

COMMUNITY HEALTH ASSESSMENT AND GROUP EVALUATION (CHANGE)



Creating
a Culture of
Healthy Living

CDC's Healthy Communities Program



Building a Foundation of Knowledge to Prioritize Community Needs

AN ACTION GUIDE



COMMUNITY ASSESSMENT

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FOREWORD

Our nation faces a crisis in the burden of chronic disease. Today, 7 of the 10 leading causes of death in the United States are chronic conditions. Nearly 50% of Americans are living with at least one chronic disease. The Centers for Disease Control and Prevention (CDC) recognizes that the scope and impact of chronic disease requires transforming the places and organizations that touch people's lives every day - communities and community organizations, work sites, health care organizations, and schools - to improve the health of the nation. To undertake this work, states and communities will need to address multiple factors through policy interventions including broad-based policies such as smoking bans and laws; targeted regulations, such as those promoting breastfeeding; and community-wide interventions, such as community- and street-scale urban design and land use policies.

In order to effectively identify, plan, and implement needed policy, systems and environmental changes, communities need to be able to assess the current policy landscape and monitor changes over time. The Community Health Assessment and Group Evaluation (*CHANGE*) Action Guide: *Building a Foundation of Knowledge to Prioritize Community Health Needs* was designed to meet this need. Although the *CHANGE* tool is not intended to promote any specific policy, it serves as a critical tool to help communities discover the array of approaches being used in the field. The *CHANGE* tool also helps communities identify and monitor important policy, systems, and environmental changes over time.





As the CDC collaborates with communities on the development and implications of policy, systems, and environmental change strategies, this important *CHANGE* Action Guide offers communities a valuable tool in our efforts to promote health and prevent disease.

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Director

National Center for Chronic Disease Prevention and Health Promotion

LEGEND

Icon	Usage
	Boxes marked with this light bulb icon present tips, ideas, and additional information on implementing an action step and may also provide web site links to helpful resources.
	Boxes marked with this hurdler icon describe possible obstacles that may occur during implementation and offer suggestions for successfully overcoming those hurdles.
	Boxes marked with this icon indicate additional resources are available on the CD-ROM.
	Boxes marked with this icon indicate questions generated by users of the <i>CHANGE</i> tool and are included to assist in executing the Action Steps.

ABOUT THE CD-ROM



The CD-ROM included with this Action Guide contains resources to support your community assessment and evaluation efforts. The resources are:

- *CHANGE* Sector Excel Files (i.e., the *CHANGE* tool) that provide a list of the items and definitions for each sector (i.e., Community-At-Large Sector, Community Institution/Organization Sector, Health Care Sector, School Sector, and Work Site Sector).
- Blank versions of the *CHANGE* Summary Statement, Sector Data Grid, *CHANGE* Strategy Worksheets, Community Health Improvement Planning Template, and Community Action Plan contained in Action Steps 7-8. Print and use these worksheets during strategy and brainstorming sessions.
- A template for a policy brief or one-pager to use as *CHANGE* activities come to a close and your team begins to develop products to share success stories with stakeholders.
- A Microsoft Office PowerPoint presentation template for town hall meetings, road shows, or site visits with partners.
- A resource list of assessment tools and evaluation guides that have been used and developed by CDC and its partner organizations.

SNAP SHOT OF ACTION STEPS FOR COMPLETING THE *CHANGE* TOOL

The following is a summary of the action steps that are suggested for successfully completing the *CHANGE* tool.

ACTION STEP 1: Assemble the Community Team

Identify and assemble the community team; diverse representation is preferred. Consider the make-up of the team to include 10-12 individuals maximum.

ACTION STEP 2: Develop Team Strategy

Decide whether to complete *CHANGE* as a whole team or divide into subgroups. Communities tend to divide the team into subgroups ensuring there are two people collecting and analyzing data and reporting back to the team to gain consensus.

ACTION STEP 3: Review All 5 *CHANGE* Sectors

Review all 5 sectors prior to completing them so the community team understands the total picture of what is being assessed. These include the Community-At-Large Sector, Community Institution/Organization (CIO) Sector, Health Care Sector, School Sector, and Work Site Sector.

ACTION STEP 4: Gather Data

Use multiple methods (two or more) to gather data from each site to maximize the data quality. Methods could include, for example, focus groups, windshield surveys, or questionnaires. Consider the amount of time needed for each of the methods selected.

ACTION STEP 5: Review Data Gathered

Gather with the community team to review the data received. Brainstorm, debate and dialogue with the team to gain consensus on what these data mean in terms of parameters of the *CHANGE* tool. Data should be rated based on a comprehensive review of all sources and agreement of everyone involved.

ACTION STEP 6: Enter Data

Use the *CHANGE* Sector Excel File to enter data. Within the community team, make sure there is a designated data manager to input the data. Complete a separate *CHANGE* Sector Excel File for each site.

ACTION STEP 7: Review Consolidated Data

Once ratings have been assigned to each sector, the following steps will need to be completed so the team can begin to determine areas of improvement to develop a Community Action Plan based on the community-level data.

ACTION STEP 7a: Create a *CHANGE* Summary Statement

ACTION STEP 7b: Complete the Sector Data Grid

ACTION STEP 7c: Fill Out the *CHANGE* Strategy Worksheets

ACTION STEP 7d: Complete the Community Health Improvement Planning Template

ACTION STEP 8: Build the Community Action Plan

The final step is to build a Community Action Plan. This will be organized by project period and annual objectives, and reflect the data collected during the *CHANGE* process.

BACKGROUND OF THE *CHANGE* TOOL

Community Health Assessment and Group Evaluation (*CHANGE*) is a data-collection tool and planning resource for community members who want to make their community a healthier one. The Healthy Communities Program (www.cdc.gov/HealthyCommunitiesProgram) within the Division of Adult and Community Health, at the National Center for Chronic Disease Prevention and Health Promotion of the Centers for Disease Control and Prevention (CDC) developed the *CHANGE* tool. The CDC's Healthy Communities Program designed the *CHANGE* tool for all communities interested in creating social and built environments that support healthy living.

A Community Action Plan is a living document, usually time based, that enables a community to structure its activities around a common purpose and to prioritize needs.

The purpose of *CHANGE* is to gather and organize data on community assets and potential areas for improvement prior to deciding on the critical issues to be addressed in a Community Action Plan. Development of the *CHANGE* tool began in fall 2007, and the first iteration was piloted with a set of CDC-funded communities. The tool comprises a set of

easy-to-use Microsoft Office Excel spreadsheets for collection of local-level data from schools, work sites, community organizations, and health care facilities. *CHANGE* walks you through a community assessment process and helps define and prioritize improvement areas by providing community-level data on current policy, systems, and environmental change strategies. With *CHANGE* data as a guide, you can map out a course for health improvement in your community with specific, targeted action. The *CHANGE* tool improves community health with feedback on actions that should be developed and implemented to transform communities into those that support healthy living.

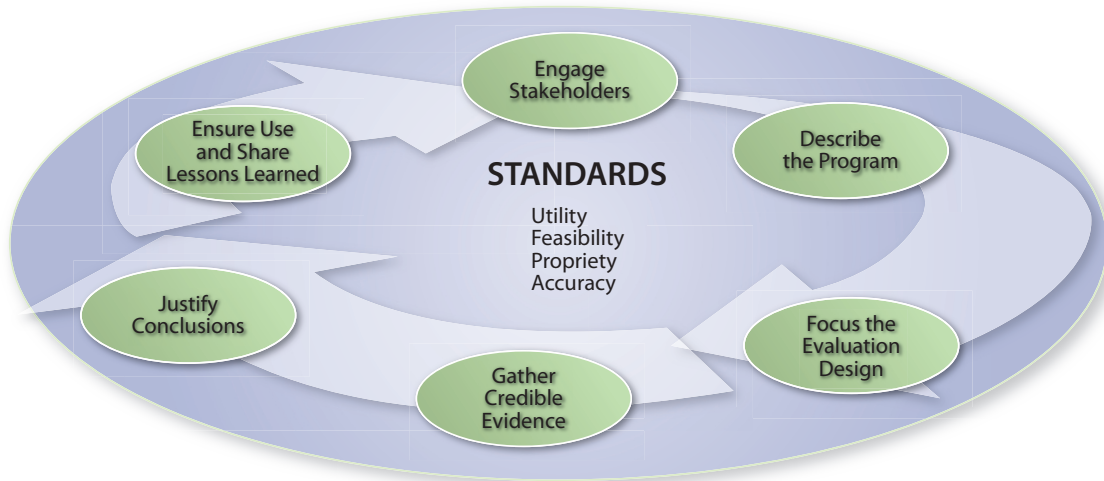
CHANGE combines items that have scientific support for policy, systems, and environmental changes with items that communities are initiating and assessing based on their practical experience but may lack stronger scientific support. As a result, this tool should not be construed as promoting any particular policy, systems, and environmental change strategy; it helps communities to assess potential approaches that are innovative as well as approaches that show strong evidence of effectiveness. For example, the scientific literature on tobacco use and exposure strongly recommends the use of a smoke-free indoor policy as a first point of action. Communities have utilized smoke-free indoor policies to reduce exposure to second-hand smoke as well as begun to utilize smoke-free outdoor policies, such as smoke-free parks and beaches, and tobacco-free indoor and outdoor policies at work sites, such as CDC's tobacco-free campus policy.^[1] Ultimately, this demonstrates *CHANGE*'s dual benefit of science coupled with community innovation being documented and tracked through the use of this assessment tool. As an annual process, the tool also allows your community to address incremental change and track progress against key policy, systems, and environmental change strategies.

CHANGE provides a foundation for utilizing CDC’s Recommended Framework for Program Evaluation.^[2] Program evaluation is important because it permits the community to measure efforts that can inform decisions. Therefore, start with the end in mind by weaving evaluation into your work from the very beginning. Formulate evaluation questions when you begin the process. For example, how well was a program implemented? Did it meet expectations? If so, how can we capitalize on the success; if not, what areas need improvement?

An accurate evaluation process is stakeholder-driven, and requires clear steps. Figure 1 shows how the steps of the evaluation process are interrelated. The process begins with engaging stakeholders; that is, connecting with individuals and organizations within the community whose interests and goals are similar (or even in opposition). The next evaluation steps focus on design and gathering the data needed to make decisions. Evaluators finalize the process by again engaging stakeholder groups. *CHANGE* embraces this stakeholder-driven process by using credible evidence to support and justify conclusions. *CHANGE* encourages your community team to share information with all stakeholders, and to share the information on an annual basis as a projection for future community action.

Assets are the community strengths; community areas that have achieved great progress or environmental change strategies.

Figure 1. Program Evaluation Framework



Why the *CHANGE* Tool?

Change can be achieved at many levels—individual, interpersonal, organizational, and community. The *CHANGE* tool enables users to consider the factors needed for multi-level impact and multi-level change. By supporting the collection of data from a variety of sources, *CHANGE* provides a community snapshot of the policy, systems, and environmental change strategies currently in place

and helps to identify areas for improvement. The Socio-Ecological Model, depicted in Figure 2, provides a useful framework for showing the multiple influences on community health, and barriers to health improvement. Understanding these factors and barriers aids in developing strong, actionable strategies for your community. Examples of such strategies include tobacco-free policies at schools and restaurants, healthy vending machine policies in work sites, safe sidewalks in all neighborhoods, and stair use promotion in public buildings.

The *CHANGE* tool development began by analyzing relationships among living conditions, culture, economics (e.g., community and/or individual wealth, financial stability), social networks, and lifestyle factors. Community health is affected by more than just individual behavior; multiple conditions and factors determine individual health decisions. Allowing for external issues, such as policy, systems, and environmental changes, provides a more comprehensive view of how to impact change at a community level.

Why is it important to consider community-level change? Community-level changes such as policy are more sustainable, impact infrastructure, and aid in shifting social norms. For example, an effort to educate parents on healthy food choices for children is sustainable only if parents have safe, affordable, and accessible locations to purchase food. Education alone is not as viable a change strategy because other factors may impede its success. Figure 2 also shows the connections among public policy, community, and interpersonal aspects such as social networks. None of these factors can be analyzed alone. The *CHANGE* tool assists you in conducting assessments, gathering data, examining the connections, and convening community teams for action. The *CHANGE* tool provides community teams with the data needed to strategize for change, identify the policies for change, and build the partnerships for change.

Figure 2. The Socio-Ecological Model^[3]



Community Change Process and the *CHANGE* Tool

Every community is different, but there are similarities in the process by which communities mobilize to affect change. The five phases of this process are depicted in Figure 3.

- Commitment.
- Assessment.
- Planning.
- Implementation.
- Evaluation.

Why is this process important to consider when completing the *CHANGE* tool? The process to complete the *CHANGE* tool mirrors these five phases and has been used as a basis to set up this Action Guide. Consider that, while there are five phases to the community change process, this Action Guide focuses specifically on the first three – Commitment, Assessment, and Planning, as they frame the step-by-step process for completing the *CHANGE* tool.

Figure 3. Community Change Process



1. **Commitment** involves assembling a team — or coalition — of community members to address key issues and establish partnerships with other agencies. Coalitions and partnerships give participants ownership of the process and a ready pool of fiscal and human resources to support policy, systems, and environmental change strategies.
2. **Assessment** involves gathering data and input on what the community needs. Assessment also provides a way for the community's voice to be heard. Change strategies must reflect the needs of the community to have the intended impact. As Chang has noted (1994), “a community assessment process is not just a matter of surveying what people need, but it is a community organizing strategy. By rigorously and creatively assessing community needs, the process gives real ‘voice’ to individuals in the community...voices that can significantly influence program design.”^[4]

3. **Planning** is the natural progression from assessing community needs. Now that the information is available, your team takes action to develop the Community Action Plan for change.
4. **Implementation** is executing the plan you have developed, in collaboration with the community team, stakeholders, and partners. Implementation requires maintenance of the commitment and ownership established in the beginning; without this support the plan can fall apart.
5. **Evaluation** is woven throughout the community change process and provides the basis for answering key questions: Are you implementing the right strategies? Are you creating the measurable impact envisioned? Evaluation, whether formal or informal, gathers lessons from what you are doing and provides recommendations for what can be done in the future. Evaluation also helps to inform key decision makers. Evaluation is listed as the final component of this cyclical process, but it should be considered from the beginning and included throughout all phases.

Purpose of *CHANGE*

The purpose of the *CHANGE* tool is to enable local stakeholders and community team members to survey and identify community strengths and areas for improvement regarding current policy, systems, and environmental change strategies. The definitions of policy change, systems change, and environmental change are below. These terms and others used in the *CHANGE* tool itself are in the Glossary of Terms (Appendix A).

Policy change:

Laws, regulations, rules, protocols, and procedures, designed to guide or influence behavior. Policies can be either legislative or organizational in nature. Policies often mandate environmental changes and increase the likelihood that they will become institutionalized or sustainable. Examples of legislative policies include taxes on tobacco products, provision of county or city public land for green spaces or farmers' markets, regulations governing the National School Lunch Program, and clean indoor air laws. Examples of organizational policies include schools requiring healthy food options for all students, a district ban on the sale of less than healthy foods throughout the school day, menu labeling in restaurants, required quality assurance protocols or practices (e.g., clinical care processes), or a human resources policy that requires healthy foods to be served at meetings.

Systems change:

Change that impacts all elements, including social norms of an organization, institution, or system; may include a policy or environmental change strategy. Policies are often the driving force behind systems change. Examples are implementing the National School Lunch Program across the state school system or ensuring a hospital system goes tobacco free.

Environmental change (Environment):

Physical, social, or economic factors designed to influence people's practices and behaviors. Examples of alterations or changes to the environment include:

- *Physical:* Structural changes or the presence of programs or services, including the presence of healthy food choices in restaurants or cafeterias, improvements in the built environment to promote walking (e.g., walking paths), the availability of smoking cessation services to patients or workers, and the presence of comprehensive school health education curricula in schools.
- *Social:* A positive change in attitudes or behavior about policies that promote health or an increase in supportive attitudes regarding a health practice, including an increase in favorable attitudes of community decision makers about the importance of nonsmoking policies or an increase in nonacceptance of exposure to second-hand smoke from the general public.
- *Economic:* The presence of financial disincentives or incentives to encourage a desired behavior, including charging higher prices for tobacco products to decrease their use or the provision of nonsmoker health insurance discounts.

The *CHANGE* tool has four key objectives and three benefits.

Objectives:

- Identify community strengths and areas for improvement.
- Identify and understand the status of community health needs.
- Define improvement areas to guide the community toward implementing and sustaining policy, systems, and environmental changes around healthy living strategies (e.g., increased physical activity, improved nutrition, reduced tobacco use and exposure, and chronic disease management).
- Assist with prioritizing community needs and consider appropriate allocation of available resources.

Benefits:

- Allows local stakeholders to work together in a collaborative process to survey their community.
- Offers suggestions and examples of policy, systems, and environmental change strategies.
- Provides feedback to communities as they institute local-level change for healthy living.

In addition, *CHANGE* can assist you in proposing, developing, and justifying strategic areas for improvement within your Community Action Plan. *CHANGE* also serves as a vehicle for developing and operationalizing principles to guide your community team, such as decision-making and member participation. Tips for ensuring a strong team are discussed in Action Step 1.

PURPOSE OF THE *CHANGE* ACTION GUIDE

CHANGE is a useful tool for all communities; however, many communities are new to the process or have community teams in varying stages of formation. To support and promote use of the *CHANGE* tool, CDC's Healthy Communities Program has produced this step-by-step Action Guide for completing the tool. It is designed to support *CHANGE*'s accessibility. This Action Guide is designed to walk you through the completion of the tool, to provide resources for team building, and to support the data-collection and review processes. The Action Guide summarizes the technical assistance that has been provided to communities and incorporates feedback from actual users. The guidance and supplemental resources are designed to make this process simple, seamless, and effective. As you begin to complete the *CHANGE* tool, share this guide with community members.

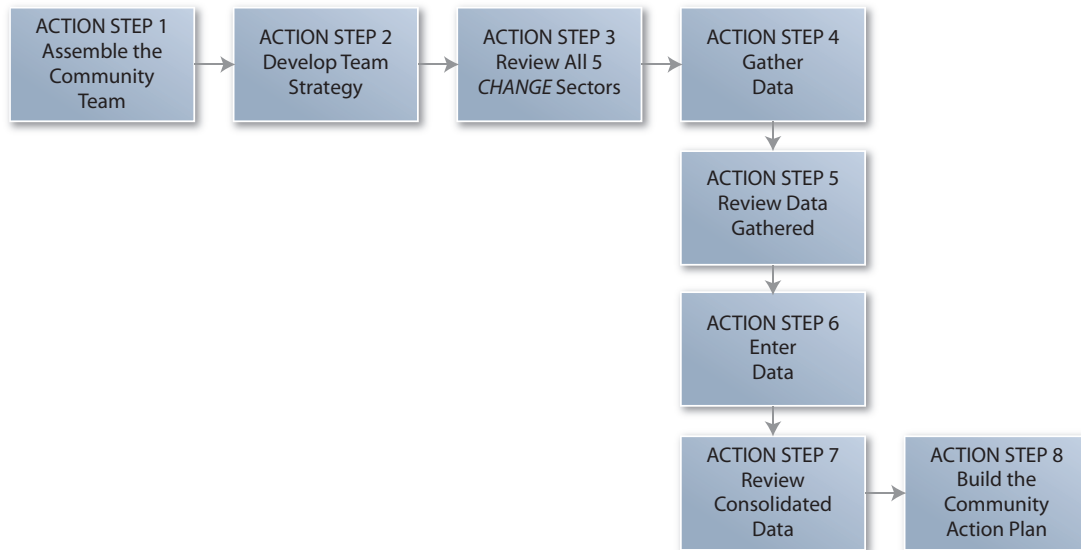
This Action Guide:

- Provides clear action steps to complete the *CHANGE* tool.
- Provides examples of resources that users can leverage for their own communities.
- Supports the consistent implementation of the *CHANGE* tool across communities.

HOW TO COMPLETE THE *CHANGE* TOOL

The *CHANGE* tool involves eight action steps (see Figure 4). Much of your effort should be focused initially on establishing a strong community team. This section will walk you through these steps in more detail. Consider the other activities being conducted in your community that may complement the work you need to do to complete the *CHANGE* tool. For example, will the completion of this tool coincide with the initial formation of your community team? Do not start the *CHANGE* process without a community team. The estimated timeline to complete the *CHANGE* tool is 3-5 months. However, that range will vary depending on the characteristics of each community. If a community team already exists, the process should be much faster. If there is a dedicated person who is coordinating *CHANGE* activities for the community team, the process should be shorter than if multiple or even a single person is spending only a portion of his or her time on *CHANGE* activities. Keep in mind that, typically, members of the community team are donating their time and have other commitments, which may extend or shrink the overall timeline for completing *CHANGE*. Pace your activities to take full advantage of members' time, and ensure their shared ownership of the process.

