**Evaluation in Action: New York State Healthy Communities Capacity Building Initiative**

**The New York State Healthy Communities Capacity Building Initiative ( HCCB) was an expert training and mini-grant program administered by the New York State Department of Health to New York State Counties through their local health departments. This initiative was successful in building county level capacity to implement policy, system and environmental changes to improve community health in 56 of 62 counties. Two years after the start of the training opportunity, implementation of recommended policy, systems and environmental change strategies was evident in participating counties. This report describes the Healthy Communities Capacity Building Initiative and recommendations for practice based on its evaluation.**

**Background:** Community health programs that use policy, systems and environmental (PSE) strategies are more likely to have a greater impact on the community’s health than programs using strategies directed at individual behaviors.1 To build the capacity to lead community PSE change at the local level, the Obesity Prevention Program of the New York State Department of Health (NYSDOH) implemented the Healthy Communities Capacity Building Initiative (Initiative). Beginning in December 2009, all 62 New York State counties were offered training and technical assistance to develop strategies to implement PSE changes directed toward physical activity and nutrition objectives. A two-day in-person training (called an Action Institute) was provided in February 2010 to county participants and their partners facilitated by local health departments. Training at the Action Institute was provided by external experts from the Prevention Institute of Oakland, California. Through their local health departments, counties received a one-time grant of $34,000, which represented a 1.9 million dollar investment in county level capacity building. Counties identified representatives from health departments and the community to attend the Action Institute trainings, initiate PSE changes, and to recruit local coalitions to participate in the work. During the Action Institute, each participating county completed an action plan which included up to three strategies for change. The training participants’ perception of their own self-efficacy was thought to play an important role in the implementation of this Initiative.3

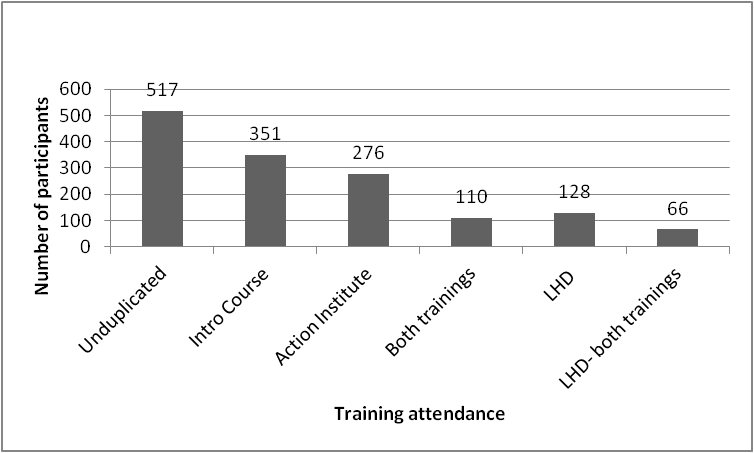
**Initiative Evaluation:** The RE-AIM framework was used to evaluate this Initiative over a twenty-month period.2 The RE-AIM framework is a comprehensive framework which evaluates public health interventions using five dimensions: reach, efficacy, adoption, implementation, and maintenance. This framework was adapted to evaluate this county Initiative. To measure reach, the number of counties that participated and the range of different partners who participated in the Action Institute were assessed. Efficacy was assessed by administering a self-confidence scale to all county participants who attended the Action Institute. Administration occurred both before the Action Institute, immediately after, and again three months later. This scale was developed by evaluation staff with content based on the goals and objectives from the course syllabus and on principles of self-efficacy.3 Additional skills and concepts covered as part of the Action Institute were assessed at the end of the Action Institute. Adoption and implementation were measured using a web-based survey administered to all county partnerships six months after the Action Institute. Interviews of county partnership leaders occurred in August –September 2011 to measure maintenance.

**Reach**

Reach is defined in the RE-AIM framework as “the proportion of the target population that participated in the intervention”.2 90% of New York state counties (56 of 62) chose to participate in the Initiative. Counties which did not participate were all small, upstate counties, but the decision to participate was unrelated to county socioeconomic status as measured by whether or not the median income of residents in the county was above or below the federal poverty line.

As shown in Figure 1, the training reached an unduplicated count of more than 500 county participants with 21% attending both the Introductory and Action Institute trainings. 128 local health department staff, representing all of the participating counties, attended at least one of the trainings with 52% attending both the Introductory Course and Action Institute. Local partners identified by county leaders were also invited to participate as important contributors to enacting change in the community. County teams attending together ranged in size from 2 (Lewis County) to 45 (New York City) with an average team size of 9.

