REACH

FEATURING **FOUR YEARS** OF PROGRAMS FOR RACIAL & ETHNIC APPROACHES TO COMMUNITY HEALTH IN **MONTGOMERY, MACON,** AND **LOWNDES COUNTIES**

INSIDE:

WORKING TOGETHER TO IMPROVE HEALTH AND ACCESS FOR ALL

The Wellness Coalition

ABOUT THE WELLNESS COALITION

The Wellness Coalition works with community partners to coordinate services and share information to increase quality, efficiency, and effectiveness of healthcare services. We focus on improving access to healthcare for persons with chronic diseases and limited or no health insurance in Central Alabama.

OUR VISION: A community that promotes health and wellness through a coordinated system of care.

OUR MISSION: The Wellness Coalition facilitates a coordinated, community-wide system to improve the health and wellness of people with limited or no health insurance through collaboration, services, and education.

TWC provides planning and coordination of healthcare services for uninsured and underserved persons, along with direct services and education including:

- Wellness Case Management—assisting clients to link with a medical home for primary care, access free or low-cost medications through local or pharmaceutical company patient assistance programs, establish and achieve wellness goals, and apply for health insurance through Medicaid or the Federally-Facilitated Exchange
- Chronic Disease Self-Management—utilizing evidence-based Chronic Disease Self-Management Education and the National Diabetes Prevention Program to educate clients about the self-management of chronic diseases such as diabetes, heart disease, asthma, obesity, mental illness and others
- Continuing Education—conducting conferences on chronic disease prevention and management for health and social service professionals

The Wellness Coalition's vision and mission are summed up in our motto, "Working Together to Improve Health and Wellness for All," signifying our values of working together with partners to assist underserved community members to become healthier and to access healthcare.

The Wellness Coalition

LETTERS FROM THE DIRECTORS

Four years ago, on a Friday in September, I received a congratulatory e-mail from CDC that The Wellness Coalition had been recommended for funding for the 2014 REACH Cooperative Agreement. Thus began an extremely informative and pleasant relationship with CDC and one of the most rewarding experiences we have had as a coalition—implementing interventions that would improve the health of our community and link people with healthcare.

I have been so proud to be associated with the excellent staff added to our team and the more than 60 community partners we collaborated with to implement REACH. The project has truly been a godsend for The Wellness Coalition, its partners, and the thousands of lives it has impacted.

Many thanks to all,

Cynthia Bisbee, PhD
Executive Director
2007–2017

When I became The Wellness Coalition's director a year ago, the REACH projects were well established, and it has been my good fortune to work alongside the dedicated REACH team as they continue to find innovative and sustainable ways to positively impact the health of our community. The Coalition is committed to improving access to healthcare for the underserved in the River Region, and the goals of the REACH project align perfectly with the Coalition's fundamental work, while providing opportunities for expansion and growth.

Through REACH, the Coalition built lasting relationships with like-minded community partners and touched many more lives in its service area than would have previously been possible. The legacy of REACH will be the seeds planted, the programs established, and the lessons learned that will blossom into a healthy future for the residents of the River Region.

With thanks,

Molly M. Stone
Executive Director
2017–Present

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Made possible with funding from the Centers for Disease Control and Prevention.

REACH PROJECT SUMMARY

In September 2014, The Wellness Coalition was awarded a cooperative agreement for the Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH) program. The purpose of REACH is to use evidence-based strategies to create healthier communities for populations experiencing chronic disease health disparities.