Figure 4. Action Steps to Complete the *CHANGE* Tool



Action Step 1: Assemble The Community Team

Action Step 1, assembling a community team, starts the commitment phase of the community change process. Representation from diverse sectors is key to successful teamwork, enables easy and accurate data-collection, and enables data assessment, which is the next phase of the community change process. All members of the community team should play an active role in the assessment process, from recommending sites within the sectors, to identifying the appropriate data-collection method. This process also ensures the community team has equitable access to and informed knowledge of the process, thereby solidifying their support. Consider the makeup of the community team (10-12 individuals maximum is desirable to ensure the size is manageable and to account for attrition of members). Include key decision-makers — the CEO of a work site or the superintendent of the school board—to diversify the team and utilize the skill sets of all involved.



Tip! Consider the following points when forming your community team:^[5]

- Set the tone by defining the purpose of the team.
- Define the community capacity of the team and identify potential barriers to success.
- Ensure that activities focus on policy, systems, and environmental change.
- Clarify the mission of the team.
- Include representatives of all identified stakeholder groups; community representation is key.
- Formalize rules, roles, procedures, and responsibilities (e.g., bylaws, standard operating procedures, goals and objectives, memoranda of understanding).
- Raise community awareness of the team and the issues it is addressing.
- Generate additional funds to support the community team.
- Community teams must provide benefits (e.g., solidarity, appreciation, evidence of impact) that exceed costs (e.g., time, frustration) to sustain membership and momentum.
- Assign tasks based on skills and available resources.

When focusing on policy, consider talking with high-level decision-makers. However, be mindful that staff and employees at all levels of the organization may be able to provide useful information. Consider who in the community functions as a gatekeeper of information. Note the selection of community members in Figure 5. This list is not exhaustive; form the team with a selection of individuals that can appropriately support the team's needs.

Figure 5. Possible Elements of a Community Team



Action Step 2: Develop Team Strategy

Action Step 2 involves collaboration to develop a team strategy. One approach is to meet with your community team to determine the best way to complete the tool. For example, decide whether to complete *CHANGE* as a whole team or to divide the community team into subgroups. Typically, communities divide the team into subgroups, ensuring each has a minimum of two people collecting and reviewing data and reporting results back to the whole team. This information sharing is essential to build a foundation of community knowledge on needs and assets and to reach consensus for strategy planning. At this step, your team should also use its bylaws and standard operating procedures to create a decision-making process. For your team, does reaching consensus involve taking a vote to see how the majority of the team feels or gaining 100% agreement? Determine which method works best and utilize it throughout the *CHANGE* tool completion process.

Action Step 3: Review All Five *CHANGE* Sectors

CHANGE is divided into five sectors for assessment:

- Community-At-Large Sector.
- Community Institution/Organization (CIO) Sector.
- Health Care Sector.
- School Sector.
- Work Site Sector.

The **Community-At-Large Sector** includes community-wide efforts that impact the social and built environments, such as food access, walkability or bikeability, tobacco-free policies, and personal safety.

The **Community Institution/Organization (CIO) Sector** includes entities within the community that provide a broad range of human services and access to facilities, such as childcare settings, faith-based organizations, senior centers, boys and girls clubs, health and wellness organizations, YMCAs, and colleges and universities.

The **Health Care Sector** includes places people go to receive preventive care or treatment, or emergency health care services, such as hospitals, private doctors' offices, and community clinics.

The **School Sector** includes all primary and secondary learning institutions (e.g., elementary, middle, and high schools, whether private, public, or parochial).

The **Work Site Sector** includes places of employment, such as private offices, restaurants, retail establishments, and government offices.

Within each *CHANGE* sector are modules (i.e., leadership, chronic disease management, demographics, physical activity, after school, district, tobacco, and nutrition) that contain the specific questions to be asked for each sector. For example, within the Community-At-Large Sector, Physical Activity Module, a *CHANGE* item is *To what extent does the community maintain a network of biking routes (e.g., institute a bike lane program to repave bike lanes when necessary)?* As your team reviews the

sectors, it will be helpful to familiarize yourself with the modules and the information within each. Please note District and After School are modules found only in the School Sector.

The *CHANGE* tool assists in gathering information about specific community health indicators and identifying areas for improvement in each sector. The *CHANGE* tool enables you to document changes made as problem areas are identified, new policies are implemented, and environmental change strategies are put into place. Make sure to review all five sectors prior to completing the assessment, so your community team understands what is being assessed and can brainstorm whom to include and the sites to use. Specific instructions on how many sites to visit within each sector are included in Action Step 4.



Question: How should the community team define the concept of “community” for completing *CHANGE*?

Answer: It is up to the community team to determine how it wants to define “community.” A community can be identified as a city, a town, a county, a neighborhood, a development of houses and shops, a school district, or other specified area. The determination of what a community is develops through team consensus during the community team’s meetings and conversations. The definition should be kept the same throughout the entire assessment process (i.e., as you complete *CHANGE*, develop the Community Action Plan, and determine which individuals are most representative of the community).



Question: Can “community” be defined by the Metropolitan Statistical Area (MSA) or by a smaller geographic area?

Answer: It is up to the community team to decide what geographic area will be used for *CHANGE*. Previously established areas (e.g., zip codes, school districts, city limits) may be helpful, but it is up to the community team to define its own community. As the community team decides on its community size, it should consider picking a smaller geographic area to start; it might be easier to attain greater impact than in a larger geographic area within the first year.

Use the Dialogue Guide shown in Figure 6 to develop “talking points” for why you are conducting *CHANGE* and what help you need to complete it. Use it when identifying participants to provide data, to introduce the concept to your community team, or to explain the process to anyone who is curious about *CHANGE* activities. This Dialogue Guide also helps to standardize language being used by the community team to discuss *CHANGE* activities. Community team members should speak with one voice to ensure consistency of message.

Figure 6. CHANGE Dialogue Guide

- *CHANGE* is a data-collection tool and planning resource for community members interested in making their community a healthy community.
- *CHANGE* provides a community snapshot of the policy, systems, and environmental change strategies currently in place and helps identify areas for improvement. Examples of these strategies include tobacco-free policies at schools, healthy vending machine policies at work sites, safe sidewalks in all neighborhoods, and stair use promotion in public buildings. The strategies *CHANGE* measures are all population-based; *CHANGE* does not measure individual-level strategies, such as health fairs and cooking classes.
- Completing *CHANGE* involves working together to answer questions about specific community sectors (i.e., Community-At-Large Sector, Community Institution/Organization Sector, Health Care Sector, School Sector, and Work Site Sector). Each sector is made up of multiple modules (e.g., physical activity, nutrition, tobacco use, chronic disease management, leadership). As a group, we will decide whether to complete all sectors of *CHANGE* as a whole team or divide into subgroups and report results back to the whole team.
- Completing sectors involves answering questions about our community. We will decide what methods this requires, for example talking with a community leader from this sector to gather additional information, walking or driving through the community, calling people we know in the setting who could answer the question for us, or other methods. We can also answer questions by reviewing results from other community assessments we, or other community members, have conducted here. Since *CHANGE* is not an interview guide, multiple methods may be required to complete the tool and gain an accurate picture of our community.
- Having broad participation from the community is important. We hope to include key persons from the community — school superintendents and principals, school board members, business leaders, mayors, city council members, department of health directors, city planners, departments of park and recreation, police chiefs, hospital administrators, medical staff chiefs, faith leaders, daycare owners, YMCA directors, and others — who have access to the information we need or can point us in the right direction.
- As we identify problem areas, implement policies, and put strategies into place, we can use *CHANGE* to document this work within our community. The tool can be utilized annually to review past efforts and offer ideas for the year ahead. Because we will be documenting and storing all data we collect to complete *CHANGE*, we will be creating an important record about our community's assets, needs, and priorities.
- *CHANGE* is not used to compare sectors, to compare one community to another, or to find fault in our community for our weaknesses. Instead, it is used *by* us to identify areas *in our own community* to highlight our strengths. It is up to us to decide if sharing *CHANGE* data with the public or outside of the community team is warranted in order to rally attention or public support for our efforts. Confidentiality is always an important element of data-collection; thus, we will not list who we talked with or provide specific details about data that could be specifically linked to an individual, community organization, or institution.
- *CHANGE* has already been used by communities like ours. Users have noted how helpful the tool is for identifying possible policy, systems, and environmental change strategies; guiding conversations and generating ideas for community change; providing a systematic way for communities to assess and plan for change; reviewing numerous sectors of their community, including schools, businesses, work sites, and health care settings; and promoting collaboration among community members.

Action Step 4: Gather Data

Action Step 4 is data-collection and begins the assessment phase, during which information is collected from individual sites. Sites are the locations within each sector your team will visit to collect data. At each site, the information gathered will provide answers to the *CHANGE* items listed in each module. For example, sites within the Community-At-Large Sector could be county government, news media, restaurants, grocery stores, or the health department in your community. Remember that your team will observe and document multiple sites when completing the Community-At-Large Sector because items cut across community-wide indicators, including walkability, food access, and tobacco use and exposure, which cannot be assessed by using only one site. For example, when answering questions around physical activity for your defined community, you may need to observe and document more than one park, neighborhood street, sidewalk network, or bike route to understand community walkability or bikeability, which are not limited to one location but are within the geographic boundaries of your identified community. However, with the other four sectors, your team will collect data specific to that one particular location, such as a single work site or health care facility. The relationship between sectors, sites, and modules will be explored in greater detail in this action step. The *CHANGE* tool is not designed to grade communities on their progress, but rather to assist you in making decisions about where change is needed and taking the steps necessary to reach out to those individuals and organizations (including your community team) that can help you to make an impact.



Tip! Review the *CHANGE* Sector Excel Files for inspiration on questions to ask during interviews. However, do not print out the document and ask contacts to complete it. *CHANGE* is designed to be a dialogue in which questions are asked, feedback is generated, and notes are taken to document the process. It is not designed as a self-report assessment or a tool that individuals should fill out for their own sites.

At this action step, use a mixture of two or more data-collection methods at each site, for example, focus groups and walkability audits. Table 1 lists the advantages and disadvantages of various data-gathering methods. This is not a comprehensive list, but rather a sample of methods you can use. Richer data enable a more effective action plan, so take this step slowly to ensure the data needed to make decisions are available.

Perhaps your community has already gathered data for another purpose? To determine if that information can be leveraged for the *CHANGE* process, consider the following:

- How old are the data? If data are 6 months old or newer, they can be used. If not, it is time to gather new data.
- Do you have all the information?
- Is the information relevant?

- Can you use the data in the existing format?
- Do you need more data?
- Does anyone on your team have experience with analyzing data?

Table 1. Advantages and Disadvantages of Data Collection Methods

Method	Definition	Advantages	Disadvantages
Observation ^[6]	Data collection method that allows you to use the phenomenon around you to gather clues and generate conclusions about specific locales or experiences. One example is to stand on a street corner to observe or watch the ease or difficulty with which pedestrians can cross a busy street. Windshield surveys are also a form of direct observation — making visual observations of a neighborhood or community while driving — literally “looking through the windshield”	<ul style="list-style-type: none"> ▪ Relatively inexpensive ▪ Efficient ▪ Can be conducted on foot 	<ul style="list-style-type: none"> ▪ Provide only an overview of community ▪ Require closer observation to identify previously unrecognized assets/ issues
Photovoice ^[7]	Combines photography with grassroots social action; subjects represent their community or point of view by taking photographs; attempts to bring perspectives of those “who lead lives that are different from those traditionally in control of the means for imaging the world” into the policy-making process	<ul style="list-style-type: none"> ▪ Provides a method for describing the community from the viewpoint of those who live there as opposed to those who govern it ▪ Enables people to record their community’s strengths and concerns ▪ Promotes critical dialogue and knowledge about community issues through large and small group discussions of photographs 	<ul style="list-style-type: none"> ▪ Analysis of photographs can be complex due to the volume of information ▪ Requires photo release form, particularly if individuals appear in the photographs ▪ Can be expensive to develop photos
Walkability Audit ^[8]	Designed to broadly assess pedestrian facilities, destinations, and surroundings along and near a walking route and identify improvements to make the route more attractive and useful to pedestrians	<ul style="list-style-type: none"> ▪ Unbiased examination of the walking environment ▪ Can also be performed at different stages of development, including planning and designing, construction, and on completed or established facilities/walking environments 	<ul style="list-style-type: none"> ▪ Inexperience in conducting walkability audits ▪ Can be time-consuming

Method	Definition	Advantages	Disadvantages
Focus Groups ^[9,10]	Involve gathering information and opinions from a small group of people (8 to 10 per group). These group discussions often provide insights that might not emerge in interviews	<ul style="list-style-type: none"> ▪ Can assess body language ▪ Observers can be present without distracting participants ▪ If videotaped, can share with others who couldn't attend ▪ Have participants' undivided attention 	<ul style="list-style-type: none"> ▪ Responders lose anonymity ▪ Higher travel expenses when multiple locales are used ▪ Logistical challenge in rural areas or small towns
Postal Survey ^[11,12]	Mailing self-completion questionnaires to a targeted group of people. (e.g., a client's customers or people living in a certain area)	<ul style="list-style-type: none"> ▪ Relatively inexpensive ▪ Less potential for people to give answers they assume the interviewer wants to hear ▪ No interviewer training required 	<ul style="list-style-type: none"> ▪ Suitable only for short and straightforward surveys ▪ Data collection takes a long time ▪ Relatively low response rates ▪ Moderate literacy level required
Telephone Survey ^[12]	Collection of data from a sample population using a standardized questionnaire by telephone	<ul style="list-style-type: none"> ▪ Minimizes missing data ▪ Can use open-ended questions and more complex interviewing schedules ▪ Can record reasons and characteristics of nonconsenters ▪ Quick and inexpensive ▪ Does not require a high level of literacy 	<ul style="list-style-type: none"> ▪ Can be hard to prevent consultation with/interference from others ▪ Need to keep questions few and short ▪ Unable to ask questions requiring visual cues ▪ Some likelihood of socially desirable responses
Face-to-face Survey ^[13,14]	A face-to-face survey is a telephone survey without the telephone. The interviewer physically travels to the respondent's location to conduct a personal interview	<ul style="list-style-type: none"> ▪ Allows flexibility in number and style of questions ▪ Minimizes missing data ▪ Allows physical measurements & direct observations ▪ Minimizes literacy level issues 	<ul style="list-style-type: none"> ▪ High likelihood of socially desirable responses ▪ Can be hard to prevent consultation with or interference from others ▪ Very expensive, especially if respondents are widespread geographically ▪ Time-consuming
Web-based Surveys ^[13]	A group of potential respondents is invited to participate in completing a web-based survey, and their responses are submitted electronically via the Internet	<ul style="list-style-type: none"> ▪ Can be relatively inexpensive ▪ Relatively quick method of data-collection ▪ Minimizes social desirability biases 	<ul style="list-style-type: none"> ▪ High set-up costs ▪ Useful only for relatively large-scale surveys ▪ High level of literacy and basic computer skills required ▪ Requires access to good hardware, programming, and support services ▪ No information on non-respondents ▪ Best suited to pre-coded questions



Tip! Make sure to use the same methods (e.g., survey, focus group) from one year to the next so that you have consistent data to analyze. You can expand on the methods from one year to the next, but be sure to maintain the ones from previous years.

Brainstorm sites for each sector as well as people (or key informants) in the community who can assist you in completing the *CHANGE* tool by providing appropriate insight, knowledge, or documentation. Figure 7 provides more detail on the connections between sectors and sites. Community team members can then reach out and contact people from the community (e.g., school superintendent, school principal, business leaders, mayor, city planners, police chief, hospital administrator, faith leaders, or daycare owners) who should have access to the desired information or can point them in the right direction. You can use existing data sources, such as U.S. Census, Behavioral Risk Factor Surveillance System (BRFSS), National Health and Nutrition Examination Survey (NHANES), and Chronic Disease Indicators (CDI) to capture community information where possible. These sources capture and utilize nation-wide data to reflect demographic data updated on an annual basis. BRFSS data is especially helpful as they can be splintered to show state, county, and metropolitan area data. These are examples of the only sources of data older than 6 months that are acceptable to use. However, pay attention to the frequency with which the data are collected. The next set of data from the U.S. Census, for example, will be available in 2010; BRFSS alternates asking questions on certain key indicators (e.g., physical activity, nutrition) each year. As such, it is suggested that your team review a 2-year range of data to ensure a complete set of data. Remember that these sources do not provide policy, systems, and environmental change strategies, but rather a snapshot of the types of needs located in a given community. For example, CDI data may indicate that the prevalence of childhood obesity is higher in one county compared to a neighboring one. Using that data, your community team may begin to devise strategies on how to address that evidence-based need. State or nation-wide data paint a bigger picture of what is happening and can be used as a comparison for the rich, community-level data you generate using *CHANGE*. The data from these sources can be used in conjunction with the original data you collect from sites to gain a more comprehensive picture of the community needs. This strategic dialogue around identifying priorities can drive the creation of your Community Action Plan.



Tip! For additional datasets go to the following web sites: U.S. Census—www.census.gov; BRFSS—www.cdc.gov/BRFSS; NHANES—<http://www.cdc.gov/nchs/nhanes.htm>; Chronic Disease Indicators—<http://apps.nccd.cdc.gov/cdi/>.

You are encouraged to use a variety of data-gathering methods to access and collect information for each site. Data come in many forms; varying data-collection methods provides a more comprehensive assessment of your community. For example, direct observation enables you to better understand the environment in which people interact and to see the things others may not be aware of. It may also produce useful information that may not be apparent from your other data-collection methods, such as a key informant interview or focus group. This type of data-collection allows you, the observer, to choose a location or event and watch what is happening. Coupling or grouping multiple methods can help to fill in gaps. For example, photographs of walkable streets or congested intersections unfriendly to pedestrians may supplement the feedback from an independent survey. The goal is to reflect the voices of the community through a diverse set of data-collection methods and to mobilize support by demonstrating a detailed, thorough method of data-collection. Finally, keep a comprehensive file of all sources of information, key contacts, and data to review at a later date or to share with coalition members. The file can be in multiple forms—notebooks or bound volumes, facilitator guides, field notes, meeting minutes, or an electronic data file. The purpose of cataloguing all the data files is to ensure that everything your team collects can be accessed and used.

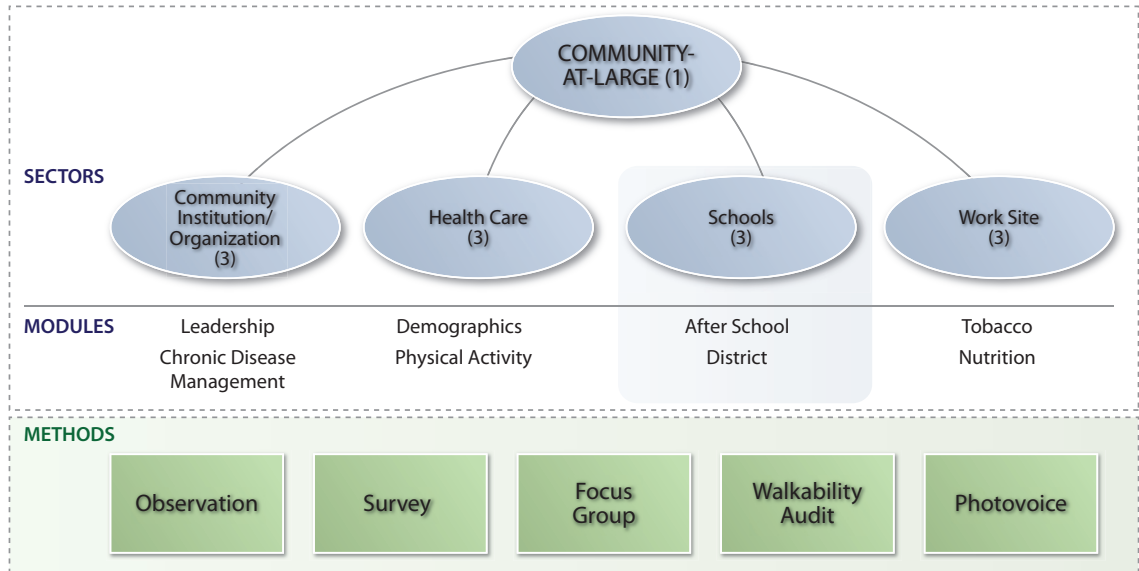


Tip! Be sure to choose a variety of sites within your sector to show the breadth of work being done in your community. Some schools, for example, may be on the brink of passing a physical activity policy, while others have not yet begun to consider the need. A diversity of policy implementation enhances your data-gathering process. If you only choose sites that are excelling it is more challenging to identify gaps and needs for your Community Action Plan.

We suggest that you gather data from at least 13 sites. While this may seem daunting, consider there are only five sectors in the tool. Complete one site for the Community-At-Large Sector. Complete a minimum of three sites each for the other four sectors (i.e., Community Institution/Organization, Health Care, School, and Work Site). The more sites completed, the greater the capacity of your team to understand the intricacies of the community. Having more sites can be beneficial to your team as it shows a breadth and depth of data generated. Every community has different assets and needs, so do as much as possible with the time and resources available.