Figure 1. Training participation including Local Health Department Representation



Participants at the Action Institute were categorized according to which sector of the community each reported representing: government, community non-for-profit, health care, schools, childcare centers, worksites, parks and recreation departments, transportation agencies and the media. Participating partners were more frequently community not-for-profit agencies and health care organizations. There was less representation from the media and from Parks and Recreation Departments, and transportation agencies.

**Recommended Action for Reach:**

**A small, noncompetitive grant was found to be effective in recruiting a high proportion of counties and should be considered for future training efforts. Counties may need assistance to recruit nontraditional partners. Additional resources may be needed to enable greater participation by smaller counties.**

**Efficacy**

Efficacy is defined in the RE-AIM framework as “the success rate if implemented as in guidelines; defined as positive outcomes minus negative outcomes”.2 For the purpose of this evaluation, the measure of positive outcomes of the Initiative was the degree to which participants reported self-confidence in applying the skills and concepts taught in the Initiative. Participants made ratings from 0 to 100 (0 = cannot do at all; 50 = moderately confident can do; 100 = highly confident can do). The training was provided by trainers from The Prevention Institute in Oakland, California who are experts in defining and implementing PSE change. For those skills measured at three points in time, county partnerships’ assessment of their own skills increased across time. The greatest gains in self-confidence was seen in identifying necessary resources and technical support and maintaining coalition vitality. By the three-month follow-up period, respondents reported confidence that was between moderately and highly confident. For the additional skills taught during the Action Institute, County partnerships were again quite confident of their abilities to implement taught skills, reporting scores which ranged from 76 to 87 (Table 1). There were no instances where participant self-confidence did not improve at post or follow up.

**Recommended Action for Efficacy**

**Expert training in the implementation of policy systems and environmental change was effective in increasing the confidence of counties to implement PSE strategies. Offering expert training in PSE change with clear deliverables should be considered as a kick off to any future initiatives for that expect the implementation of PSE change strategies.**

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**Adoption**

Adoption is defined in the RE-AIM framework as “the proportion and representativeness of settings that adopt this intervention”.2 For the purposes of this evaluation, the outcome measure for adoption was the proportion of county coalitions which were able to begin work on least one of the strategies from their action plans within a six-month period. Among the 56 counties that participated in the Initiative, 52 (93%) were able to initiate at least one of the strategies included in their action plans. The four counties which did not initiate any of the strategies at the six-month mark were all small, upstate counties. Respondents identified lack of leadership, staff turnover and problems with coalitions as barriers to beginning work on action plan strategies. Adoption was unrelated to county socioeconomic status as measured by whether or not the median income of residents in the county was above or below the federal poverty line.

Strategies in the county action plans which were adopted were reviewed and categorized as directed toward: 1)community assessment; 2)education or health promotion; 3)coalition building; 4)environmental change; 5)systems change;6) policy change; and7) increasing opportunities for physical activity or better nutrition. The distribution of strategies adopted by counties is displayed in Figure 2.

Figure 2. Prevention Strategies Adopted by Counties in Action Plans

Nearly half of counties began education or health promotion strategies. Among 44% of counties, environmental change strategies were undertaken. Fewer counties undertook strategies to enact policy (17.3%) or systems change (19.2%). For 25% of counties, strategies were included that mentioned increasing opportunities for physical activity or nutrition but without much specificity.

**Recommended Action for Adoption:**

**In any future PSE training, emphasis should be placed on the initial steps required in implementing policy and systems change so that training participants are as likely to begin work on these long term strategies as they are to begin work on short term environmental improvements or health promotion/educational activities.**

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**Implementation:** Implementation is defined in the RE-AIM framework as “the extent to which the intervention is implemented as intended in the real world2. “ For the purpose of this evaluation, the outcome measure of implementation was the proportion of counties for which the strategies identified in the action plan were either ongoing or completed at the six-month mark. A total of 127 strategies were identified among counties adopting at least one strategy six months after training. All but three counties reported either completing or continuing to work on at least one of their strategies. The remaining counties reported not beginning their strategies or being in the planning stage. A total of 119 strategies were identified among those counties including either at least one PSE change strategy, or coalition building in their action plans. Of these 119 strategies, 19% had not been started or were still being planned, 34% had been completed, and 46% were ongoing. Among the remaining counties not using either PSE or coalition building strategies, 8 strategies were identified in the action plans, with 1 strategy not started, 1 ongoing, and the remaining 6 completed.