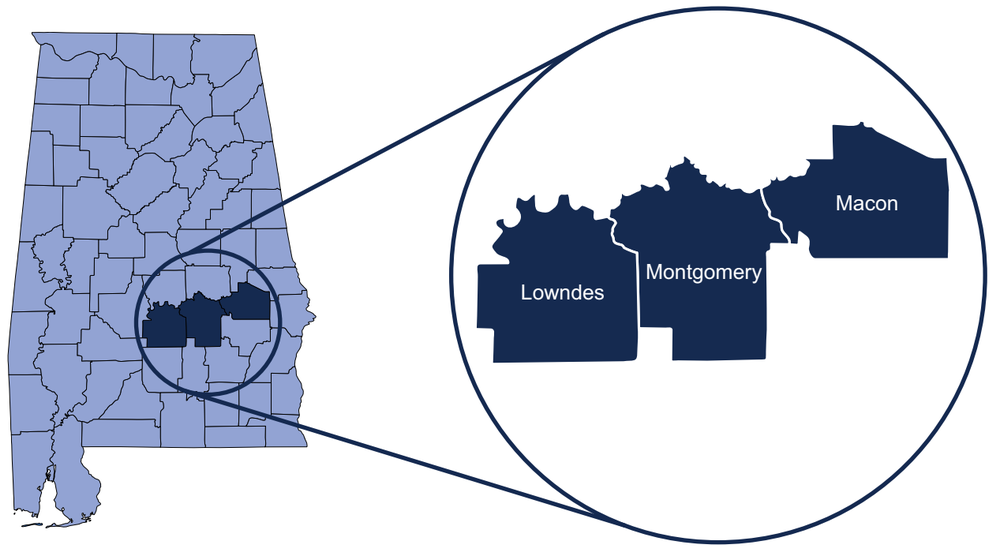
The River Region has strength in its people, its history, and its vision for a better future; however it bears the burden of high rates of chronic disease such as diabetes and heart disease. Alabama ranks among the top states in the nation for the prevalence of both heart disease and diabetes, with heart disease being the leading cause of death and diabetes being the sixth leading cause of death in the state. These numbers are even higher in minority communities, with African Americans having a cardiovascular disease mortality rate and diabetes rate higher than Caucasians.

Many people in the River Region, particularly those in minority groups, are at risk due to insufficient knowledge, resources, or support to make healthy lifestyle changes such as healthy eating, regular physical activity, and chronic disease prevention or management. Without system-level changes that affect community and societal risk factors for chronic disease, more people will be added to the count of those whose lives are burdened by these disparities.

The Wellness Coalition collaborated with the City of Montgomery's River Region Obesity Task Force, to plan, implement, and evaluate community-based REACH strategies to reduce disparities in the impact of chronic disease in the River Region. Interventions were aimed at 21 census tracts in Lowndes, Macon, and Montgomery Counties, selected because of their high percentages of African Americans, low income levels, and low education levels. After being awarded funding, The Wellness Coalition worked cooperatively with the CDC to tailor the project's goals and interventions for successful implementation. The resulting final Community Action Plan focused on improving (1) access to healthy food through the Healthy Corner Store program and Community Garden Training program and (2) access to community clinical linkages through new community health worker sites, reduced-cost fitness centers, the Green Prescription Program, and new sites for the Chronic Disease Self-Management Program. These interventions are described in detail in this report.

Through REACH, The Wellness Coalition has helped area residents access healthy food by bringing fresh produce into the corner stores where they are often forced to shop because they live too far from a grocery store, in hopes they will select an apple rather than a candy bar for a snack. The project brought gardening knowledge into African-American churches, knowing that they are the hub of many communities and can set an example for growing healthy food.

The Coalition improved healthcare access by inspiring medical providers to prescribe eating better and being more active, connecting residents with low-cost fitness center memberships, teaching African-American church congregations to lead chronic disease self-management programs, and expanding the cadre of community health workers. With REACH funding, the Coalition also filled the airwaves, print, and social media with excellent, public-informed communications about health and access for all. Over the course of the four-year REACH project, The Wellness Coalition has collaborated with dozens of partners and established sustainable programs to set the Region's low income, high minority areas on a path to a healthier future.