Figure 7 shows the relationship among the sectors, modules, and data-collection methods. Start with defining the community, whether that is a county, city, or geographic area. Given the boundaries of the community, the other four sectors will fall within those boundaries. For example, if your community is defined as two adjoining zip codes within a county, the Community Institution/Organization, Health Care, School, and Work Site Sectors are completed by selecting sites within that geographic designation. Then, define the sites within each and the methods your team will use to collect the data.

Figure 7. Framework for Completing CHANGE



Once you have data that fully represent your community, identify areas for improvement within your Community Action Plan. Specific individuals who have the information will vary depending on the size of the organization. Use the community team members to access businesses or organizations with which you are less familiar. Sometimes it may be challenging to choose sites. The Sector Participant List, found in Appendix B, helps to identify key sites and the individuals to contact.

Action Step 5: Review Data Gathered

Action Step 5 is to review the data. Before you enter data into the *CHANGE* Sector Excel Files, review the data collected for each site to gain consensus on how to rate each item. Teams are discouraged from averaging ratings. The team should discuss the data, share what each person found, and identify evidence to support the team’s rating. Refer back to Action Step 2 when your team devised a decision-making strategy. Some examples are the Delphi method, simple voting tactics, or a discussion among members that indicates all or most are in agreement. Choose a method based on your team’s preference but you are encouraged to use that same method consistently throughout the process. This is the exciting part! Yet it also represents the hard work needed prior to entering data into the tool. Gather with your community team (in a board room, at a park, or at the local coffee shop) to brainstorm about what was heard in town hall meetings, observed during walkability audits, and garnered from existing data sources. There may be a pile of information in front of the group: pictures from the walkability audit, responses from a survey e-mailed to school staff, notes from an interview with the CEO of the local hospital. Establish consensus on what these data mean in terms of the parameters of the *CHANGE* tool. Be sure to record comments in the *CHANGE* Sector Excel file for every single response, to document why the decision was made. Make sure the information

is representative of the site you assessed so information can be used from one year to the next. Rating the data should be based on a comprehensive review of all sources and the agreement of the individuals on your team.



Tip! When possible, have the person who collected the data in the room when the team reviews the information. The person's memory and experience are data sources that may be just as important as whatever notes he or she may have taken.

The rating scale in each sector has been created to examine and easily determine where a site has progressed. Allocate a number between 1 and 5 for both the policy and environment columns for each of the five sectors. Table 2 shows a scale, with examples for scores 1–5. A response of 99 has been incorporated into the scale to be used only when the item is not applicable at the site (e.g., stair promotion not suitable in a one-story building). This item response (99) does not factor into the module's column total or percentage calculations. During this action step, data are reviewed. One or two members of your team should take note of what type of data was collected from the site being discussed, where it came from, and add it to the comprehensive data file. This information can be entered into the comment boxes and will provide valuable, historical documentation for the reassessment phase. Table 2 also provides a detailed explanation of the rating scale for the Community-At-Large Sector, Physical Activity Module. The module addresses the item *require sidewalks to be built for all developments (e.g., housing, schools, commercial)*.

Table 2. CHANGE Tool Policy and Environment Scale for Community-At-Large Sector and Physical Activity Module

	Policy	Environment
Response #	Item #1: Require sidewalks to be built for all developments (e.g., housing, schools, commercial)	
1	This stage represents the time when the issue has not yet been identified as a concern or a problem. For example (examples provided correspond to item #1), the city or county government has never discussed instituting a sidewalk policy; complaints have never been filed and issues have not been raised by residents.	At this point, no elements are in place in the environment. For example (examples provided correspond to item #1), there are no sidewalks that are fully accessible to all pedestrians (including those in wheelchairs), there is no appropriate lighting, there are no stoplights, and there are no crosswalks.
2	This stage involves getting a problem onto the radar screen of the authoritative body that must deal with the issue. This is usually done when the issue or problem is categorized as a social or public problem. For example (examples provided correspond to item #1), the city or county government discusses instituting a sidewalk policy after complaints are filed by residents who are not able to safely walk in their neighborhoods; policy implications and issues are being considered.	At this point, only a few elements are in place in the environment. For example (examples provided correspond to item #1), there are sidewalks that are fully accessible to all pedestrians (including those in wheelchairs), but there is no appropriate lighting, there are no stoplights, and there are no crosswalks.
3	This stage involves analyzing policy goals and solutions, the development or creation of alternative recommendations to resolve or address the identified public problem, and final selection of a policy. For example (examples provided correspond to item #1), the city or county government developed and approved the policy, but it has not yet been implemented. It will be implemented in the next fiscal year.	At this point, there are some elements in place in the environment. For example (examples provided correspond to item #1), there are sidewalks that are fully accessible to all pedestrians (including those in wheelchairs) and there is appropriate lighting, but there are no stoplights and there are no crosswalks.
4	This occurs within organizations directed to carry out adopted policies. Implementation begins once a policy has been formulated and adopted, and administrators have made a decision about how to deploy necessary resources (human and financial) to actualize the policy. For example (examples provided correspond to item #1), the sidewalk policy was established and passed last year by the city or county government, communicated to residents, and implemented this year. The end of this year will be the review and comment period of the policy.	At this point, most elements are in place in the environment. For example (examples provided correspond to item #1), there are sidewalks that are fully accessible to all pedestrians (including those in wheelchairs), there is appropriate lighting, and there are stoplights, but there are no crosswalks.
5	This stage involves determining to what extent the policy has been enforced, and what occurred as a result of the policy. Based on the evaluation results, adjustments can be made to the current policy to ensure effectiveness. For example (examples provided correspond to item #1), the sidewalk policy was in place last year, and a comment period was held. The policy was revamped, and is now implemented with revisions including increased funding for implementation and increased punishment for violations.	At this point, all elements are in place in the environment. For example (examples provided correspond to item #1), there are sidewalks that are fully accessible to all pedestrians (including those in wheelchairs), there is appropriate lighting, there are stoplights, and there are crosswalks.
99	This type of policy is not appropriate for this community	This type of environmental change strategy is not appropriate for this community

Action Step 6: Enter Data

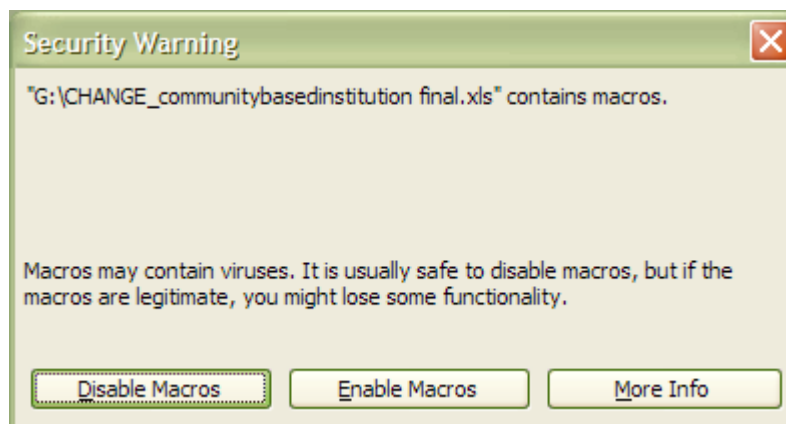
Designate one person as the data manager within your community team. The data manager is responsible for entering the data for each of the sites into the *CHANGE* Sector Excel File. It may be helpful if this person is familiar with Excel; extensive skill is not necessary, but a basic working knowledge of the program (e.g., opening and closing files, entering macros, and entering data) facilitates the use of the tool. Each site should be labeled and saved appropriately using the recommended *CHANGE* Sector Excel File name.



Tip! Recommended file name.

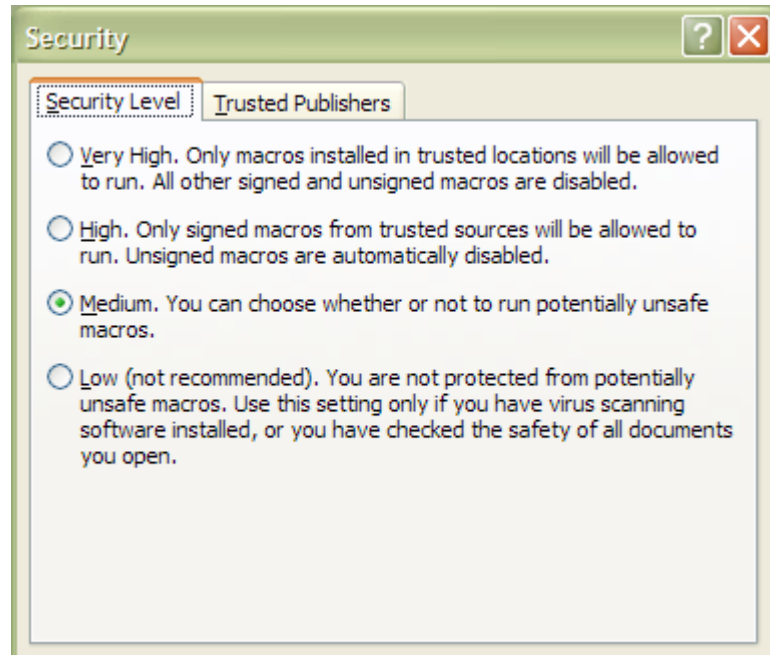
CHANGE_sector_site#_community_year.xls;
e.g., CHANGE_school_2_Atlanta_2010.xls.

When opening a *CHANGE* Sector Excel File, click **Enable Macros** when the security warning message below appears.



If you do not see the security message above and are therefore not able to click **Enable Macros**.

1. Open Excel.
2. Click the **Tools** menu across the top.
3. Within the **Tools** menu, click the **Macro** option.
4. Within the **Macro** option, click the **Security** option.
5. Within the **Security** option, select the **Medium** radio button.
6. Click **OK**.



7. Open the *CHANGE* Sector Excel File and click **Enable Macros** in the Security Warning.



Tip! Please note some organizations block users from changing the security level for macros. If this is the case, ask the Information Technology staff to follow the steps outlined here.

Using the five-point scale and the guidance provided in Action Step 5, indicate in both the highlighted Policy and Environment response columns the most appropriate rating for each item, based on the community team's observations and information collected. Data managers are encouraged to use the comment boxes in the *CHANGE* Sector Excel Files; providing detailed records of how and from where the data were collected helps when you get to the reassessment phase. Remember, *CHANGE* is an annual process so the data should be consistent from one year to the next and a valid reflection of what the team observed, heard, and recorded.



Question: If the community team assesses four sites, are four separate Excel files needed?

Answer: Yes. For every site, the community team should have a separate *CHANGE* Sector Excel File. After gathering information and gaining community team consensus on *CHANGE* item responses, the team's data manager enters the data for each site into the correct sector file. To ensure proper data management, there should be only one data manager, such as the community team's evaluator, and all data should be forwarded to this individual. The assessment tool automatically completes all data calculations within each sector. Once *CHANGE* Sector Excel Files have been completed and saved by the data manager, data can be included in a *CHANGE* Summary Statement.



Question: Can community team members simultaneously work on files while others work on the same file?

Answer: Yes, you can simultaneously work on *CHANGE* sectors once data-collection methods for their completion are determined by the community team. We recommend that you print hard copies of *CHANGE*, so that all community team members can note additions, deletions, or revisions to the data by hand. Once combined and finalized, the data manager enters all data into the Excel files. The community team is strongly encouraged to designate one member as data manager. The data manager is responsible for entering and saving all data sheets. While a *CHANGE* Sector Excel File is open, only one person can enter data at a time.

Figure 8. Snapshot of the *CHANGE* Sector Excel File

Community-At-Large: Physical Activity

Based on your team's knowledge or observations of the community, use the following Policy and Environment scales to indicate the most appropriate responses for each statement. Position the cursor over each rating option to see further explanation and an example (examples provided are for item #1).

In the two response columns, please indicate the appropriate number (#) from the scales below that best represents your answers for each item. Provide both a Policy Response # and Environment Response # for each statement in the appropriate column, with supporting documentation in the corresponding comment boxes. Response # 99 should be used only when the strategy is not applicable at the site (e.g., stair promotion not suitable in one-story building).

Response #	Policy	Environment
1	Not identified as problem	Elements not in place
2	Problem identification/gaining agenda status	Few elements in place
3	Policy formulation and adoption	Some elements are in place
4	Policy implementation	Most elements are in place
5	Policy evaluation and enforcement	All elements in place
99	Not applicable	Not applicable

To what extent does the community:	Policy Response #	Environment Response #
1. Require sidewalks to be built for all developments (e.g., housing, schools, commercial)?		
2. Adopt a land use plan?		
3. Require <u>bike facilities</u> (e.g., bike boulevards, <u>bike lanes</u> , bike ways, multi-use paths) to be built for all developments (e.g., housing, schools, commercial)?		
4. Adopt a <u>complete streets</u> plan to support walking and biking infrastructure?		
5. Maintain a network of walking routes (e.g., institute a sidewalk program to fill gaps in the sidewalk)?		
6. Maintain a network of biking routes (e.g., institute a bike lane program to repave bike lanes when necessary)?		
7. Maintain a network of parks (e.g., establish a program to repair and upgrade existing parks and playgrounds)?		
8. Provide access to parks, <u>shared-use paths and trails</u> , or open spaces within <u>reasonable</u>		

Demographic Information | **Physical Activity** | Nutrition | Tobacco | Chronic Disease Management | Leadership

Figure 8 is an example of the Community-At-Large Sector and the Physical Activity Module that you will see on opening the *CHANGE* Sector Excel File. Note the rating scale (1–5) for Policy and Environment with an explanation for how the ratings are determined. For example, a rating of 1 under Policy means the item was not identified as a problem based on the data collected. Also in this screen shot, you see a list of items related to physical activity. For example, the first item is *Require sidewalks to be built for all developments*. A policy response of 1 next to item number 1 indicates *Requiring sidewalks to be built for all developments* has not been identified as a problem in the community. In the neighboring tabs, you enter similar information for the other modules (e.g., nutrition, tobacco, and chronic disease management).

Figure 9. Definitions of Terms in the *CHANGE* Sector Excel File

Community At-Large: Physical Activity

Based on your team's knowledge or observations of the community, use the following Policy and Environment scales to indicate the most appropriate responses for each statement. Position the cursor over each rating option to see further explanation and an example (examples provided are for item #1).

In the two response columns, please indicate the appropriate number (#) from the scales below that best represents your answers for each item. Provide both a Policy Response # and Environment Response # for each statement in the appropriate column, with supporting documentation in the corresponding comment boxes. Response # 99 should be used only when the strategy is not applicable at the site (e.g., stair promotion not suitable in one-story building).

Response #	Policy	Environment
1	Not identified as problem	Elements not in place
2	Problem identification/gaining agenda status	Few elements in place
3	Policy formulation and adoption	Some elements are in place
4	Policy implementation	Most elements are in place
5	Policy evaluation and enforcement	All elements in place
99	Not applicable	Not applicable

Environment: Physical, social, or economic settings designed to influence people's practices and behaviors. Examples of alterations or changes to the environment include:
 Physical: Structural changes or the presence of programs or services, including the presence of healthy food choices in restaurants or cafeterias, improvements in the built environment to promote walking (e.g., walking paths), the availability of smoking cessation services to patients or workers, and the presence of comprehensive school health education curricula in schools.
 Social: A positive change in attitudes or behavior about policies that promote health or an increase in increase in favorable attitudes community decision makers have about the importance of nonsmoking policies or an increase in non-acceptance of exposure to secondhand smoke from the general public.
 Economic: The presence of financial disincentives or incentives to encourage a desired behavior, including paying higher prices for tobacco products to decrease their use or the provision of nonsmoker health insurance discounts to encourage smoking cessation.

Environment: Physical, social, or economic settings designed to influence people's practices and behaviors. Examples of alterations or changes to the environment include:
 Physical: Structural changes or the presence of programs or services, including the presence of healthy food choices in restaurants or cafeterias, improvements in the built environment to promote walking (e.g., walking paths), the availability of smoking cessation services to patients or workers, and the presence of comprehensive school health education curricula in schools.
 Social: A positive change in attitudes or behavior about policies that promote health or an increase in favorable attitudes community decision makers have about the importance of nonsmoking policies or an increase in non-acceptance of exposure to secondhand smoke from the general public.
 Economic: The presence of financial disincentives or incentives to encourage a desired behavior, including paying higher prices for tobacco products to decrease their use or the provision of nonsmoker health insurance discounts to encourage smoking cessation.

To what extent does the community:

	Policy Response #	Environment Response #
1. Require sidewalks to be built for all developments (e.g., housing, schools, commercial)?		
2. Adopt a land use plan?		
3. Require bike facilities (e.g., bike boulevards, bike lanes, bike ways, multi-use paths) to be built for all developments (e.g., housing, schools, commercial)?		
4. Adopt a complete streets plan to support walking and biking infrastructure?		
5. Maintain a network of walking routes (e.g., institute a sidewalk program to fill gaps in the sidewalk)?		
6. Maintain a network of biking routes (e.g., institute a bike lane program to repave bike lanes when necessary)?		
7. Maintain a network of parks (e.g., establish a program to repair and upgrade existing parks and playgrounds)?		
8. Provide access to parks, shared-use paths and trails, or open spaces within reasonable		

Demographic Information / Physical Activity / Nutrition / Tobacco / Chronic Disease Management / Leadership

The definitions of policy and environment are critical to form the basis for decisions on how each column is scored. Definitions are embedded into the *CHANGE* tool. Figure 9 shows that when you move your cursor to the corner of the Environment or Policy column (note the red marker) a box with the definition pops up. The definitions of both terms can also be found in Appendix A, Glossary of Terms.

Figure 10. Definitions of Item Responses

Community-At-Large: Physical Activity

Based on your team's knowledge or observations of the community, use the following Policy and Environment scales to indicate the most appropriate responses for each statement. Position the cursor over each rating option to see further explanation and an example (examples provided are for item #1).

In the two response columns, please indicate the appropriate number (#) from the scales below that best represents your answers for each item. Provide both a Policy Response # and Environment Response # for each statement in the appropriate column, with supporting documentation in the corresponding comment boxes. Response # 99 should be used only when the strategy is not applicable at the site (e.g., stair promotion not suitable in one-story building).

Response #	Policy	Environment
1	Not identified as problem	Elements not in place
2	Problem identification/gaining agenda status	Few elements in place
3	Policy formulation and adoption	Some elements are in place
4	Policy implementation	Most elements are in place
5	Policy evaluation and enforcement	All elements in place
99	Not applicable	Not applicable

At this point, no elements are in place in the environment. For example (examples provided correspond to item #1), there are no sidewalks that are fully accessible to all pedestrians (including those in wheelchairs), there is no appropriate lighting, there are no stoplights, and there are no crosswalks.

To what extent does the community:	Policy Response #	Environment Response #
1. Require sidewalks to be built for all developments (e.g., housing, schools, commercial)?		
2. Adopt a land use plan?		
3. Require <u>bike facilities</u> (e.g., bike boulevards, <u>bike lanes</u> , bike ways, multi-use paths) to be built for all developments (e.g., housing, schools, commercial)?		
4. Adopt a <u>complete streets</u> plan to support walking and biking infrastructure?		
5. Maintain a network of walking routes (e.g., institute a sidewalk program to fill gaps in the sidewalk)?		
6. Maintain a network of biking routes (e.g., institute a bike lane program to repave bike lanes when necessary)?		
7. Maintain a network of parks (e.g., establish a program to repair and upgrade existing parks and playgrounds)?		
8. Provide access to parks, <u>shared-use paths and trails</u> , or open spaces within <u>reasonable</u>		

At this point, no elements are in place in the environment. For example (examples provided correspond to item #1), there are no sidewalks that are fully accessible to all pedestrians (including those in wheelchairs), there is no appropriate lighting, there are no stoplights, and there are no crosswalks.

Demographic Information / **Physical Activity** / Nutrition / Tobacco / Chronic Disease Management / Leadership

Figure 10 shows the definitions for the item responses. Study these carefully to make sure your rating is accurate based on the parameters of the response. For example, a response of 1 under Environment indicates *At this point, no elements are in place in the environment. For example (examples provided correspond to item #1), there are no sidewalks that are fully accessible to pedestrians (including those in wheelchairs), there is no appropriate lighting, and there are no crosswalks.*

Figure 11. Item Responses and Accompanying Comment Boxes

Community-At-Large: Physical Activity

Based on your team's knowledge or observations of the community, use the following Policy and Environment scales to indicate the most appropriate responses for each statement. Position the cursor over each rating option to see further explanation and an example (examples provided are for item #1).

In the two response columns, please indicate the appropriate number (#) from the scales below that best represents your answers for each item. Provide both a Policy Response # and Environment Response # for each statement in the appropriate column, with supporting documentation in the corresponding comment boxes. Response # 99 should be used only when the strategy is not applicable at the site (e.g., stair promotion not suitable in one-story building).

