) and Northern California (n=3). The total number of people reached by CHI interventions is nearly 500,000 or approximately one-third of the total population of youth and adults in those communities. Examples of strategies being implemented include:

- **Environmental change**: Installing a lighted walking trail to provide access to safe physical activity and increasing purchase or distribution points for fresh fruits and vegetables in the community
- **Organizational change**: Implementing standards-based physical activity curriculum during school hours in local elementary schools
- **Programs**: Incorporating physical activities in after-school programs and implementing Body Mass Index (BMI) as a health clinic vital sign into well-visits and offering routine obesity counseling and referral
- **Public policy**: Impacting urban planning via the city general plans and exploring other smart growth opportunities
- **Capacity building**: Mobilizing residents to create an ongoing grassroots effort to advocate for healthy eating and physical activity options in their neighborhoods.

Implementation has been staggered across KP regions. We have baseline information from the IVR surveys (automated phone surveys) in most of the Colorado communities. In the Northern California communities we have baseline and follow-up survey data for youth (school surveys) and adults (IVR surveys) in all three communities that are currently being analyzed. We have three years of KP member data in communities with a high percentage of KP members, but these outcomes are more distal (e.g., BMI, prevalence of diabetes) so we expect to see changes only over the longer term.

**Future Directions**

We are currently completing a "strategic refresh" of both intervention and evaluation approaches, incorporating the lessons learned from first five years of the initiative. One key finding was that intervention "dose", or the combination of number reached and strength or intensity of the interventions, must be increased in order to achieve population-level change. We are working to increase the dose of the interventions and developing evaluation approaches that will be more sensitive in picking up effects from lower-dose interventions. We are also recalibrating intervention strategies and evaluation approaches for low capacity sites.
### CHANGES IN COMMUNITY CAPACITY

**Process Outcomes**
- **Short-term**
  - Health Promoting System Changes
  - Changes in Individuals
    - Awareness
    - Knowledge
    - Attitudes
    - Self-efficacy
  - Action
  - Nutrition
  - Improved Biometric (e.g., BMI) and Physiologic Measures
- **Intermediate**
  - \( \uparrow \) Activity
  - \( \uparrow \) Nutrition
  - Improved Biometric (e.g., BMI) and Physiologic Measures
- **Long-term**
  - \( \downarrow \) in chronic conditions
  - \( \uparrow \) in other health measures
  - Thriving, Empowered Communities

### Effective Intervention Strategies
- Qualities of interventions (e.g., evidence informed)
- Mix of interventions (e.g., co-op of different socio-ecological levels, PA and nutrition, multiple sectors)
- Intensity/focus of interventions
- Program outputs (e.g., volume, participation, etc)

### Community Capacity Building Strategies
- Partnership building
- Leadership development
- Advocacy training
- Other strategies

### Inputs
- **Baseline Conditions**
  - Community health status
  - Community readiness
- **Existing Community Assets**
  - Individuals and organizations
  - Programs/services
  - Partnerships
- **KP Assets**
  - Funding
  - Clinical expertise
  - Research
  - Other in-kind
  - Volunteers
  - Technical assistance
- **Design Principles**
  - Change at multiple levels
  - Focus on environ, policy change
  - Commitment to learning and evaluation
  - Focus on disparities
  - Multi-sectoral collaboration
  - Place-based
  - Long-term partnerships
  - Community engagement/ownership
  - Assets based

### Sustaining Effectiveness
- (Healthy residents can engage; engaged residents act on health; community capacity gets refocused on next challenge after each new win)

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