**Recommended Action for Implementation:**

**The high percentage of counties which were able to report PSE strategies that were ongoing or completed indicates that participants benefit from a training model which includes the deliverable of a written action plan and the expectation that they will report back on their progress. The expectation of follow up on implementation should be incorporated into all expert trainings that are offered on policy, systems and environmental change.**

**Maintenance:** Maintenance is defined in the RE-AIM framework as “the extent to which a program is sustained over time”.2 For the purpose of this evaluation, the outcome measure of maintenance was the proportion of counties which indicated that work on one specific strategy from their action plans was either completed as defined in the action plans, was ongoing or was completed with additional work beyond that defined in the action plan. To assess this measure, nearly two years following the start of the Initiative, and eighteen months after the Action Institute, telephone interviews were made to all 56 counties which participated in the Initiative. Telephone interviews were completed with 80% of all participating counties and 84% of those counties which included at either least one PSE change strategy coalition building or coalition building in the action plans. Of these, only 10% had yet to begin implementing this strategy, 29% had completed the strategy with no further work, 12% had completed work on the strategy along with reporting additional work, and 49% indicated work on the strategy was ongoing. Interviews with representatives from counties that either did not have PSE or coalition building in their action plans or reported being unable to implement strategies from their action plans reported activity concentrated on early states of implementation. Finally, eighteen months after the training, 82% of respondents reported that coalitions consisting of three or more partners were directly involved in carrying out the strategy under discussion.

**Recommended Action for Maintenance:**

**Two years out from the training, over half of the counties indicated work from their action plans was ongoing. Future training should cover ways to assist counties in taking on policy and system change strategies which are more complicated or take longer to accomplish.**

**Summary**

There is significant evidence that the Healthy Communities Capacity Building Initiative set into motion a number of strategies to bring about community-level changes to improve healthy eating and increase physical activity. Nearly all participating counties included either coalition building or at least one PSE strategy in their action plans; foci of the HCCB introductory course and Action Institute. Nearly two years after the Initiative began, 29% of counties reported completing the work on the action plan strategy under discussion; nearly half of counties (49%), work identified in their action plans was still ongoing and 12% reported that strategies led to additional work beyond the initial action plan to promote healthy eating and physical activity in their communities.

**References**

1Frieden TR. (2010). A framework for public health action: the health impact pyramid. *Am J Public Health*, Apr;100(4):590-5.

2Glasgow RE, Vogt TM and Boles SM. (1999). Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *Am J Public Health*, 89(9): 1322-27.

3Bandura, A. (2006). Chapter 14. guide for constructing self efficacy scales. In A. Pagares & A. Pagares (Eds.),

4Cohen L, Swift S. The spectrum of prevention: developing a comprehensive approach to injury prevention. *Injury Prevention*. 1999;5:203-207.

**Table 1 Reported self-confidence of training participants to implement skills to promote healthy communities**

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| --- | --- | --- | --- |
| **How confident are you that you can…** | **Before Initiative** | **After Action Institute** | **Three-month Followup** |
| Devise a set of preliminary objectives and activities | 66 | 71 | 82 |
| Convene a coalition | 64 | 70 | 81 |
| Identify the necessary resources to carry out your action plan | 50 | 59 | 80 |
| Identify the necessary technical support to carry out your action plan | 56 | 63 | 79 |
| Maintain coalition vitality | 57 | 67 | 78 |
| Make improvements through evaluation | 64 | 70 | 80 |
| Articulate the role environment plays in community health outcomes | -- | 83 | -- |
| Apply the Spectrum of Prevention4 objectives and activities | -- | 76 | -- |
| Define elements of a successful coalition structure | -- | 81 | -- |
| Adapt examples of success from other settings to your own community | -- | 80 | -- |
| Identify action steps that address physical activity in your community | -- | 86 | -- |
| Identify action steps that address nutrition in your community | -- | 87 | -- |
| Identify key partners to recruit to work on action steps in your action plan | -- | 87 | -- |
| Access local policy makers | -- | 77 | -- |
| Tie action steps in your plan to defined and measurable outcomes | -- | 79 | -- |
| Begin work on your action plan within six months | -- | 79 | -- |

**Rating Scale** *0 = cannot do at all 50= moderately confident can do 100 = highly confident can do*