Response #	Policy	Environment
1	Not identified as problem	Elements not in place
2	Problem identification/gaining agenda status	Few elements in place
3	Policy formulation and adoption	Some elements are in place
4	Policy implementation	Most elements are in place
5	Policy evaluation and enforcement	All elements in place
99	Not applicable	Not applicable

To what extent does the community:	Policy Response #	Environment Response #	Comment:
1. Require sidewalks to be built for all developments (e.g., housing, schools, commercial)?		4	
2. Adopt a land use plan?			
3. Require <u>bike facilities</u> (e.g., bike boulevards, <u>bike lanes</u> , bike ways, multi-use paths) to be built for all developments (e.g., housing, schools, commercial)?			
4. Adopt a <u>complete streets</u> plan to support walking and biking infrastructure?			
5. Maintain a network of walking routes (e.g., institute a sidewalk program to fill gaps in the sidewalk)?			
6. Maintain a network of biking routes (e.g., institute a bike lane program to repave bike lanes when necessary)?			
7. Maintain a network of parks (e.g., establish a program to repair and upgrade existing parks and playgrounds)?			
8. Provide access to parks, shared-use paths and trails, or open spaces within reasonable			

Demographic Information / **Physical Activity** / Nutrition / Tobacco / Chronic Disease Management / Leadership

Figure 11 depicts how each item is scored for Policy and Environment. For example, if you put a number 4 in the box under Environment, this score indicates that *most elements are in place* for your community to have sidewalks. Specifically, they are fully accessible to pedestrians, even those in wheelchairs, there is appropriate lighting, and there are stoplights but no crosswalks. The comment box that pops up next to the item response serves as documentation on how each of the items was rated by the team. You are highly encouraged to enter detailed comments in each of the comment boxes for each of the items. This information augments the reassessment phase.

Figure 12. Definitions of Key Terms

Community-At-Large: Physical Activity

Based on your team's knowledge or observations of the community, use the following Policy and Environment scales to indicate the most appropriate responses for each statement. Position the cursor over each rating option to see further explanation and an example (examples provided are for item #1).

In the two response columns, please indicate the appropriate number (#) from the scales below that best represents your answers for each item. Provide both a Policy Response # and Environment Response # for each statement in the appropriate column, with supporting documentation in the corresponding comment boxes. Response # 99 should be used only when the strategy is not applicable at the site (e.g., stair promotion not suitable in one-story building).

Response #	Policy	Environment
1	Not identified as problem	Elements not in place
2	Problem identification/gaining agenda status	Few elements in place
3	Policy formulation and adoption	Some elements are in place
4	Policy implementation	Most elements are in place
5	Policy evaluation and enforcement	All elements in place
99	Not applicable	Not applicable

To what extent does the community:	Policy Response #	Environment Response #
1. Require sidewalks to be built for all developments (e.g., housing, schools, commercial)?		
2. Adopt a land use plan?		
3. Require <u>bike facilities</u> (e.g., bike boulevards, <u>bike lanes</u> , bike ways, multi-use paths) to be built for all developments (e.g., housing, schools, commercial)?		
4. Adopt a <u>complete streets</u> plan to support walking and biking infrastructure?		
5. Maintain a network of walking routes (e.g., institute a sidewalk program to fill gaps in the sidewalk)?		
6. Maintain a network of biking routes (e.g., institute a bike lane program to repave bike lanes when necessary)?		
7. Maintain a network of parks (e.g., establish a program to repair and upgrade existing parks and playgrounds)?		
8. Provide access to parks, <u>shared-use paths and trails</u> , or open spaces within <u>reasonable walking distance</u> of most homes?		

Bike facilities: A general term denoting improvements and provisions made by public agencies to accommodate or encourage bicycling, including parking and storage facilities, and shared roadways not specifically designated for bicycle use.

Bike lanes: Portions of a roadway that have been designated by striping, signing, and pavement markings for the preferential or exclusive use of bicyclists.

Additional bike facility definitions and design recommendations can be found in AASHTO's [Guide for the Development of Bicycle Facilities](http://www.scrtc.org/bikes/AASHTO_1999_BikeBook.pdf).

As you review all the items, and begin to rate them, the *CHANGE* tool provides additional definitions, as shown in Figure 12. Move your cursor to the right-hand corner of the cell and a pop-up box appears with the definition for all underlined terms in the items. Each of these definitions can also be found in Appendix A, Glossary of Terms.

Figure 13. Module Percentages and Tabulated Ratings

Community-At-Large: Physical Activity		
To what extent does the community:	Policy Response #	Environment Response #
1. Require sidewalks to be built for all developments (e.g., housing, schools, commercial)?	4	3
2. Adopt a land use plan?	3	2
3. Require <u>bike facilities</u> (e.g., bike boulevards, <u>bike lanes</u> , bike ways, multi-use paths) to be built for all developments (e.g., housing, schools, commercial)?	2	1
4. Adopt a <u>complete streets</u> plan to support walking and biking infrastructure?	4	3
5. Maintain a network of walking routes (e.g., institute a sidewalk program to fill gaps in the sidewalk)?	3	2
6. Maintain a network of biking routes (e.g., institute a bike lane program to repave bike lanes when necessary)?	1	2
7. Maintain a network of parks (e.g., establish a program to repair and upgrade existing parks and playgrounds)?	3	2
8. Provide access to parks, <u>shared-use paths and trails</u> , or open spaces within <u>reasonable walking distance</u> of most homes?	5	3
9. Institute <u>mixed land use</u> ?	2	1
10. Require sidewalks to comply with the <u>Americans with Disabilities Act (ADA)</u> (i.e., all routes accessible for people with disabilities)?	3	2
11. Provide access to <u>public recreation facilities</u> (e.g., parks, play areas, community and wellness centers) for people of all abilities?	3	3
12. Enhance access to public transportation (e.g., bus stops, light rail stops, van pool services, subway stations) within <u>reasonable walking distance</u> ?	1	1
13. Provide street <u>traffic calming measures</u> (e.g., road narrowing, central islands, roundabouts, speed bumps) to make areas (e.g., neighborhoods, major intersections) where people are or could be physically active (e.g., walk, bike) safer?	2	2
14. Adopt <u>strategies</u> (e.g., neighborhood crime watch, lights) to enhance personal safety in areas (e.g., playgrounds, parks, bike lanes, walking paths, neighborhoods) where people are or could be physically active (e.g., walk, bike)?	2	3
COLUMN TOTAL:	38	30
PHYSICAL ACTIVITY SCORE:	56.72%	46.15%
Please remember to answer every item. Do not leave any item blank.		

Continue to add the item responses per column for each of the sectors and modules for which you have data. Be sure to confer with the team on item response, but, for accuracy and precision, rely on the designated data manager to actually input the data. Answer every item. Do not leave anything blank; doing so will impact the validity of the module percentages. Remember, if an item does not apply to your community use the 99 rating, which will not tabulate into the final score. Figure 13 shows that, once you have completed all modules, your percentage scores are tabulated for both Policy and Environment. This is an automatic process, not a manual one, and ensures the scores are accurate.

Figure 14. Module Score Summaries

Community Health Assessment and Group Evaluation
COMMUNITY-AT-LARGE

Additional information about the community can be included in the comment box denoted by the red tab.
COMMUNITY'S NAME:

Module Score Summaries		
Policy	Environment	Module
56.72%	46.15%	Physical Activity
56.92%	45.52%	Nutrition
49.20%	65.45%	Tobacco Use
55.50%	60.50%	Chronic Disease Management
43.25%	52.75%	Leadership

GENERAL INSTRUCTIONS
Please indicate your answer by typing an 'X' or the correct information in the appropriate box for your response. Additional information can be included in each comment box denoted by the red corner tab.

DEMOGRAPHIC INFORMATION

Community density:
Approximate number of people who reside in the community (population):
Approximate size of the area (square miles):

<p>Best description of the community setting (choose ONE only):</p> <table border="1"> <tr> <td>Rural</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>Suburban</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Urban</td> <td><input type="checkbox"/></td> </tr> </table>	Rural	<input checked="" type="checkbox"/>	Suburban	<input type="checkbox"/>	Urban	<input type="checkbox"/>	<p>The approximate percentage of people in the community with no high school diploma (choose the best estimated category):</p> <table border="1"> <tr> <td>< 5%</td> <td><input type="checkbox"/></td> </tr> <tr> <td>5 - 9%</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>10 - 14%</td> <td><input type="checkbox"/></td> </tr> <tr> <td>15 - 19%</td> <td><input type="checkbox"/></td> </tr> <tr> <td>≥ 20%</td> <td><input type="checkbox"/></td> </tr> </table>	< 5%	<input type="checkbox"/>	5 - 9%	<input checked="" type="checkbox"/>	10 - 14%	<input type="checkbox"/>	15 - 19%	<input type="checkbox"/>	≥ 20%	<input type="checkbox"/>				
Rural	<input checked="" type="checkbox"/>																				
Suburban	<input type="checkbox"/>																				
Urban	<input type="checkbox"/>																				
< 5%	<input type="checkbox"/>																				
5 - 9%	<input checked="" type="checkbox"/>																				
10 - 14%	<input type="checkbox"/>																				
15 - 19%	<input type="checkbox"/>																				
≥ 20%	<input type="checkbox"/>																				
<p>The median household income of the community (choose the best estimated category):</p> <table border="1"> <tr> <td>< \$25,000</td> <td><input type="checkbox"/></td> </tr> <tr> <td>\$25,000 - \$34,999</td> <td><input type="checkbox"/></td> </tr> <tr> <td>\$35,000 - \$49,999</td> <td><input type="checkbox"/></td> </tr> <tr> <td>\$50,000 - \$74,999</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>≥ \$75,000</td> <td><input type="checkbox"/></td> </tr> </table>	< \$25,000	<input type="checkbox"/>	\$25,000 - \$34,999	<input type="checkbox"/>	\$35,000 - \$49,999	<input type="checkbox"/>	\$50,000 - \$74,999	<input checked="" type="checkbox"/>	≥ \$75,000	<input type="checkbox"/>	<p>The approximate percentage of people in the community who are living in poverty (choose the best estimated category):</p> <table border="1"> <tr> <td>< 5%</td> <td><input type="checkbox"/></td> </tr> <tr> <td>5 - 9%</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>10 - 14%</td> <td><input type="checkbox"/></td> </tr> <tr> <td>15 - 19%</td> <td><input type="checkbox"/></td> </tr> <tr> <td>≥ 20%</td> <td><input type="checkbox"/></td> </tr> </table>	< 5%	<input type="checkbox"/>	5 - 9%	<input checked="" type="checkbox"/>	10 - 14%	<input type="checkbox"/>	15 - 19%	<input type="checkbox"/>	≥ 20%	<input type="checkbox"/>
< \$25,000	<input type="checkbox"/>																				
\$25,000 - \$34,999	<input type="checkbox"/>																				
\$35,000 - \$49,999	<input type="checkbox"/>																				
\$50,000 - \$74,999	<input checked="" type="checkbox"/>																				
≥ \$75,000	<input type="checkbox"/>																				
< 5%	<input type="checkbox"/>																				
5 - 9%	<input checked="" type="checkbox"/>																				
10 - 14%	<input type="checkbox"/>																				
15 - 19%	<input type="checkbox"/>																				
≥ 20%	<input type="checkbox"/>																				
	<p>The approximate percentage of people in the community who are currently unemployed (choose the best estimated category):</p> <table border="1"> <tr> <td>< 5%</td> <td><input type="checkbox"/></td> </tr> <tr> <td>5 - 9%</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>10 - 14%</td> <td><input type="checkbox"/></td> </tr> <tr> <td>15 - 19%</td> <td><input type="checkbox"/></td> </tr> <tr> <td>≥ 20%</td> <td><input type="checkbox"/></td> </tr> </table>	< 5%	<input type="checkbox"/>	5 - 9%	<input checked="" type="checkbox"/>	10 - 14%	<input type="checkbox"/>	15 - 19%	<input type="checkbox"/>	≥ 20%	<input type="checkbox"/>										
< 5%	<input type="checkbox"/>																				
5 - 9%	<input checked="" type="checkbox"/>																				
10 - 14%	<input type="checkbox"/>																				
15 - 19%	<input type="checkbox"/>																				
≥ 20%	<input type="checkbox"/>																				

Demographic Information
 Physical Activity
 Nutrition
 Tobacco Use
 Chronic Disease Management

After you have finished completing each of the item responses for all the sectors and modules for which your team generated data, the *CHANGE* tool provides a summary of all the scores, as shown in Figure 14. The percentages automatically populate into the table for each of the modules. You can then manually enter the numbers into the *CHANGE* Summary Statement, Figure 15, which is discussed in further detail in Action Step 7.

Action Step 7. Review Consolidated Data

After ratings have been assigned to the items in each sector, your team determines areas for improvement, and develops a Community Action Plan. Reviewing the data is a critical process to ensure resulting strategies are supported by evidence. Action Step 7 is divided into four tasks (7a–7d) for ease of completion:

- Step 7a—Create a *CHANGE* Summary Statement.
- Step 7b—Complete the Sector Data Grid.
- Step 7c—Fill out the *CHANGE* Strategy Worksheets.
- Step 7d—Complete the Community Health Improvement Planning Template.

Action Step 7a: Create a *CHANGE* Summary Statement

CHANGE data can be transferred into a *CHANGE* Summary Statement (see example in Figure 15) for quick reference of all sites with module percentages across all sectors. This is a manual process, so double-check the work to ensure ratings are copied accurately. At this step, it is important to look at the numbers generated using *CHANGE* and to identify the greatest community needs. After all sites have been completed for the five sectors, tabulate and summarize data to prioritize key actions to be included in your Community Action Plan. Use the data for all sites in each sector to develop the *CHANGE* Summary Statement, which helps to organize and review module data (e.g., physical activity, nutrition, chronic disease management) within each sector. A low score for a module indicates that policy and environmental change strategies are missing from that site. A high score indicates that the site has begun to implement strategies or has strong ones already in place.

Figure 15. Example *CHANGE* Summary Statement (Community-At-Large Sector)

Community Health Assessment and Group Evaluation		
Community-At-Large Summary		
COMMUNITY NAME: <input type="text"/>		
Module	Community	
	Policy	Environment
Physical Activity	56.72%	46.15%
Nutrition	56.92%	45.52%
Tobacco Use	49.20%	65.45%
Chronic Disease Management	55.50%	60.50%
Leadership	43.25%	52.75%
Demographic Information		
Community Density - Population	686,712	
Community Density - Sq Miles	271	
Community Setting	Rural	
Median Household Income	51,437	
% No High School Diploma	5	
% Poverty	8	
% Unemployed	3.1	

Action Step 7b: Complete the Sector Data Grid

Use the *CHANGE* Summary Statement to fill out the Sector Data Grid. By providing a quick data reference across all five *CHANGE* sectors, a completed Sector Data Grid helps communities to easily review and determine areas to address through the Community Action Plan. Identifying sectors and related modules with low scores is useful for informing priority areas for improvement and determining what specific strategies to incorporate into the plan.

The grid is set up to show the sector designation for the data in the summary statement. For each sector, indicate where each site's module (row) percentages fall in the appropriate column. School, for example would have the designation SP1 (for the first school site assessed for policy) and SE1 (for the first school site assessed for environment). For Community-At-Large, place a CALP1 (remember there is only one site assessed for this sector) in each row to denote this site's policy module percentages across the scale (low [0–20%] to high [81–100%]). The area of the table highlighted in red indicates the proper way to denote the single Community-At-Large Sector. Add additional sites on the Sector Data Grid until all sites are represented. Repeat this process for environmental change strategies for all sites (e.g., WE1, WE2, and

WE3). This action step supports a comprehensive view of all the data and reveals how the sites compare to each other. It builds a spectrum against which your community team can begin thinking about gaps, needs, assets, and areas of change. Table 3 shows an example of a completed grid. This Action Guide recommends collecting data from a minimum of three sites, but you are encouraged to expand to more whenever possible. In Table 3, the Work Site/Physical Activity row shows that five sites (WP1–WP5) were evaluated.

Table 3. Example of a Sector Data Grid

		LOW		MED		HIGH
		0-20%	21-40%	41-60%	61-80%	81-100%
Community-At-Large (CAL)	Physical Activity			CALP1, CALE1		
	Nutrition		CALP1, CALE1			
	Tobacco				CALP1, CALE1	
	Chronic Disease Mgt				CALE1	CALP1
	Leadership		CALE1	CALP1		
Community Institution/ Organization (CIO)	Physical Activity		CIOP1	CIOE1	CIOP2, CIOE2, CIOP3	CIOE3
	Nutrition			CIOE1, CIOP1, CIOE2	CIOP2, CIOE3	CIOP3
	Tobacco				CIOP2, CIOE3, CIOP3	CIOP1, CIOE1, CIOE2
	Chronic Disease Mgt	CIOP1, CIOE1	CIOP2	CIOE2, CIOP3, CIOE3		
	Leadership		CIOE2, CIOP2	CIOE3	CIOP3, CIOE1	CIOP1
School	District	SP1, SE2		SIE	S3P	
	Physical Activity	SP1, SE1, SP2, SE2	S3P, S3E			
	Nutrition		SP1, SP2, SE2	SE1	SP3	SE3
	Tobacco	SP3, SE3	SE2	SP2, SE1	SP1	
	Chronic Disease Mgt	S1P, S1E	S2P	SE2, SP3, SE3		
	Leadership		SP1	SE1, SP3, SE3	SE2, SP2	
	After-School	SP3	SP1, SE1, SE3	SP2, SE2		

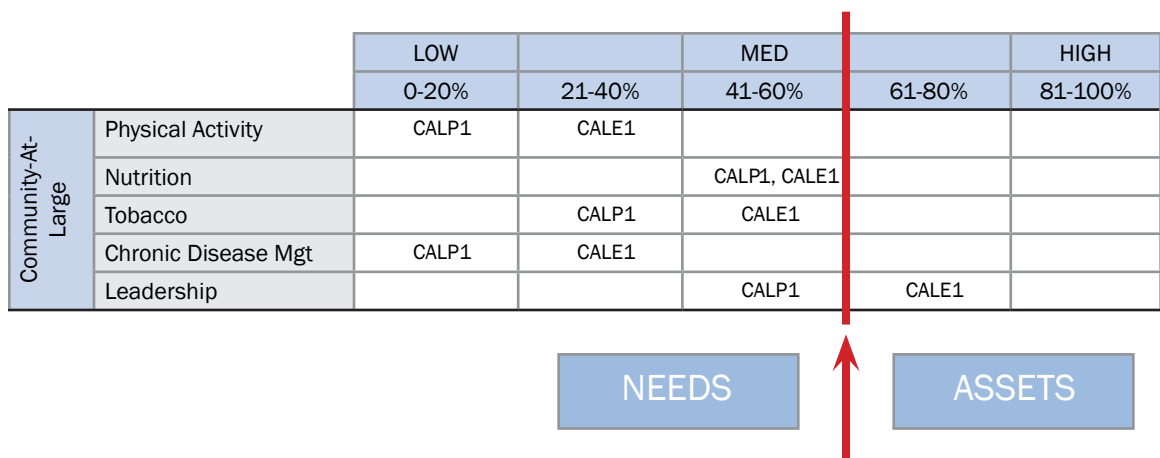
Work Site	Physical Activity			WE1, WP2, WE5	WP1, WE2, WP3, WP4, WE4, WP5	WE3
	Nutrition		WP1, WE1	WP2, WE2	WP3	
	Tobacco		WP2		WP1, WE1, WE2, WP3, WE3	
	Chronic Disease Mgt				WE1, WP3, WE3, WE5	WP1, WP2, WE2
	Leadership		WE1		WE2, WP3, WE3	WP2

Health Care	Physical Activity				HE2, HP3, HE3	HP1, HE1, HP2
	Nutrition			H2P	HE2, HP3, HE3	HP1, HE1
	Tobacco				HE2, HP3, HE3	HP1, HE1, HP2
	Chronic Disease Mgt		HP1, HE1	HE2, HP3, HE3	HP2	
	Leadership			HP1, HE1, HP2	H2E2, HP3, HE3	

CAL E1 CAL = Community-At-Large Sector E = Environment 1= Site number (if you have multiple sites, number them consecutively, 1, 2, 3 and so forth)

Some communities find it useful to designate a “cut-off point” between the community’s assets and needs. In Figure 16, the red line is the cut-off point, dividing assets and needs. As a group, decide on cut-off points. This process helps to develop Community Action Plan strategies as you move into Action Step 7d.

Figure 16. Designation of Assets and Needs



Action Step 7c: Fill Out the *CHANGE* Strategy Worksheets

With the help of the Sector Data Grid, look across all the data for needs and assets. Identify focal policy, systems, and environmental change strategies that are both in place (i.e., assets) and missing (i.e., needs). Refer back to Figure 16 where your team designated a cut-off point—those elements to the right of the line would be considered assets; those to the left are the needs. Augment both worksheets with supplemental data gathered during the community assessment process. These worksheets are important starting points in your community dialogue to define community needs, inform priority areas, and create a data-driven process for the development of the Community Action Plan. Create as many bullets as your data affords. You may consider opening the actual *CHANGE* Sector Excel Files to list out the policy, systems, and environmental change strategies as assets and needs. The bulleted list of items called for in the worksheets could be generated from this information. The *CHANGE* Strategy Worksheets are built in Microsoft Office Word specifically to expand to fit the volume of information your team may generate. The worksheets augment the *CHANGE* data and serve as living documents to record thoughts, brainstorm with the team, and prioritize the assets and needs that will shape the Community Action Plan. The data collected for the Community Institution/Organization, Health Care, School, and Work Site Sectors should be relevant to the geographic boundaries of your defined community. Be specific because not only will you be able to relate the strategies back to data, but also doing so will aid in the evaluation process.

Policy, Systems, and Environmental Change Strategy Worksheet 1

Policy, Systems, and Environmental Change Strategies: Assets

Community-At-Large Sector:

- Playgrounds and public parks are well-maintained.
- Sidewalks are well-maintained and well-lit in the downtown area.
- City government is proactive about developing support for healthy lifestyles due to mayor's Get Active initiative.

Community Institution/Organization (CIO) Sector:

- Bike trail proposed (Rails to Trails considered).
- Bike patrol around senior center walking paths by police department.
- 3 out of the 4 child care sites assessed have voluntary tobacco-free campus policies.

Health Care Sector:

- Private physician's office takes routine body mass index readings (BMIs) when patients appear for office visits.
- Patients referred to tobacco quit line; one provider is conducting a health mentoring program.
- Pediatricians are proactive about the youth obesity problem by participating in city school board meetings regarding school compliance with 150 minutes per week of physical education for elementary school children.

School Sector:

- Joint use agreement exists for playgrounds with city in summer months.
- School gardens at 2 out of the 5 elementary schools assessed supply fresh produce to school cafeteria.
- Extension staff members in schools teach gardening skills to students in grades 9–12.
- District-wide tobacco-free campus policy is in place for grades K–12.

Work Site Sector:

- Large work sites (e.g., casino and city government) make discounts to YMCA available to employees.
- Employee wellness coalition developed by local small business.

Policy, Systems, and Environmental Change Strategy Worksheet 2

Policy, Systems, and Environmental Change Strategies: Needs

Community-At-Large Sector:

- County budget cuts threaten development of sidewalks for all new neighborhoods.
- County architecture board reviewing guidelines for all new developments and sidewalks.
- Bike lanes are needed in congested areas of the city, especially downtown.

Community Institution/Organization (CIO) Sector:

- Need safe place to walk and bike around senior centers.
- Safety issues (e.g., lighting and fences) around city-owned walking trail and recreational areas.
- 2 out of 3 churches identified a need to enhance current health ministries or create new ones to promote healthy church environment (e.g., offering healthy food options at church-sponsored events).

Health Care Sector:

- Assessments used by health care provider speak to nutrition but not physical activity.
- Primary providers addressing physical activity and nutrition through patient education and referrals but not tobacco use and exposure.

School Sector:

- No structured physical education class in grades 9-12.
- Would like CPR training for teachers district-wide.
- Need for fundraisers involving things other than candy bars and cookies in grades K-5.
- 3 out of 5 elementary schools assessed were found to use pizza parties and candy as rewards for school competitions (e.g., top fundraiser or class with least absences in nine-week period).

Work Site Sector:

- Lack of established, marked (distance) walking areas at work sites.
- Work site health screenings available but at a high cost to employees.

Action Step 7d: Complete the Community Health Improvement Planning Template

Now it is time to start crafting the strategies! Using the *CHANGE* Strategy Worksheets, prioritize and list the top strategies for the Community Action Plan along with crucial information about next steps for implementation, lead or primary contact for action, and timeline for strategy completion. Teams should not feel pressured to address every weakness and strength. The goal is to prioritize what is doable given the time and resources. Table 4 shows examples of strategies and the timeline to execute each. The team determines how many strategies to include. Some considerations are resources, timing, and competing community priorities. Remember this is a roadmap: balance the enthusiasm of the team with achievable strategies.

Consider your priorities. Decide which strategies are the most doable. Once the team has agreed on priorities, enter the first strategy into the box. Think about the next step to achieve the change. Do you need to speak with someone at the organization to gain additional data? Is there an existing policy that can be leveraged? Who in the community is able to provide feedback to aid in the evaluation?

Next, identify the person within your team who is responsible for completing the strategy and enter his or her name in the Lead/Primary Contact column. Next, estimate and enter the time to complete the change strategy. Be specific and realistic! If the strategy's completion depends on actions by several individuals or organizations, allow time for stakeholder coordination. Finally, outline what can be accomplished within the timeline. Abundant detail allows the team to come back and measure progress against goals next year. If a different person is conducting the evaluation in the future, or new members join the team, documentation is available.

Table 4. Community Health Improvement Planning Template

Sector: Policy/ Environmental Change Strategy	Next Steps	Lead/Primary Contact	Timeline
Community-At-Large Sector: Require sidewalks to be built for all developments (e.g., housing, schools, commercial)	<ul style="list-style-type: none"> ▪ Review sidewalk ordinance for policy language and language gaps. ▪ Meet with county architecture board about sidewalk development and share draft of revised ordinance language for new developments. ▪ Attend city council meeting to inquire about stance on sidewalks for future developments and current budget for developing sidewalk network. ▪ Hold town halls with neighborhood home owners' associations to build local support for revised ordinance. 	<ul style="list-style-type: none"> ▪ John Smith ▪ Amy Coleman ▪ Nathan Fisher ▪ Geoffrey Bowker 	<ul style="list-style-type: none"> ▪ 6–12 weeks from initial planning meeting ▪ 6 weeks from completion of gap analysis (next step #1) ▪ 6–8 weeks from initial planning meeting ▪ 6 weeks from city council meeting

Action Step 8. Build the Community Action Plan

The final action step for completing *CHANGE* is to build the Community Action Plan. Careful execution of the previous seven action steps makes this task fairly straightforward. A quality plan contains sufficient details to map a clear course of action. Table 5 shows an example of a Community Action Plan. As you complete the Community Action Plan and craft the objectives, be sure they are SMART—specific, measurable, achievable, realistic, and time-phased. The definition of a SMART objective is explored in more detail in Figure 17. Of particular importance in this example is the presence of two objectives: project period objective and annual objective. The project period objective allows your team to look at the big picture of what can be accomplished over a multi-year period. For example, in Table 5, the project period objective is *by Year 3 increase the percent of total miles of physical infrastructure for walking by 30%*. Always provide a description of the project period objective to give context for what your team hopes to achieve (e.g., the establishment of sidewalks, trails, or walking paths across the community). As you think about your work, narrow the focus to certain chronic diseases and conditions and their related risk factors, such as obesity and physical inactivity. Concentrating on these priority areas rather than a broader view will enable your team to craft very specific, actionable objectives with real impact.

Annual objectives cover a 12-month timeframe and show incremental progress toward completion of the project period objective. As with the project period objective, it is important to provide a description of the annual objective. In Table 5, only one annual objective, *at the end of 12 months, increase percent of developments (e.g., housings, schools, and commercial) with paved sidewalks to 100%*, is listed for the project period objective. However, your team could write two additional annual objectives that address trails and walking paths to fully achieve the project period objective. Similar to the Community Health Improvement Planning Template in Action Step 7, it is important to associate each annual objective with a particular sector. You may develop multiple annual objectives that cut across more than one sector for a project period objective. While, in this example, the sector impacted is Community-At-Large Sector, a second objective could be developing trails around senior centers, which would impact the Community Institution/Organization Sector. For each annual objective, indicate the number of people reached through its successful completion. Reach is the extent to which a policy affects the intended audience. Think about how many people will be affected by a sidewalk ordinance requiring paved sidewalks for all developments.

The final section of the Community Action Plan template is where you list the activities that support the accomplishment of an annual objective. When listing activities, be sure to provide a title and clear descriptions of key milestones. Avoid listing tactical tasks in this section. For example, the town hall meeting is more significant than the telephone calls your team makes to secure the time, date, and location of the meeting. The activities listed in Table 5 serve as examples; for each annual objective the recommendation is to list no more than ten activities, which may limit these activities to key actions for completing the annual objective.

Table 5. Example of a Community Action Plan

Project Period Objective	Description of the Objective	Priority Area
By Year 3, increase the percent of total miles of physical infrastructure for walking by 30%.	Very few neighborhoods and community common areas have sidewalks, trails, or walking paths that can support residents' need for active transportation to school and work and the ability to be physically active within the majority of the community.	Obesity and Physical Inactivity
Annual Objective	Description of the Objective	Sector
At the end of 12 months, increase percent of developments (e.g., housing, schools and commercial) with paved sidewalks to 100%.	Current sidewalk ordinance does not require sidewalks to be paved for new housing developments with less than 120 homes; schools and commercial developments can receive a waiver if building in rural areas (designated by certain zip codes). Ordinance must be evaluated, revised, and approved to exclude such exceptions and begin developing stronger sidewalk networks.	Community-At-Large
		Number of People Reached 167,000
Activities	Activity Title	Description
	Gap analysis on existing ordinance	Review sidewalk ordinance for policy language and language gaps
	Meeting with county architecture board	Meet with county architecture board about sidewalk development and share draft of revised ordinance language for new developments
	City Council meeting	Attend city council meeting to inquire about stance on sidewalks for future developments and current budget for developing sidewalk network
	Town hall meetings	Hold town hall meetings with neighborhood home owners associations to build local support for revised ordinance

Figure 17. Definitions of Objectives in Community Action Plan

SMART Objectives are :

1. **Specific:** Objectives should provide the “who” and “what.” Use only one action verb, because objectives with more than one verb imply that more than one activity or behavior is being measured. Remember, the greater the specificity, the greater the measurability.
2. **Measurable:** The focus is on “how much” change is expected. Objectives should quantify the amount of change expected. The objective provides a reference point from which a change in the target population can clearly be measured (e.g., over the next 12 months).
3. **Achievable:** Objectives should be attainable within a given time frame and with available community resources.
4. **Realistic:** Objectives are most useful when they accurately address the scope of the problem and action steps that can be implemented within a specific time frame. Also, make sure the objective addresses the scope of the health issue and proposes reasonable next steps.
5. **Time-phased:** Objectives should provide a time frame indicating when the objective will be measured or a time by which the objective will be met. Including a time frame in the objectives helps to plan and evaluate the strategy.

Project Period Objectives are SMART, span the lifecycle of a project period (e.g., 3 years or 5 years), and identify the long-term objective for the selected priority area(s).

Annual Objectives are SMART objectives that quantify the results achieved within a 12-month period and identify policy, systems or environmental strategies promoting healthy practices and increased exposure to healthy environments.

Activities are milestones or actions that a community team implements in order to achieve an objective. Activities support the accomplishment of annual objectives. Milestones are the most significant activities that a community team will conduct and not the day-to-day tasks, such as conference calls.

LOOKING BEYOND

Congratulations on completing the *CHANGE* tool! Your team successfully executed a mixed-method data-collection effort, and crafted a detailed set of recommendations on how to achieve necessary community change.

But the work does not end here. You are in the fourth phase of the community change process - implementation. As the Community Action Plan takes shape, consider steps to maintain the momentum of your *CHANGE* activities. Your Community Action Plan has tight timelines associated with it, so begin to coordinate your resources to make sure your plans are completed. Track your progress, note key successes, and document obstacles to completing the Community Action Plan. This is the time to connect with partner organizations, reach out to stakeholders, and rally support for your work. The knowledge that you have unique data to support your efforts will be compelling.

As the Community Action Plan progresses, share the data and your accomplishments with the individuals and organizations that contributed their time and expertise. Although anonymity is important to protect the interests of those who participated, everyone will be interested in the community-wide data your team collected. What about a town hall meeting to share the results? Could you write a policy brief or one-pager? Perhaps you can add a section to the community e-newsletter? Brainstorm ways to share your success and maintain the energy of the *CHANGE* process. You may be pleasantly surprised at the number of people who can use your hard work to further their own initiatives.



A template for building a concise summary of your *CHANGE* activities (e.g., one-pager) can be found on the CD-ROM included with this Action Guide.

Finally, applaud your achievements! Share your thoughts about the *CHANGE* process with your community team, other communities like yours, and partners. Be sure to document successes and lessons learned, identify resources your team needs, and plan for next year. Reflect on how things are working, the viability of the Community Action Plan, and methods to ensure that your activities have been completed according to the plan. Consider key evaluation questions to aid in this process.



Question: How should the community team share community data from *CHANGE* with the media and/or other public forums?

Answer: It is up to each community team to decide if sharing *CHANGE* data is warranted in order to rally attention or public support for your efforts. Confidentiality is always an important element of data-collection; thus, community teams should not list who they talked with or provide specific details about data that could specifically link with an individual, community organization, or institution. Instead, the suggestion would be to share data in aggregate for a sector. For example, you could provide insight about work sites by stating that “across the ten work sites examined by the community team, four had policies requiring healthy food choices in vending machines in work sites, two were in the process of formulating a policy, and four had no formal policy regarding vending machine healthy food choices.” The appropriate information about local employers is still shared without singling out a specific work site. Lastly, just as you have a designated data manager, you may also want to choose a point person for all communication to media and other information outlets. A communications manager maintains the consistency of the type and quality of information being shared.

EVALUATION AND REASSESSMENT

Welcome to the evaluation phase! This is the fifth phase of the community change process. Evaluation is important, and is woven into every aspect of the work you have done thus far.

Many communities have asked “now that I have completed the *CHANGE* tool, what is the expectation for how these data can be used?” Your dataset is a reflection of what is happening in your community, so the possibilities of how to utilize the information are endless.

Two critical components of the evaluation phase are:

- Defining the criteria for success.
- Establishing a way to measure impact.

Include these two components in the evaluation plan to ensure your team answers questions about its process and outcomes. Evaluation should be reflected throughout all the phases and not saved until the end.

In defining the criteria for success, consider what success looks like for your community. Look across all the data and think about what is reasonable in the time allocated with the resources available. Note obstacles to success, such as implementation of policy that is in direct opposition to the change you are trying to

make. Each time you complete an assessment, it raises awareness of areas of the community that have greatest need. Assessment is a vehicle for change to occur. By simply going through this process, you create a greater knowledge base. Circle back continuously to share new information so it radiates out to other areas of the community with which you may not have had direct contact. Change in one sector can spill over into another with a positive impact. For example, the e-newsletter your team generates may report on policies implemented in the School Sector; it may be read by a Health Promotion Director in a work site who is able to capitalize on that information for successful implementation with his or her employees.

How will your team determine if success has been achieved? A strong evaluation involves asking questions, which may require you to revisit the sites and sectors from which you gathered the original data. For example, if a work site is in the initial stages of implementing a policy that supports annual wellness exams for employees at a reduced cost, the evaluation question could be: *Have you seen an increase in the number of employees receiving annual exams since instituting this policy?*

Be sure to evaluate your team's progress. Progress takes many forms, starting with completing the *CHANGE* tool the way it is laid out in this Action Guide. Did you skip any action steps? Did you complete at least three sectors? Did you use multiple data-collection methods? How effective have you been in implementing your Community Action Plan? Are there any areas that went unaddressed? If so, why?

Remember that *CHANGE* is an annual process. As your assessment activities come to a close, think about how to reassess next year. What progress has been made against the objectives of your Community Action Plan? What obstacles posed a challenge to meeting your objectives? What steps can your community take to clear those hurdles and move forward? Assessment helps to pinpoint areas of interest for you. Going through the process enables change to occur whether your community team focuses on those areas or not. There may be successes in the two or more sectors you examined in one year; reassessment may necessitate adding more sectors so you have current, reliable data to modify your Community Action Plan. Reassessment also involves reviewing first-year *CHANGE* data and evaluating your community's progress. How have the scores for each sector changed over time and why? What relationships should your community build to ensure continued success? Your team may have generated a list of needs and assets that were only partially addressed in the first year. How can you now further implement these strategies? This may also be an opportunity to expand the data-collection process. For example, if in the first year your community team utilized focus groups and walkability audits to gather data, add telephone surveys or windshield tours in the reassessment phase. This will expand your dataset and provide new examples of actionable strategies for your community.

CONCLUSION

We applaud your team's vision and efforts to create a healthier community. The time and energy dedicated to completing *CHANGE* as well as the relationships established between and among the members of your team will definitely benefit your community. We encourage you to continue the assessment and evaluation efforts started here by utilizing the resources included on the attached CD-ROM. Please share this Action Guide with your stakeholders and other organizations that could benefit from using *CHANGE*.

APPENDIX A. GLOSSARY OF TERMS

This Glossary of Terms contains all the underlined terms in the *CHANGE* tool and key terms contained within this Action Guide.

Access to farmers' markets: All of the following variables would support having access to farmers' markets:

- Located within 1 mile of a public transportation stop.
- Open ≥ 2 days per week.
- Having more than one farmer on site.
- Accepting Electronic Benefits Transfer (EBT) cards.
- Accepting farmers' market coupons.
- Accepting senior farmers' market coupons.

More information can be found at:

<http://www.leadershipforhealthycommunities.org/content/view/352/154>

http://www.cdc.gov/obesity/downloads/community_strategies_guide.pdf

Active time: Engaging in physical activity that is moderately to vigorously active, and equal in intensity to (or more strenuous than) fast walking. More information can be found at:

<http://www.thecommunityguide.org/pa/pa-ajpm-recs.pdf>

American Heart Association (AHA): A national voluntary health agency whose mission encompasses: "Building healthier lives free of cardiovascular diseases and stroke." AHA treatment guidelines can be found at:

<http://www.americanheart.org/presenter.jhtml?identifier=3004546>

Americans with Disabilities Act (ADA): Gives civil rights protection to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. ADA guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government services, and telecommunications. More information can be found at:

<http://www.ada.gov/>

Appropriate BMI: Body Mass Index (BMI) is a number calculated from a person's weight and height. For adults 20 years old and older, BMI is interpreted using standard weight status categories that are the same for all ages and for both men and women. For children and teens, aged 2 through 19 years old, the interpretation of BMI is both age- and sex-specific. More information can be found at:

http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

<http://apps.nccd.cdc.gov/dnpabmi/>

Bike facilities: Improvements and provisions made by public agencies to accommodate or encourage bicycling, including parking and storage facilities, and shared roadways not specifically designated for bicycle use. More information can be found at:

<http://www.fhwa.dot.gov/environment/bikeped/design.htm>

<http://adironackresearch.com/projects/bicycle/hglossary.html>

<http://www.rvarc.org/bike/bicyclefacilitieschapter3.pdf>

Bike lanes: Portions of a roadway that have been designated by striping, signing, and pavement markings for the preferential or exclusive use of bicyclists. More information can be found at:

<http://www.bicyclinginfo.org/engineering/facilities-bikelanes.cfm>

Breastfeeding initiative: An initiative that protects, promotes, and supports breastfeeding by providing staff such as nurses, physicians, radiology staff, pharmacy staff, food service and housekeeping staff with education and training, encouraging early breastfeeding initiation, supporting cue-based feeding, restricting supplements and pacifiers for breastfed infants; educating mothers to increase their breastfeeding knowledge and skills; and providing professional support by health professionals, focusing on counseling, encouragement, and managing lactation crises. More information can be found at:

http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf

Case-management Plan: A comprehensive set of services provided by either an individual or a team of medical professionals, school staff, and/or social work staff. These services include:

- Providing referrals to primary health care providers.
- Ensuring an appropriate written action plan is obtained.
- Ensuring access to and appropriate use of medications and tools (e.g., spacers, peak flow meters, glucose monitors) at home and at school.
- Offering education related to a disease or condition for a student and family.
- Facilitating environmental modifications at home and at school.
- Identifying and addressing psychosocial issues related to a disease or condition.
- Providing additional support services as needed.

More information can be found at:

http://www.cdc.gov/HealthyYouth/Asthma/pdf/Addressing_Asthma.pdf

Child Nutrition and WIC Reauthorization Act of 2004: Congress began the process of reauthorizing federal child nutrition programs in early 2003. The process concluded in June 2004 with the passage of reauthorization legislation that will improve both the child nutrition programs and health outcomes for children. Specifically, it expanded the availability of nutritious meals and snacks to more children in schools and improved the quality of food in schools. More information can be found at:

http://www.fns.usda.gov/cnd/Governance/Legislation/Historical/PL_108-265.pdf

Chronic Care Model: Provides an organizational approach for caring for people with chronic disease in a primary care setting. The Chronic Care Model advocates that improvements in approaches to chronic conditions can be accomplished by creating a health care system that is practical, supportive, population- and evidence-based, and promotes an interactive relationship between patients informed and motivated and a health care team that is prepared and proactive. Components of the Chronic Care Model can be found at:

http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Models=2

Comfortable, private space: Includes at a minimum: four solid walls, a lockable door, a power outlet, a chair, and appropriate signage to locate and identify room, and procedures for gaining access to it (such as access to key or lock combination). More information can be found at:

http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf

Community gardens: Gardening on land that is owned by a community group, institution, municipality, land trust, or some other entity. The process of growing, processing, and distributing food in and around cities and suburbs or urban agriculture provides individuals and families with many benefits. Advantages of urban agriculture include an alternative source of fresh produce, improved life satisfaction, and a way to preserve cultural identity and traditions. Most importantly, community gardening and urban farming have the potential to provide a supplemental source of fruits and vegetables. Food grown on these plots can be kept for personal consumption or used to procure supplemental income. Additional benefits of urban agriculture beyond food provision include building job skills, improving self-esteem, and contributing to community revitalization. Characteristics of community gardening initiatives comprise: land and supply procurement; organization of participants; reduction of barriers to fresh produce; production of primary or alternative source of fresh produce; and entrepreneurial gardens. More information can be found at:

<http://www.communitygarden.org/learn/>

Company-sponsored meetings and events: Meetings, conferences, and other work-related events should follow guidelines for selecting foods and beverages for breaks or meals. This is a process that can be institutionalized at a work site. Guidelines for healthy food and beverage options, which include whole grains, low sugar, fat-free and low-fat options as well as fruits and vegetables, at meetings and events can be found at:

www.cdc.gov/nccdphp/dnpaol/hwi/downloads/healthy_worksite_food.pdf

Complete streets: Streets that are designed and operated to enable safe access along and across the street for all users, including pedestrians, bicyclists, motorists, and transit riders of all ages and abilities. More information can be found at:

<http://www.completestreets.org/changing-policy/>

Cultural competence: Ability to interact effectively with people of different cultures. Cultural competence comprises four components: 1) awareness of one's own cultural worldview, 2) attitude towards cultural differences, 3) knowledge of different cultural practices and worldviews, and 4) cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with, people across cultures. More information can be found at:

http://www.xculture.org/NWRC_CultComp_Resource_Guide.php

Environmental Change (Environment): Physical, social, or economic factors designed to influence people's practices and behaviors. Examples of alterations or changes to the environment include:

- *Physical:* Structural changes or the presence of programs or services, including the presence of healthy food choices in restaurants or cafeterias, improvements in the built environment to promote walking (e.g., walking paths), the availability of smoking cessation services to patients or workers, and the presence of comprehensive school health education curricula in schools.
- *Social:* A positive change in attitudes or behavior about policies that promote health or an increase in supportive attitudes regarding a health practice, including an increase in favorable attitudes of community decision makers about the importance of nonsmoking policies or an increase in nonacceptance of exposure to second-hand smoke from the general public.
- *Economic:* The presence of financial disincentives or incentives to encourage a desired behavior, including charging higher prices for tobacco products to decrease their use or the provision of nonsmoker health insurance discounts.

More information can be found at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a2.htm>

Flexible work arrangements: When the work hours established by the employer are changed at the request of the employee. A flexible work arrangement is often requested by an employee who is trying to successfully meet work obligations while fulfilling a personal need or concern. Examples include: telecommuting, compressed work week, and flextime. More information can be found at:

<http://www.workplaceflexibility2010.org/>

Food as a reward or punishment: An example of using food as a reward is providing candy or fast-food coupons to students or patrons because they have behaved well or met an academic or fundraising goal. An example of withholding food as punishment is not giving one student or patron a snack or meal that is offered to all others because of his or her inappropriate behavior. More information can be found at:

<http://www.cdc.gov/HealthyYouth/SHI>

Greenways: Open space corridors that can be managed for conservation, recreation, and/or alternative transportation. Greenways often follow natural or existing land or water features such as ridgelines, stream valleys, rivers, canals, utility corridors, and abandoned rail lines. More information can be found at:

<https://www.msu.edu/~jaroszjo/greenway/green/what.htm>

Health disparities: Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States. More information can be found at:

<http://ncmbd.nih.gov/>

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=106_cong_public_laws&docid=f:publ525.106.pdf

Health Risk Appraisal: An assessment tool used by health promoters to evaluate an individual's health. The appraisal usually takes the form of an extended questionnaire on personal lifestyle, and personal and family medical history. The appraisal may also include a physical examination, laboratory tests of blood chemistry (e.g., of cholesterol level), blood pressure, and physical fitness levels. The outcome is a profile identifying specific risks (e.g., heavy smoking and sedentary lifestyle) with strategies and targets for reducing the risks. More information can be found at:

<http://www.wellness-program-incentives.com/wellness-program-incentives-health-risk-appraisals-health-risk-assessments/>

<http://www.bsu.edu/web/sdhaines/hra.htm>

Healthy food and beverage options: Healthy foods are fruits, vegetables, whole grains, and related combination products, and nonfat and low-fat dairy that are limited to 200 calories or less per portion as packaged. Healthy beverages are water without flavoring, additives, or carbonation, low-fat and nonfat milk, 100% fruit juice, and caffeine-free drinks. More information can be found at: Dietary Guidelines for Americans, 2005:

<http://www.health.gov/dietaryguidelines/dga2005/document/pdf/DGA2005.pdf>

<http://www.iom.edu/Reports2007/Nutrition-Standards-for-Foods-in-Schools-Leading-the-Way-toward-Healthier-Youth/CDC-Fact-Sheets-Nutrition-Standards-Food-Schools.aspx>

Incentives: Factors (financial or nonfinancial) that provide a motive for a particular course of action, or counts as a reason for preferring one choice to the alternatives. Examples are: certificates of appreciation or certificates of participation in the program, movie passes, transportation passes or tokens, phone cards, meal certificates, or cash. More information can be found at:

<http://www.policylink.org/site/c.lkIXLbMNJrE/b.5137443/apps/s/content.asp?ct=8047759>

Joint National Committee 7 (JNC7): The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure synthesizes the available scientific evidence and offers guidance to primary care clinicians. Guidelines can be found at:

<http://www.nhlbi.nih.gov/guidelines/hypertension/#guidelines>

Joint use agreement: A formal agreement between two entities — often a school and a city or county — setting forth the terms and conditions for shared use of public property or facilities. Agreements can range in scope from relatively simple (e.g., opening school playgrounds to the public outside of school hours) to complex (allowing community individuals and groups to access all school recreation facilities, and allowing schools to access all city or county recreation facilities). More information can be found at:

<http://www.cdc.gov/shpps>

Less than healthy foods and beverages: As defined by the Institute of Medicine, foods and beverages with a high content of calories, sugar, fat, and sodium and low content of nutrients, including protein, vitamins A and C, niacin, riboflavin, thiamin, calcium, and iron. More information can be found at:

<http://www.iom.edu/CMS/3788/30181/42502.aspx>

http://www.nap.edu/catalog.php?record_id=11015

Large grocery stores: Stores with 10 – 49 annual payroll employees. More information can be found at:

<http://www.policylink.org/site/c.lkIXLbMNJrE/b.5137443/apps/s/content.asp?ct=6994695>

<http://www.policylink.org/site/c.lkIXLbMNJrE/b.5137443/apps/s/content.asp?ct=6966229>

Mixed land use: The use of safe and well-maintained sidewalks, crosswalks, bicycle paths, trails, parks, recreational facilities, and community designs featuring mixed-use development (e.g., mixing residential and commercial in same area) and a connected grid of streets. More information can be found at:

<http://www.healthyplaces.org.au/userfiles/file/Mixed%20Land%20Use%20June09.pdf>

National Evidence-based Guidelines to Prevent Heart Disease, Stroke, and Related Risk Factors: Guidelines intended to assist primary care providers in their assessment, management, and follow-up of patients who may be at risk for but who have not yet manifested cardiovascular disease. More information on these guidelines can be found at:

<http://circ.ahajournals.org/cgi/content/full/106/3/388>.

National Health Education Standards: Expectations for what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health. Students will:

- Comprehend concepts related to health promotion and disease prevention to enhance health.
- Analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.
- Demonstrate the ability to access valid information, products, and services to enhance health.
- Demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
- Demonstrate the ability to use decision-making skills to enhance health.

- Demonstrate the ability to use goal-setting skills to enhance health.
- Demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.
- Demonstrate the ability to advocate for personal, family, and community health.

More information can be found at:

<http://www.cdc.gov/HealthyYouth/SHER/standards/index.htm>

National Physical Education Standards:

- Standard 1: The learner demonstrates competency in motor skills and movement patterns needed to perform a variety of physical activities.
- Standard 2: The learner demonstrates understanding of movement concepts, principles, strategies, and tactics as they apply to the learning and performance of physical activities.
- Standard 3: The learner participates regularly in physical activity.
- Standard 4: The learner achieves and maintains a health-enhancing level of physical fitness.
- Standard 5: The learner exhibits responsible personal and social behavior that respects self and others in physical activity settings.
- Standard 6: The learner values physical activity for health, enjoyment, challenge, self-expression, and/or social interaction.

More information can be found at:

<http://www.cdc.gov/HealthyYouth/PECAT/pdf/PECAT.pdf>

National School Lunch Program: A federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or free lunches to children each school day. More information can be found at:

<http://www.fns.usda.gov/cnd/Lunch/>

Pharmacological quitting aids: Because nicotine is a physical addiction, many smokers are better able to quit with Nicotine Replacement Therapy (NRT) products. These aids include nicotine gum, nicotine patch, nicotine inhaler, or other FDA-approved products. Many of these are available without a prescription. Some smokers also can benefit from the antidepressant drugs Zyban® or Welbutrin®, which require a prescription. More information can be found at:

<http://www.centerforcessation.org/documents/PharmacotherapyFINAL.pdf>

Physical activity as a punishment: An example of using physical activity as punishment is making students run laps or do push-ups as a consequence of inappropriate behavior. Withholding physical activity or education as punishment means not allowing students to attend all or part of physical education class as a consequence of inappropriate behavior in another class or failure to complete an assignment in another class. It does not refer to the physical education teachers' disciplining students during physical education class by having them sit out for a period of time. More information can be found at:

<http://www.cdc.gov/HealthyYouth/SHI>

Policies: Laws, regulations, rules, protocols, and procedures, designed to guide or influence behavior. Policies can be either legislative or organizational in nature. Policies often mandate environmental changes and increase the likelihood that they will become institutionalized or sustainable. Examples of legislative policies include taxes on tobacco products, provision of county or city public land for green spaces or farmers' markets, regulations governing the National School Lunch Program, and clean indoor air laws. Examples of organizational policies include schools requiring healthy food options for all students, a district ban on the sale of less than healthy foods throughout the school day, menu labeling in restaurants, required quality assurance protocols or practices (e.g., clinical care processes), or a human resources policy that requires healthy foods to be served at meetings. More information can be found at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a2.htm>

Portion size: Amount of a single food item served in a single eating occasion (e.g., a meal or a snack). Portion size is the amount of food offered to a person in a restaurant, the amount in the packaging of prepared foods, or the amount a person chooses to put on his or her plate. One portion of food might contain several U.S. Department of Agriculture (USDA) food servings. More information can be found at:

<http://www.cnpp.usda.gov/Publications/DietaryGuidelines/2000/2000DGBrochureHowMuch.pdf>

<http://www.rwjf.org/files/research/20090508lhcactionstrategiestoolkit.pdf>

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a2.htm>

Pricing strategies: Intentional adjustment to the unit cost of an item (e.g., offering a discount on a food item, selling a food item at a lower profit margin, or banning a surcharge on a food item). More information can be found at:

http://www.ehow.com/about_5432682_food-pricing-strategies.html

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm>

Protect a woman's right to breastfeed: This includes state laws and organizational policies defending a mother's rights to breastfeed in any location where the mother and child are authorized to be present. More information can be found at:

http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf

Provider-reminder system: Systems in health care settings that are successful in helping improve the delivery of their services. For example, systems that prompt health care providers to identify tobacco-using patients and to advise those patients against tobacco use at every visit. More information can be found at:

<http://www.prevent.org/content/view/159/178/>

Public policy process: Engaging in the public policy process is often the most effective way to implement and sustain environmental (social, built, economic) changes. The public policy process requires attention and action from decision-makers — elected officials, agency officials, institutional leaders, and other policymakers — as well as the constituencies that influence them, including community residents and leaders. Consequently, policies and practices that give rise to healthy environments must be identified, advocated for, and enacted within community-based organizations and throughout multiple levels of government. In this way, the public policy process can be seen as the steps a government or community-based organization takes to address a public problem. More information can be found at:

<http://www.mrsc.org/Publications/polmakpro.pdf>

Public recreation facilities: Facilities listed in the local jurisdiction's facility inventory that have at least one amenity that promotes physical activity (e.g., walking/hiking trail, bicycle trail, or open play field/play area). More information can be found at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a2.htm>

Quit Line: An information and counseling service that offers telephone support for people who want to quit using tobacco. Some quit lines offer additional services, such as nicotine replacement therapy, online cessation information and programs, and referral to tobacco-use treatment programs in the community. Quit lines that have proactive services provide clients with multiple scheduled follow-up sessions with quit line counselors during the quit process that do not need to be initiated by the client. The U.S. National Network of Tobacco Cessation Quit Lines is a state/federal partnership that provides tobacco users with access to the tools and resources they need to quit. The toll-free number 1-800-QUIT-NOW (1-800-784-8669) serves as a national portal to state-based quit lines—which have been established in every state—on the basis of the area code where the call originated. More information can be found at:

www.naquitline.org/?page=factsheetsetc

Reasonable walking distance: One mile is considered a reasonable distance to walk. More information can be found at:

http://www.cdc.gov/pcd/issues/2008/jul/pdf/07_0087.pdf

Referral system: A resource to which tobacco users are referred for more intensive interventions that supplement the tobacco-use treatment delivered by a health care provider. Users can be referred to programs or services within the health care delivery system itself or in the larger community. A quit line, the American Lung Association, and the American Cancer Society are examples of possible referral resources. More information can be found at:

<http://www.prevent.org/actionguides/Tobacco-UseTreatment.pdf>

Road diets: Techniques in transportation planning whereby a road is reduced in number of travel lanes and/or effective width in order to achieve systemic improvements (for walking and bicycling). More information can be found at:

<http://www.tfhrc.gov/safety/hsis/pubs/04082/index.htm>

Screen time: Time spent watching television, playing video games, or engaging in noneducational computer activities. More information can be found at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a2.htm>

Sequential health education: A curriculum that identifies, defines, and describes the skills and activities that should be covered on a yearly basis. Of special importance is the sequence of instruction throughout students' educational experience (i.e., K–12). Sequential means that current concept and skill learning is built on prior learning and sets a new foundation for learning more advanced concepts and skills in the future. Within health education, students need to be taught increasingly more complex nutrition concepts and advanced application of skills as they progress through their educational experience. More information can be found at:

<http://www.cdc.gov/HealthyYouth/HECAT/>

Sequential physical education: A curriculum that identifies, defines, and describes the skills and activities that should be covered on a yearly basis. Of special importance is the sequence of instruction throughout students' educational experience (i.e., K - 12). Sequential means that current concept and skill learning is built on prior learning and sets a new foundation for learning more advanced concepts and skills in the future. Within physical education, students need to be taught increasingly advanced forms of physical activity skills and concepts as they progress through their educational experience. More information can be found at:

<http://www.cdc.gov/HealthyYouth/PECAT/pdf/PECAT.pdf>

Shared use paths or trails: Part of a transportation circulation system that supports multiple recreation opportunities, such as walking, bicycling, and inline skating. A shared-use path typically has a surface that is asphalt, concrete, or firmly packed crushed aggregate. Shared-use paths can provide both transportation and recreation. More information can be found at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a2.htm>

Smoke-free policy 24/7 for indoor public places: A policy that prohibits smoking in indoor areas around the clock 24 hours a day, 7 days a week by anyone. Smoke-free policy can be extended to private residences used to provide childcare, foster care, adult care, and similar social services. The policy does not apply to the use of tobacco for cultural or traditional purposes. See sectors for sector-specific language. More information can be found at:

<http://www.tobaccofreekids.org/research/factsheets/pdf/0144.pdf>

http://www.cdc.gov/tobacco/basic_information/secondhand_smoke/guides/business/index.htm

<http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet4.html>

Smoke-free policy 24/7 for outdoor public places: Prohibit smoking in all outdoor areas 24 hours a day, 7 days a week by anyone. Smoke-free policy can be extended to private residences used to provide childcare, foster care, adult care, and similar social services. The policy does not apply to the use of tobacco for cultural or traditional purposes. See sectors for sector-specific language. More information can be found at:

<http://www.tobaccofreekids.org/research/factsheets/pdf/0144.pdf>

http://www.cdc.gov/tobacco/basic_information/secondhand_smoke/guides/business/index.htm

<http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet4.html>

Strategies: Means by which policy, programs, and practices are put into effect as population-based approaches (e.g., offering healthy food and beverage options in vending machines at schools, implementing activity breaks for meetings longer than one hour) versus individual-based approaches (e.g., organizing health fairs, implementing cooking classes, disseminating brochures). More information can be found at:

<http://www.rwjf.org/pr/product.jsp?id=42514>

<http://www.cdc.gov/mmwr/pdf/rr/rr5807.pdf>

Subsidized membership: A free or reduced-price membership, which is fully or partially financially supported by an individual's employer. More information can be found at:

http://findarticles.com/p/articles/mi_m0675/is_4_22/ai_n6113353/

http://www.hewittassociates.com/ MetaBasicCMAAssetCache /Assets/Legislative%20Updates/2008/State_and_Federal_Wellness_Initiatives_0408.pdf

Sugar-sweetened beverages: Beverages that contain added caloric sweeteners, primarily sucrose derived from cane, beets, and corn (e.g., high-fructose corn syrup), including nondiet carbonated soft drinks, flavored milks, fruit drinks, teas, and sports drinks. More information can be found at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a2.htm>

Supermarkets: Stores with ≥ 50 annual payroll employees. More information can be found at:

http://www.policylink.org/atf/cf/%7B97C6D565-BB43-406D-A6D5-ECA3BBF35AF0%7D/groceryattraction_final.pdf

Support breastfeeding: Support for breastfeeding in the workplace includes several types of employee benefits and services, including writing corporate policies to support breastfeeding women; teaching employees about breastfeeding; providing designated private space for breastfeeding or expressing milk; allowing flexible scheduling to support milk expression during work; giving mothers options for returning to work, such as teleworking, part-time work, and extended maternity leave; providing on-site or near-site child care; providing high-quality breast pumps; and offering professional lactation management services and support. More information can be found at:

<http://www.cdc.gov/breastfeeding/promotion/index.htm>

Systems change: Change that impacts all elements, including social norms of an organization, institution, or system; may include a policy or environmental change strategy. Policies are often the driving force behind systems change. Examples are implementing the National School Lunch Program across the state school system or ensuring a hospital system goes tobacco free.

Systematic approach to processes of diabetes care: Intended to provide clinicians, patients, researchers, and other interested individuals with the components of diabetes care, treatment goals, and tools to evaluate the quality of care. More information can be found at:

<http://care.diabetesjournals.org/cgi/content/full/26/10/2722>.

Tobacco cessation products: Over-the-counter nicotine patch, gum, or lozenge; prescription varenicline, bupropion SR, nicotine inhaler, or nasal spray. More information can be found at:

<http://www.abrq.gov/clinic/tobacco/medsmoktab.htm>.

Tobacco cessation services: Health care delivery administrators, insurers, and purchasers can promote the treatment of tobacco dependence through a systems approach. Purchasers (often business entities or other employers, state or federal government units, or other consortia that purchase health care benefits for a group of individuals) should make tobacco assessment and coverage of treatment a contractual obligation of the health care insurers and/or clinicians who provide services to them. Treating Tobacco Use and Dependence, a Public Health Service-sponsored Clinical Practice Guideline can be found at:

<http://www.surgeongeneral.gov/tobacco/>

<http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.section.28356>.

Tobacco-free policy 24/7: Prohibit the use of all tobacco products 24 hours a day, 7 days a week by anyone. Tobacco-free policy can be extended to private residences used to provide childcare, foster care, adult care, and similar social services. The policy does not apply to the use of tobacco for cultural or traditional purposes. See sectors for sector-specific language. More information can be found at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/00026213.htm>

<http://www.tobaccofreekids.org/research/factsheets/pdf/0153.pdf>

<http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet2.html>

Tobacco-free policy 24/7 for indoor public places: Prohibit the use of all tobacco products in all indoor areas 24 hours a day, 7 days a week by anyone. Tobacco-free policy can be extended to private residences used to provide childcare, foster care, adult care, and similar social services. The policy does not apply to the use of tobacco for cultural or traditional purposes. See sectors for sector-specific language. More information can be found at:

<http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/index.htm>

Tobacco-free policy 24/7 for outdoor public places: Prohibit the use of all tobacco products in all outdoor areas 24 hours a day, 7 days a week by anyone. Tobacco-free policy can be extended to private residences used to provide childcare, foster care, adult care, and or similar social services. The policy does not apply to the use of tobacco for cultural or traditional purposes. See sectors for sector-specific language. More information can be found at:

<http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/index.htm>

Traffic calming measures: The combination of principally physical measures that reduce the negative effects of motor vehicle use and improve conditions for nonmotorized street users. More information can be found at:

<http://www.fhwa.dot.gov/environment/tcalm/>

Underserved areas: Areas without availability of services or barriers to the use of available services. More information can be found at:

http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/HFHC_SHORT_FINAL.PDF

USDA School Meal Nutrition Standards: All school meals, as part of the U.S. Department of Agriculture National School Lunch Program and School Breakfast Program should:

- Provide one-third (lunch) and one-fourth (breakfast) of the Recommended Dietary Allowances (RDA) for protein, calcium, iron, vitamin A, and vitamin C for the applicable age or grade groups.
- Provide one-third of lunch time energy allowances (calories) and one-fourth of breakfast energy allowances for children, for the applicable age or grade groups.
- Follow the recommendations of the Dietary Guidelines for Americans, which include:
 - Choosing a variety of grains daily, especially whole grains.
 - Choosing a variety of fruits and vegetables daily.
 - Keeping food safe to eat.
 - Choosing a diet that is low in saturated fat and cholesterol and moderate in total fat.
 - Choosing beverages and foods to moderate intake of sugars.
 - Choosing and prepare foods with less salt.

More information can be found at:

<http://www.fns.usda.gov/cnd/Lunch/default.htm>

Walk or bike to school initiative: Community-based programs (e.g., Safe Routes to School, Walking School Bus) that aim to increase opportunities for daily physical activity by encouraging children to walk or bike to and from school in groups accompanied by adults. Programs advocate for communities to build partnerships with the school, Parent-Teacher Association, local police department, department of public works, civic associations, local politicians, and businesses to create an environment that is supportive of walking and bicycling to school safely. More information can be found at:

<http://www.saferoutesinfo.org/>

<http://www.walkingschoolbus.org/>

Women, Infants, and Children (WIC): A federally funded program that subsidizes food purchases for low-income women and young children. WIC farmers' market vouchers are known as Farmers Market checks. With these vouchers, participants can buy fresh fruits, fresh vegetables, and fresh cut herbs at approved farmers markets throughout the country. More information can be found at:

<http://www.fns.usda.gov/wic/>

APPENDIX B. SECTOR PARTICIPANT LIST

This list provides suggestions from previous *CHANGE* tool users for organizations, institutions, and participants that may help you get started with the data-gathering and completion process. The list is organized by sector. This list is not exhaustive; feel free to identify other sites and individuals who may provide feedback to assist in your work.

Community-At-Large Sector

Site	Participants
City Government	<ul style="list-style-type: none"> ▪ Director ▪ Risk manager ▪ Administrative assistant to city planner ▪ Health planner ▪ Residents ▪ City planner ▪ City engineer ▪ Director of city leisure services ▪ Mayor ▪ Financial analyst within city finance dept.
County Government	<ul style="list-style-type: none"> ▪ County executive ▪ Assistant county manager ▪ Planning director ▪ Health director ▪ Alliance for health board member ▪ Director of county conservation board ▪ Education director ▪ Director of parks and recreation ▪ Director of community and economic development ▪ Health department division manager ▪ Health department commissioner/director ▪ Health promotion coordinator
News Media	<ul style="list-style-type: none"> ▪ News anchor ▪ Reporter
Cooperative Extension	<ul style="list-style-type: none"> ▪ Family and consumer science agent
Board of Health	<ul style="list-style-type: none"> ▪ Board member
County Commissioners	<ul style="list-style-type: none"> ▪ Chairperson of county commissioners
City Bus Transportation	<ul style="list-style-type: none"> ▪ Director of operations ▪ Director of traffic
Minority Health Council	<ul style="list-style-type: none"> ▪ Project coordinator of health disparities initiative ▪ Chairman of minority health council
Community Assembly Groups	<ul style="list-style-type: none"> ▪ Farmer representative groups ▪ Neighborhood representation groups ▪ City district representation groups ▪ Disability advocacy groups ▪ Community food groups
Bike and Pedestrian Committee	<ul style="list-style-type: none"> ▪ Committee chair ▪ Committee members
County Office for the Aging	<ul style="list-style-type: none"> ▪ Director ▪ Staff ▪ Seniors
Tobacco Use Prevention and Control Program	<ul style="list-style-type: none"> ▪ Media use strategist

Community Institution/Organization (CIO) Sector

Site	Participants
YMCA	<ul style="list-style-type: none"> ▪ CEO ▪ Senior program director ▪ Executive director ▪ Director of operations ▪ Wellness director ▪ Program staff ▪ Site director
Food Bank	<ul style="list-style-type: none"> ▪ Director of programs ▪ Community programs manager
Church Child Development Center	<ul style="list-style-type: none"> ▪ Director
Head Start Agency	<ul style="list-style-type: none"> ▪ Executive director ▪ Site director ▪ Teachers ▪ Parents
Church	<ul style="list-style-type: none"> ▪ Pastor ▪ Associate pastor ▪ Parish nurse
Childcare Center/ Childhood Development Center	<ul style="list-style-type: none"> ▪ Director
Family Center	<ul style="list-style-type: none"> ▪ Executive director
Youth Center	<ul style="list-style-type: none"> ▪ Director
Community Action Organization	<ul style="list-style-type: none"> ▪ Executive director
Community College	<ul style="list-style-type: none"> ▪ Executive vice president of instruction & student development
University	<ul style="list-style-type: none"> ▪ Administrative staff ▪ Professor
Community Center	<ul style="list-style-type: none"> ▪ Daycare director ▪ Program staff ▪ Site director

Health Care Sector

Site	Participants
Hospice	<ul style="list-style-type: none"> ▪ Executive director ▪ Vice president of access
Private Practitioner	<ul style="list-style-type: none"> ▪ Office manager
Medical Clinic	<ul style="list-style-type: none"> ▪ Executive director ▪ Clinical director ▪ Practice manager ▪ Director of ambulatory services ▪ Pediatric and adolescent services ▪ Nurse supervisor ▪ Diabetes educator ▪ Clinical director ▪ Practice manager
Medical Center/ Group	<ul style="list-style-type: none"> ▪ Vice president ▪ Director of community outreach ▪ Nurse practitioner
Pediatric and Adolescent Services Clinic	<ul style="list-style-type: none"> ▪ Chief of pediatrics ▪ Nurse practitioner
Hospital	<ul style="list-style-type: none"> ▪ President or CEO ▪ Director of community health ▪ Vice president of regional operations ▪ Vice president ▪ Chief nursing executive ▪ Chief operating medical officer ▪ Staff
Local Health Department/Department of Health	<ul style="list-style-type: none"> ▪ Director of community health services ▪ Health promotion, planning and development manager ▪ School outreach and clinic division manager ▪ Elderly, cancer and chronic disease program manager ▪ Environmental health officer ▪ Public health nurse ▪ Community program coordinator
Senior Nursing Care Facility	<ul style="list-style-type: none"> ▪ Director ▪ Staff
Federally Qualified Health Center	<ul style="list-style-type: none"> ▪ Executive director ▪ Health planner ▪ Director of medical services
Health Department	<ul style="list-style-type: none"> ▪ Health promotion director
Childcare Center/Childhood Development Center	<ul style="list-style-type: none"> ▪ Director ▪ Nurse ▪ Staff

School Sector

Site	Participants
School	<ul style="list-style-type: none"> ▪ Principal ▪ Director of elementary schools ▪ Director of child nutrition ▪ Director of secondary schools ▪ Director of community education ▪ School nurse ▪ School staff
Public School System	<ul style="list-style-type: none"> ▪ Chairperson of health services ▪ Director of child and nutrition services
Charter School	<ul style="list-style-type: none"> ▪ PE instructor ▪ Food services director
School District	<ul style="list-style-type: none"> ▪ Curriculum coordinator ▪ Director ▪ After-school coordinator ▪ Tobacco-free coordinator ▪ Safe and drug-free coordinator ▪ Director of athletics ▪ Board of cooperative educational services (BOCES) ▪ Assistant principal ▪ After-school coordinator ▪ Food service staff ▪ School board member ▪ Superintendent/assistant superintendent

Work Site Sector

Site	Participants
County Government	<ul style="list-style-type: none"> ▪ Assistant county manager
City Government	<ul style="list-style-type: none"> ▪ Risk manager ▪ Mayor's executive assistant ▪ Collections department employee ▪ Human resources director ▪ Downtown development director
Hospice	<ul style="list-style-type: none"> ▪ Vice president of access
Textile Company	<ul style="list-style-type: none"> ▪ Human resources director ▪ Administrative assistant ▪ Risk manager ▪ CEO
Planning Department	<ul style="list-style-type: none"> ▪ Director
Public Works	<ul style="list-style-type: none"> ▪ Director
Police Department	<ul style="list-style-type: none"> ▪ HR manager/employee
Pet Product Store	<ul style="list-style-type: none"> ▪ CEO (franchise) ▪ Store manager
Medical Foundation	<ul style="list-style-type: none"> ▪ Director of human resources
Public Health Office	<ul style="list-style-type: none"> ▪ Nurse manager ▪ Nutritionist ▪ WIC clerk
Manufacturing Company	<ul style="list-style-type: none"> ▪ Chief financial officer ▪ Human resources director ▪ Executive director ▪ Safety supervisor ▪ Staff development coordinator ▪ Benefits coordinator ▪ Communication director ▪ Staff
Long-Term Care Facility	<ul style="list-style-type: none"> ▪ Occupational health and safety coordinator ▪ Nurse
Restaurant	<ul style="list-style-type: none"> ▪ General manager
Supermarket	<ul style="list-style-type: none"> ▪ Store director ▪ Registered dietician
Credit Union	<ul style="list-style-type: none"> ▪ Chief executive director ▪ Human resources director
Casinos	<ul style="list-style-type: none"> ▪ Casino employees
Food Bank	<ul style="list-style-type: none"> ▪ Executive director ▪ Director of programs
Bus Companies	<ul style="list-style-type: none"> ▪ Executive director ▪ Safety supervisor ▪ Staff development coordinator ▪ Benefits coordinator ▪ Communications director ▪ Staff
Childcare Centers	<ul style="list-style-type: none"> ▪ Owner ▪ Staff

Local Health Department	<ul style="list-style-type: none"> ▪ Administrative assistant to the director ▪ Community program coordinator ▪ Commissioner/director ▪ Staff development coordinator ▪ Human resources staff ▪ Public relations staff ▪ Staff
State Department of Transportation	<ul style="list-style-type: none"> ▪ Regional director ▪ Regional staff
Fire Department	<ul style="list-style-type: none"> ▪ Employee
County Government	<ul style="list-style-type: none"> ▪ County executive ▪ Assistant county manager ▪ Planning director ▪ Health director ▪ Alliance for health board member ▪ Director of county conservation board ▪ Education director ▪ Director of parks and recreation ▪ Director of community and economic development ▪ Health department division manager ▪ Health department commissioner/director ▪ Health promotion coordinator
News Media	<ul style="list-style-type: none"> ▪ News anchor ▪ Reporter
Cooperative Extension	<ul style="list-style-type: none"> ▪ Family and consumer science agent
Board of Health	<ul style="list-style-type: none"> ▪ Board member
County Commissioners	<ul style="list-style-type: none"> ▪ Chairperson of county commissioners
City Bus Transportation	<ul style="list-style-type: none"> ▪ Director of operations ▪ Director of traffic
Minority Health Council	<ul style="list-style-type: none"> ▪ Project coordinator of health disparities initiative ▪ Chairman of minority health council
Community Assembly Groups	<ul style="list-style-type: none"> ▪ Farmer representative groups ▪ Neighborhood representation groups ▪ City district representation groups ▪ Disability advocacy groups ▪ Community food groups

APPENDIX C. COMMUNITY HEALTH ASSESSMENT AND GROUP EVALUATION (*CHANGE*) LIST OF QUESTIONS

The following pages list the questions for each sector (Community-At-Large Sector, Community Institution/Organization Sector, Health Care Sector, School Sector, and Work Site Sector) of the *CHANGE* tool. Each sector includes several modules (e.g., demographic, physical activity, nutrition, tobacco, chronic disease management, and leadership, and also district and after school for the School Sector). All of these questions are provided in the Excel spreadsheets of the *CHANGE* tool.

Community-At-Large Sector

Demographic

1. Approximate number of people who reside in the community (population).
2. Approximate size of the area (square miles).
3. Best description of the community setting:
rural, suburban, urban
4. The median household income of the community:
< \$25,000, \$25,000 – \$34,999, \$35,000 – \$49,999, \$50,000 – \$74,999, ≥ \$75,000
5. Approximate percentage of people in the community with no high school diploma:
<5%, 5 – 9%, 10 – 14%, 15 – 19%, ≥ 20%
6. Approximate percentage of people in the community who are living in poverty:
< 5%, 5 – 9%, 10 – 14%, 15 – 19%, ≥ 20%
7. Approximate percentage of people in the community who are currently unemployed:
< 5%, 5 – 9%, 10 – 14%, 15 – 19%, ≥ 20%

Physical Activity

To what extent does the community:

1. Require sidewalks to be built for all developments (e.g., housing, schools, commercial)?
2. Adopt a land use plan?
3. Require bike facilities (e.g., bike boulevards, bike lanes, bike ways, multi-use paths) to be built for all developments (e.g., housing, schools, commercial)?
4. Adopt a complete streets plan to support walking and biking infrastructure?
5. Maintain a network of walking routes (e.g., institute a sidewalk program to fill gaps in the sidewalk)?
6. Maintain a network of biking routes (e.g., institute a bike lane program to repave bike lanes when necessary)?

7. Maintain a network of parks (e.g., establish a program to repair and upgrade existing parks and playgrounds)?
8. Provide access to parks, shared-use paths and trails, or open spaces within reasonable walking distance of most homes?
9. Institute mixed land use?
10. Require sidewalks to comply with the Americans with Disabilities Act (ADA) (i.e., all routes accessible for people with disabilities)?
11. Provide access to public recreation facilities (e.g., parks, play areas, community and wellness centers) for people of all abilities?
12. Enhance access to public transportation (e.g., bus stops, light rail stops, van pool services, subway stations) within reasonable walking distance?
13. Provide street traffic calming measures (e.g., road narrowing, central islands, roundabouts, speed bumps) to make areas (e.g., neighborhoods, major intersections) where people are or could be physically active (e.g., walk, bike) safer?
14. Adopt strategies (e.g., neighborhood crime watch, lights) to enhance personal safety in areas (e.g., playgrounds, parks, bike lanes, walking paths, neighborhoods) where people are or could be physically active (e.g., walk, bike)?

Nutrition

To what extent does the community:

1. Adopt strategies to encourage food retailers (e.g., grocery, corner or convenience stores; bodegas) to provide healthy food and beverage options (e.g., fresh produce) in underserved areas?
2. Encourage community garden initiatives?
3. Enhance access to public transportation (e.g., bus stops, light rail stops, van pool services, subway stations) to supermarkets and large grocery stores?
4. Provide access to farmers' markets?
5. Accept Women, Infants and Children (WIC) Farmers' Market Nutrition Program vouchers or Food Stamp Benefits at local farmers' markets?
6. Connect locally grown foods to local restaurants and food venues?
7. Promote (e.g., signage, product placement, pricing strategies) the purchase of fruits and vegetables at local restaurants and food venues?
8. Institute healthy food and beverage options at local restaurants and food venues?
9. Institute nutritional labeling (e.g., 'low fat,' 'light,' 'heart healthy,' 'no trans fat') at local restaurants and food venues?
10. Provide smaller portion sizes at local restaurants and food venues?

11. Ban local restaurants and retail food establishments from cooking with trans fats?
12. Adopt strategies to recruit supermarkets and large grocery stores in underserved areas (e.g., provide financial incentives, lower operating costs, provide job training services)?
13. Provide comfortable, private spaces for women to nurse or pump in public places (e.g., government buildings, restaurants, retail establishments) to support and encourage residents' ability to breastfeed?
14. Protect a woman's right to breastfeed in public places?

Tobacco

To what extent does the community:

1. Institute a smoke-free policy 24/7 for indoor public places?
2. Institute a tobacco-free policy 24/7 for indoor public places?
3. Institute a smoke-free policy 24/7 for outdoor public places?
4. Institute a tobacco-free policy 24/7 for outdoor public places?
5. Ban tobacco advertisement (e.g., restrict point-of-purchase advertising or product placement)?
6. Ban tobacco promotions, promotional offers, and prizes?
7. Regulate the number, location, and density of tobacco retail outlets?
8. Restrict the placement of tobacco vending machines (including self-service displays)?
9. Enforce the ban of selling single cigarettes?
10. Increase the price of tobacco products and generate revenue with a portion of the revenue earmarked for tobacco control efforts (e.g., taxes, mitigation fees)?
11. Provide access to a referral system for tobacco cessation resources and services, such as quitlines (e.g., 1-800-QUIT-NOW)?

Chronic Disease Management

To what extent does the community:

1. Enhance access to chronic disease self-management programs (e.g., Weight Watchers for overweight/obesity)?
2. Adopt strategies to educate its residents on the importance of obesity prevention?
3. Adopt strategies to educate its residents on the importance of controlling high blood pressure?
4. Adopt strategies to educate its residents on the importance of controlling cholesterol?
5. Adopt strategies to educate its residents on the importance of controlling blood sugar or insulin levels?

6. Adopt strategies to educate its residents on heart attack and stroke symptoms and when to call 9-1-1?
7. Adopt strategies to educate its residents on the importance of preventive care?
8. Provide emergency medical services (e.g., 9-1-1, transport system)?
9. Adopt strategies to address chronic disease health disparities?

Leadership

To what extent does the community:

1. Participate in community coalitions and partnerships (e.g., food policy council, tobacco-free partnership, neighborhood safety coalition) to address chronic diseases and associated risk factors?
2. Participate in the public policy process to highlight the need for community changes to prevent and reduce chronic disease risk factors (e.g., poor nutrition, physical inactivity, tobacco use and exposure)?
3. Finance public shared-use paths or trails (by passing bonds, passing millages, levying taxes or getting grants)?
4. Finance public recreation facilities (by passing bonds, passing millages, levying taxes or getting grants)?
5. Finance public parks or greenways (by passing bonds, passing millages, levying taxes or getting grants)?
6. Finance public sports facilities (by passing bonds, passing millages, levying taxes or getting grants)?
7. Finance pedestrian enhancements (e.g., sidewalks, street crossing enhancements)?
8. Finance bicycle enhancements (e.g., bike lanes, bike parking, road diets)?
9. Address the community's operating budget to make walking, bicycling, or other physical activities a priority?
10. Promote mixed land use through regulation or other incentives?
11. Institute a management program to improve safety within the transportation system?

Community Institution/Organization Sector

Demographic

1. Best description of the community setting:
rural, suburban, urban
2. Median household income in the community:
< \$25,000, \$25,000 – \$34,999, \$35,000 – \$49,999, \$50,000 – \$74,999 ≥ \$75,000

3. Sector type:
private, public
4. Profit type:
for-profit, not-for-profit
5. Target population:
children/youth* (ages: <18), adults (ages: 18-64), seniors/older adults (ages: 65+), other.
*If serving children/youth, what grades are being served:
preschool, elementary school, middle school, high school
6. Type of institution/organization:
senior center, faith-based organization, daycare center, boys and girls club, health and wellness center, university/college, other

Physical Activity

To what extent does the community institution/organization:

1. Promote stairwell use (e.g., make stairs appealing, post motivational signs near stairs to encourage physical activity)?
2. Provide a safe area outside (e.g., through lighting, signage, crime watch) to walk or be physically active?
3. Designate a walking path on or near building property?
4. Encourage non-motorized commutes (e.g., active transportation such as walk or bike) to the facility?
5. Enhance access to public transportation (e.g., bus stops, light rail stops, van pool services, subway stations) within reasonable walking distance?
6. Provide access to onsite fitness center, gymnasium, or physical activity classes?
7. Provide a changing room or locker room with showers?
8. Provide bicycle parking (e.g., bike rack, shelter) for patrons?
9. Provide access to a broad range of competitive and noncompetitive physical activities that help to develop the skills needed to participate in lifetime physical activities?
10. Provide opportunity for unstructured play or leisure-time physical activity?
11. Prohibit using physical activity as a punishment?
12. Restrict screen time to less than 2 hours per day for children over 2 years of age?
13. Provide direct support (e.g., money, land, pavilion, recreational facilities, sponsorship, advertising) for supporting community-wide physical activity opportunities (e.g., sports teams, walking clubs)?

Nutrition

To what extent does the community institution/organization:

1. Institute healthy food and beverage options in vending machines?
2. Institute healthy food and beverage options at institution-sponsored meetings and events?
3. Institute healthy food and beverage options in onsite cafeteria and food venues?
4. Institute healthy food purchasing (e.g., to reduce the caloric, sodium, and fat content of foods offered) for cafeteria and onsite food venues?
5. Institute healthy food preparation practices (e.g., steaming, low fat, low salt, limiting frying) in onsite cafeteria and food venues?
6. Institute pricing strategies that encourage the purchase of healthy food and beverage options?
7. Ban marketing (e.g. counter advertisements, posters, other print materials) of less than healthy foods and beverages onsite?
8. Provide smaller portion sizes in onsite cafeteria and food venues?
9. Institute nutritional labeling (e.g., 'low fat,' 'light,' 'heart healthy,' 'no trans fat') at onsite cafeteria and food venues?
10. Provide safe, unflavored, cool drinking water at no cost to patrons?
11. Prohibit using food as a reward or punishment?
12. Provide direct support (e.g., money, land, pavilion, sponsorship, advertising) for supporting community-wide nutrition opportunities (e.g., farmers' markets, community gardens)?
13. Provide a comfortable, private space for women to nurse or pump to support and encourage patrons' ability to breastfeed?

Tobacco

To what extent does the community institution/organization:

1. Institute a smoke-free policy 24/7 for indoor public places?
2. Institute a tobacco-free policy 24/7 for indoor public places?
3. Institute a smoke-free policy 24/7 for outdoor public places?
4. Institute a tobacco-free policy 24/7 for outdoor public places?
5. Ban tobacco vending machine sales (including self-service displays)?
6. Ban tobacco promotions, promotional offers, and prizes?
7. Ban tobacco advertisement (e.g., restrict point-of-purchase advertising or product placement)?
8. Implement a referral system to help patrons to access tobacco cessation resources and services, such as a quitline (e.g., 1-800-QUIT-NOW)?

Chronic Disease Management

To what extent does the community institution/organization:

1. Provide access to chronic disease self-management programs (e.g., Weight Watchers for overweight/obesity)?
2. Provide access to an onsite nurse?
3. Provide an onsite medical clinic to monitor and address chronic diseases and related risk factors (e.g., high blood pressure, high cholesterol, elevated blood sugar levels)?
4. Provide routine screening, follow-up counseling and education to patrons to help address chronic diseases and related risk factors (e.g., poor nutrition, physical inactivity, hypertension, high cholesterol, elevated blood sugar levels, tobacco use and exposure)?
5. Adopt curricula or training to raise awareness of the signs and symptoms of heart attacks and strokes?
6. Adopt curricula or training to raise awareness of the importance of calling 9-1-1 immediately when someone is having a heart attack or stroke?
7. Promote chronic disease prevention to patrons (e.g., post signs reminding patrons to get blood pressure checked, quit smoking, or avoid secondhand smoke)?
8. Have an emergency response plan (e.g., appropriate equipment such as Automatic External Defibrillator, instructions for action) in place?

Leadership

To what extent does the community institution/organization:

1. Provide incentives to patrons participating in chronic disease prevention measures (e.g., quit smoking, log miles walked, blood pressure or cholesterol screening)?
2. Participate in the public policy process to highlight the need for community changes to address chronic diseases and related risk factors (e.g., poor nutrition, physical inactivity, tobacco use and exposure)?
3. Have a wellness coordinator?
4. Have a wellness committee?
5. Have a health promotion budget?
6. Have a mission statement (or a written policy statement) that includes the support of or commitment to patron health and well-being?
7. Implement a needs assessment when planning a health promotion program?
8. Evaluate health promotion programs?
9. Provide opportunities for patron feedback (e.g., interest, satisfaction, adherence) about health promotion programs?

10. Participate in community coalitions and partnerships (e.g., food policy council, tobacco-free partnership, neighborhood safety coalition) to address chronic diseases and related risk factors (e.g., poor nutrition, physical inactivity, tobacco use and exposure)?

Health Care Sector

Demographic

1. Number of staff:
fewer than 20, 20 – 99, 100 – 249, 250 – 499, 500 – 999, 1,000 – 1,499, 1,500+
2. Type of health care organization:
medical/physician office, clinic, hospital, ambulatory care, home health agency, Health Maintenance Organization (HMO), local health department, Federally Qualified Health Center (FQHC), other
3. Number of patients:
average number of patients on monthly basis
4. Sector type:
private, public
5. Profit type:
for-profit, not-for-profit

Physical Activity

To what extent does the health care facility:

1. Promote stairwell use (e.g., make stairs appealing, post motivational signs near stairs to encourage physical activity) to patients, visitors, and staff?
2. Assess patients' physical activity as part of a written checklist or screening used in all routine office visits?
3. Provide regular counseling about the health value of physical activity during all routine office visits?
4. Implement a referral system to help patients' access community-based resources or services for physical activity?

Nutrition

To what extent does the health care facility:

1. Implement breastfeeding initiative for future or current moms?
2. Assess patients' nutrition as part of a written checklist or screening used in all routine office visits?

3. Provide regular counseling about the health value of good nutrition during all routine office visits?
4. Provide free or low cost weight management or nutrition programs?
5. Implement a referral system to help patients to access community-based resources or services for nutrition?
6. Institute healthy food and beverage options in vending machines?
7. Institute healthy food and beverage options served to their patients?
8. Institute healthy food and beverage options in the onsite cafeteria and food venues?
9. Institute pricing strategies that encourage the purchase of healthy food and beverage options?
10. Institute healthy food purchasing (e.g., to reduce the caloric, sodium, and fat content of foods offered) for cafeteria and onsite food venues?
11. Institute healthy food preparation practices (e.g., steaming, low fat, low salt, limiting frying) in onsite cafeteria and food venues?
12. Institute nutritional labeling (e.g., 'low fat,' 'light,' 'heart healthy,' 'no trans fat') at the onsite cafeteria and food venues?
13. Ban marketing (e.g., counter advertisements, posters, other print materials) of less than healthy foods and beverages onsite?
14. Provide smaller portion sizes in onsite cafeteria and food venues?

Tobacco

To what extent does the health care facility:

1. Institute a smoke-free policy 24/7 for indoor public places?
2. Institute a tobacco-free policy 24/7 for indoor public places?
3. Institute a smoke-free policy 24/7 for outdoor public places?
4. Institute a tobacco-free policy 24/7 for outdoor public places?
5. Assess patients' tobacco use as part of written checklist or screening used in all routine office visits?
6. Assess patients' exposure to tobacco smoke as part of written checklist or screening used in all routine office visits?
7. Provide advice and counseling about the harm of tobacco use and exposure during all office visits?
8. Implement a referral system to help patients to access tobacco cessation resources and services, such as a quitline (e.g., 1-800-QUIT-NOW)?
9. Provide access to free or low cost pharmacological quitting aids for their patients?
10. Implement a provider-reminder system to assess, advise, track, and monitor tobacco use?

Chronic Disease Management

To what extent does the health care facility:

1. Implement a referral system to help patients to access community-based resources or services for chronic disease management?
2. Provide routine follow-up counseling and education to patients to help address chronic diseases and related risk factors (e.g., poor nutrition, physical inactivity, hypertension, high cholesterol, elevated blood sugar levels, tobacco use and exposure)?
3. Provide screening for chronic diseases in adults with risk factors (e.g., poor nutrition, physical inactivity, hypertension, high cholesterol, elevated blood sugar levels, tobacco use and exposure)?
4. Measure weight and height, and calculate appropriate body mass index (BMI) for every patient at each visit?
5. Adopt a plan or process to increase patient adherence to chronic disease (e.g., cardiovascular disease, diabetes) treatment?
6. Institute a systematic approach to the processes of diabetes care?
7. Institute the latest emergency heart disease and stroke treatment guidelines (e.g., Joint National Committee 7, American Heart Association)?
8. Provide access to resources and training for using a stroke rating scale?
9. Provide specialized stroke care units?
10. Provide specialized heart disease units?

Leadership

To what extent does the health care facility:

1. Participate in community coalitions and partnerships (e.g., food policy council, tobacco-free partnership, neighborhood safety coalition) to address chronic diseases and related risk factors (e.g., poor nutrition, physical inactivity, tobacco use and exposure)?
2. Participate in the public policy process to highlight the need for community changes to address chronic diseases and related risk factors (e.g., poor nutrition, physical inactivity, tobacco use and exposure)?
3. Enhance access to childhood overweight prevention and treatment services to reduce health disparities?
4. Promote high standards of modifiable risk factor (e.g., poor nutrition, physical inactivity, tobacco use and exposure) practice to healthcare and provider associations?
5. Institute standardized treatment and prevention protocols that are consistent with national evidence-based guidelines to prevent heart disease, stroke, and related risk factors?

6. Institute an electronic medical records system and patient data registries to provide immediate feedback on a patient's condition and compliance with the treatment regimen?
7. Adopt the Chronic Care Model in hospitals?
8. Provide patient services using provider care teams that cross specialties (e.g., physician/pharmacist teams)?
9. Provide access to medical services outside of regular working hours (e.g., late evenings, weekends)?
10. Promote collaboration between health care professionals (e.g., physicians and specialists) for managing chronic diseases (e.g., cardiovascular disease, diabetes)?
11. Partner with community agencies to provide free or low cost chronic disease health screenings, follow-up counseling, and education for those at risk?
12. Institute annual cultural competence training for all health workers for optimal care of all patients (regardless of their race/ethnicity, culture, or background)?

School Sector

Demographic

1. Total # of students served
2. School level:
elementary, middle, high (specify grades)
3. Type of school:
private, public, parochial
4. Best description of the setting of the school:
rural, suburban, urban
5. Percentage (%) of students receiving free or reduced price lunch
6. Median household income of the students in this school:
< \$25,000, \$25,000 – \$34,999, \$35,000 – \$49,999, \$50,000 – \$74,999, ≥ \$75,000

District

To what extent does the district:

1. Require 225 minutes per week of physical education for all middle school and high school students?
2. Require 150 minutes per week of physical education for all elementary school students?
3. Provide 20 minutes of recess daily for students in elementary school?
4. Ensure that students are not provided waivers or exemptions from participation in physical education for other school and community activities, such as band, chorus, Reserve Officers' Training Corps (ROTC), sports participation, or community volunteering?

5. Require that either fruits or vegetables or both are available wherever foods and beverages are offered?
6. Eliminate the sale and distribution of less than healthy foods and beverages during the school day?
7. Prohibit the sale of sugar-sweetened beverages (can exclude flavored, fat-free milk) during the school day?
8. Institute a tobacco-free policy 24/7?
9. Ban tobacco advertising on school property, at school events, and in written educational materials and publications?
10. Ban tobacco promotions, promotional offers, and prizes on school property, at school events, and in written educational materials and publications?
11. Ensure access to a full-time, qualified healthcare provider (e.g., registered school nurse) in every school?
12. Establish a case management plan for students with identified chronic diseases or conditions (e.g., asthma, diabetes, epilepsy) in consultation with their families, medical providers, and school staff?
13. Ensure immediate and reliable access to prescribed medications (e.g., inhaler, insulin, epinephrine pen) for chronic disease management throughout school day?
14. Have a district health group (e.g., school health council) comprised of school personnel, parents, students, and community partners that help plan and implement district health activities?
15. Have a designated school health coordinator who is responsible for overseeing school health activities across the district?
16. Monitor schools' compliance with the implementation of the district school wellness policy enacted as a result of the Child Nutrition and WIC Reauthorization Act of 2004 (i.e., requires that all school districts that participate in the National School Lunch Program have local wellness policies)?
17. Allow the use of school buildings and facilities by the public during non-school hours (e.g., joint use agreement)?
18. Adopt a physical education curriculum for all students in grades pre-K to grade 12, as part of a sequential physical education course of study, consistent with state or National Physical Education Standards?
19. Adopt a nutrition education curriculum, designed to help students adopt healthy eating behaviors, for all students in grades pre-K to grade 12, as part of a sequential health education course of study, consistent with state or National Health Education Standards?
20. Adopt a tobacco-use prevention curriculum for all students in grades pre-K to grade 12, as part of a sequential health education course of study, consistent with state or National Health Education Standards?

Physical Activity

To what extent does the school:

1. Ban using or withholding physical activity as a punishment?
2. Require that students are physically active during the majority of time in physical education class?
3. Provide access to a broad range of competitive and noncompetitive physical activities that help to develop the skills needed to participate in lifetime physical activities?
4. Implement a walk or bike to school initiative?
5. Ensure the availability of proper equipment and facilities (including playground equipment, physical activity equipment, and athletic or fitness facilities) that meet safety standards?

Nutrition

To what extent does the school:

1. Ensure that students are provided only healthy food and beverage options beyond the school food services (e.g., all vending machines, school stores, and food brought for celebrations)?
2. Institute school breakfast and lunch programs that meet the U.S. Department of Agriculture School Meal Nutrition Standards?
3. Ensure that healthy food preparation practices (e.g., steaming, low fat, low salt, limited frying) are always used in the school cafeteria or onsite food services?
4. Ban marketing (e.g., counter advertisements, posters, other print materials) of less than healthy foods and beverages onsite?
5. Promote and market (e.g., through counter advertisements, posters, or other print materials) only healthy food and beverage options?
6. Provide adequate time to eat school meals (10 minutes for breakfast/20 minutes for lunch, from the time students are seated)?
7. Ban using food as a reward or punishment for academic performance or behavior?
8. Provide safe, unflavored, cool drinking water throughout the school day at no cost to students?
9. Provide school garden (e.g., access to land, container gardens, or raised beds) and related resources (e.g., staff volunteer time, financial incentives)?
10. Ensure that multiple channels, including classroom, cafeteria, and communications with parents, are used to promote healthy eating behaviors?

Tobacco

To what extent does the school:

1. Implement a referral system to help students to access tobacco cessation resources or services?

Chronic Disease Management

To what extent does the school:

1. Provide access to chronic disease self-management education programs to individuals identified with chronic diseases or conditions (e.g., diabetes, asthma)?
2. Meet the nutritional needs of students with special health care or dietary requirements (e.g., allergies, diabetes, physical disabilities)?
3. Provide opportunities to raise awareness among students of the signs and symptoms of heart attack and stroke?
4. Ensure students are aware of the importance of calling 9-1-1 for emergencies?
5. Ensure cardiopulmonary resuscitation (CPR) training is made available to students?
6. Engage families in the development of school plans (e.g., school diabetes management plans) to effectively manage students with chronic diseases or conditions?

Leadership

To what extent does the school:

1. Participate in community coalitions and partnerships (e.g., food policy council, tobacco-free partnership, neighborhood safety coalition) to address chronic diseases and related risk factors (e.g., poor nutrition, physical inactivity, tobacco use and exposure)?
2. Participate in the public policy process to highlight the need for community changes to address chronic diseases and related risk factors (e.g., poor nutrition, physical inactivity, tobacco use and exposure)?
3. Have a school building health group (e.g., school health committee) comprised of school personnel, parents, students, and community partners that help plan and implement the health activities at the school building?
4. Have an individual who is responsible for leading school health activities within the school building?
5. Have a health promotion budget?
6. Have a written mission or position statement that includes the commitment to student health and well-being?
7. Recruit teachers (e.g., physical education, health) with appropriate training, education, and background?
8. Provide training and support to food service and other relevant staff to meet nutrition standards for preparing healthy meals?
9. Provide access to opportunities for professional development or continued education to staff (e.g., physical education, health, school nurse, food service manager)?

10. Provide training for all teachers and staff on school physical activity, nutrition, and tobacco prevention policies?
11. Permit only health-promoting fund raising efforts such as non-food options or only healthy food and beverage options, physical activity-related options (e.g., fun-run), or community service options (e.g., car wash, directing parking at school events)?

After School

To what extent does the after school program:

1. Ban using or withholding physical activity as a punishment?
2. Ban using food as a reward or punishment for academic performance or behavior?
3. Provide access to physical activity programs (e.g., intramural, extracurricular, interscholastic)?
4. Ensure appropriate active time during after school programs or events?
5. Institute healthy food and beverage options during after school programs or events?
6. Prohibit the sale of sugar-sweetened beverages outside of school hours?

Work Site Sector

Demographic

1. Number of employees:
fewer than 20, 20 – 99, 100 – 249, 250 – 499, 500 – 999, 1,000 – 1,499, 1,500+
2. Type of work site:
retail sales, bank or credit union, restaurant/food service, hotel/motel, auto/repair shop, gas station or convenience store, pharmacy or drug store, grocery store/food market, manufacturing, factory, warehouse, construction, school/educational institution, faith-based institution, health care (e.g., clinic, hospital, medical practice), government, other
3. Sector type:
private, public
4. Profit type:
for-profit, not-for-profit

Physical Activity

To what extent does the work site:

1. Promote stairwell use (e.g., make stairs appealing, post motivational signs near stairs to encourage physical activity)?

2. Provide flexible work arrangements or break times for employees to engage in physical activity?
3. Encourage non-motorized commutes (e.g., active transportation such as walk or bike) to work?
4. Enhance access to public transportation (e.g., bus stops, light rail stops, van pool services, subway stations) within reasonable walking distance?
5. Support clubs or groups (e.g., walking, biking, hiking) to encourage physical activity among employees?
6. Provide a safe area outside (e.g., through lighting, signage, crime watch) to walk or be physically active?
7. Designate a walking path on or near building property?
8. Provide access to onsite fitness center, gymnasium, or physical activity classes?
9. Provide a changing room or locker room with showers?
10. Provide access to offsite workout facility or subsidized membership to local fitness facility?
11. Provide bicycle parking (e.g., bike rack, shelter) for employees?
12. Implement activity breaks for meetings that are longer than one hour?
13. Provide direct support (e.g., money, land, pavilion, recreational facilities, sponsorship, advertising) for supporting community-wide physical activity opportunities (e.g., sports teams, walking clubs)?

Nutrition

To what extent does the work site:

1. Institute healthy food and beverage options at company-sponsored meetings and events?
2. Institute healthy food and beverage options in vending machines?
3. Institute healthy food and beverage options in onsite cafeteria and food venues?
4. Institute healthy food purchasing practices (e.g., to reduce the caloric, sodium, and fat content of foods offered) for onsite cafeteria and food venues?
5. Institute healthy food preparation practices (e.g., steaming, low fat, low salt, limiting frying) in onsite cafeteria and food venues?
6. Ban marketing (e.g., counter advertisements, posters, other print materials) of less than healthy foods and beverages onsite?
7. Provide smaller portion sizes in onsite cafeteria and food venues?
8. Provide safe, unflavored, cool drinking water at no cost to employees?
9. Institute nutritional labeling (e.g., 'low fat,' 'light,' 'heart healthy,' 'no trans fat') at the worksite's cafeteria and onsite food service?
10. Institute pricing strategies that encourage the purchase of healthy food and beverage options?

11. Provide refrigerator access for employees?
12. Provide microwave access for employees?
13. Provide a sink with water faucet access for employees?
14. Provide direct support (e.g., money, land, a pavilion, sponsorship, donated advertising) for community-wide nutrition opportunities (e.g., farmers' markets, community gardens)?
15. Support breastfeeding by having maternity care practices, including providing a comfortable, private space for employees to nurse or pump?

Tobacco

To what extent does the work site:

1. Institute a smoke-free policy 24/7 for indoor public places?
2. Institute a tobacco-free policy 24/7 for indoor public places?
3. Institute a smoke-free policy 24/7 for outdoor public places?
4. Institute a tobacco-free policy 24/7 for outdoor public places?
5. Ban tobacco vending machine sales (including self-service displays)?
6. Provide insurance coverage for tobacco cessation services?
7. Provide insurance coverage for tobacco cessation products (e.g., pharmacological quitting aids, medicines)?
8. Ban tobacco promotions, promotional offers, and prizes?
9. Ban tobacco advertisement (e.g., restrict point-of-purchase advertising or product placement)?
10. Implement a referral system to help employees to access tobacco cessation resources or services, such as a quitline (e.g., 1-800-QUIT-NOW)?

Chronic Disease Management

To what extent does the work site:

1. Provide routine screening, follow-up counseling and education to employees to help address chronic diseases and related risk factors (e.g., poor nutrition, physical inactivity, hypertension, high cholesterol, elevated blood sugar levels, tobacco use and exposure)?
2. Provide access to an onsite occupational health nurse?
3. Provide an onsite medical clinic to monitor and address chronic diseases and related risk factors (e.g., high blood pressure, high cholesterol, elevated blood sugar levels)?
4. Provide paid time off to attend health promotion programs or classes?
5. Provide employee insurance coverage for preventive services and quality medical care?

6. Provide access to a free or low cost employee health risk appraisal or health screenings?
7. Provide access to chronic disease self-management programs (e.g., Weight Watchers for overweight/obesity)?
8. Adopt curricula or training to raise awareness of the signs and symptoms of heart attacks and strokes?
9. Adopt curricula or training to raise awareness of the importance of calling 9-1-1 immediately when someone is having a heart attack or stroke?
10. Promote chronic disease prevention (e.g., post signs reminding employees to get blood pressure checked, quit smoking, or avoid secondhand smoke) to employees?
11. Adopt an emergency response plan (e.g., appropriate equipment such as Automatic External Defibrillator, instructions for employee action)?

Leadership

To what extent does the work site:

1. Reimburse employees for preventive health or wellness activities?
2. Participate in the public policy process to highlight the need for community changes to address chronic diseases and related risk factors (e.g., poor nutrition, physical inactivity, tobacco use and exposure)?
3. Have a wellness coordinator?
4. Have a wellness committee?
5. Have a health promotion budget?
6. Have a mission statement (or a written policy statement) that includes the support of or commitment to employee health and well-being?
7. Adopt organizational or performance objectives pertaining to employee health and well-being?
8. Provide employees with a health insurance plan?
9. Provide office-based incentives (e.g., discounted insurance premium, gift certificates) to employees participating in health risk assessments, initiatives, or support groups that promote chronic disease prevention measures (e.g., quit smoking, log miles walked, blood pressure or cholesterol screening)?
10. Implement a needs assessment when planning a health promotion program?
11. Evaluate company-sponsored health promotion programs?
12. Provide opportunities for employee feedback (e.g., employee interest, satisfaction, adherence) about health promotion programs?
13. Participate in community coalitions and partnerships (e.g., food policy council, tobacco-free partnership, neighborhood safety coalition) to address chronic diseases and related risk factors (e.g., poor nutrition, physical inactivity, tobacco use and exposure)?

APPENDIX D. CITATIONS

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