	U.S.	ALABAMA	LOWNDES COUNTY	MACON COUNTY	MONTGOMERY COUNTY
POPULATION	316,128,839	4,833,722	10,703	19,688	226,659*
CAUCASIAN	77.7%	69.8%	25.6%	16.7%	39.5%
AFRICAN AMERICAN	13.2%	26.6%	73.1%	81.5%	56.3%
OTHER**	9.1%	3.6%	1.3%	1.8%	4.1%

*201,332 reside in the City of Montgomery. **American Indian & Alaska Native, Asian, Pacific Islander, Two or More Races. All statistics are from the U.S. Census. Population numbers come from the 2013 population estimates. All other numbers come from the 2010 Census. http://quickfacts.census.gov/qfd/states/01000.html

FAMILIES BELOW POVERTY LEVEL	10.9%	13.9%	22.6%	23.8%	16.3%
INDIVIDUALS BELOW POVERTY LEVEL	14.9%	18.1%	23.6%	28.1%	20.4%

All statistics are from the 2010 U.S. Census and the 2008-2012 American Community Survey 5-year estimates.

	ALABAMA	LOWNDES COUNTY	MACON COUNTY	MONTGOMERY COUNTY
POOR / FAIR HEALTH	20%	33%	25%	20%
ADULT OBESITY	33%	45%	41%	34%
PHYSICAL INACTIVITY	31%	38%	31%	30%
LIMITED ACCESS TO HEALTHY FOOD	8%	26%	19%	11%
PREVALENCE OF DIABETES	13%	19%	16%	14%

2013 County Health Rankings for Alabama

	LOWNDES COUNTY	MACON COUNTY	MONTGOMERY COUNTY
RATE OF GENERAL PRACTICE PHYSICIANS	0/100,000	4.72/100,000	.86/100,000

THANK YOU TO OUR DEVOTED BOARD

Susan Douglass (to 5/15)	Alabama Department of Public Health East Central District
Kimberly Edwards	Alabama Department of Public Health East Central District
Ben F. Kelley	Baptist Health
Michael Briddell	City of Montgomery
Ashley Lough (to 4/15)	Community-at-Large Representative
Jessica Hudson	Community-at-Large Representative
Terrence Jones	Community-at-Large Representative
C. Bernell Mapp	Community-at-Large Representative
Kara Watts	Community Care Network
Heather Johnson (to 6/17)	Community Hospital
Jennie Rhinehart	Community Hospital
C. Bernell Mapp (to 9/15)	Health Services, Inc.
Bob Orrison (to 12/15)	Health Services, Inc.
Gilbert Darrington	Health Services, Inc.
Janet McQueen (to 6/18)	Jackson Hospital
Hannah Chadee	Jackson Hospital
Mary Weidler	Joint Public Charity Hospital Board
Nancy Hogan	Medical Outreach Ministries
Molly Stone (to 4/17)	Mid-Alabama Coalition for the Homeless
Nancy Fitzpatrick	Mid-Alabama Coalition for the Homeless
Henry Parker (to 4/18)	Montgomery Area Mental Health Authority
Pam Hall	Montgomery Area Mental Health Authority
Lou Ialacci	Montgomery County
Alice Toles (to 12/15)	Montgomery County Health Department
Connie King	Montgomery County Health Department

THANK YOU TO OUR DEDICATED STAFF

Justin Alexander	CDC Public Health Associate
Cynthia Berry	Wellness Navigator (to 9/16)
Cynthia Bisbee, PhD	Executive Director (to 9/17); Program Consultant
Don Bogie, PhD	REACH Evaluation Consultant
Lakeesa Butler	REACH Community Liaison (to 8/15)
Sara Byard	REACH Program Coordinator (to 4/16)
Ghandi Daniels	Wellness Programs Coordinator
Joshlynn Edwards	Wellness Navigator (to 5/16)
Monica Fountain	REACH Community Liaison (to 12/16)
Tonie Hall	Wellness Navigator (to 9/16)
Stacey Ingram	REACH Evaluation Consultant
Jerry Ingram, PhD	REACH Evaluation Consultant
Eileen Knott	REACH Community Liaison
Carol Landreau	Wellness Navigator
Hattie Leflore	Wellness Navigator
Latrice Lewis	REACH Healthcare Access Coordinator (to 4/16)
	REACH Program Coordinator
Anissa McCants	REACH Program Assistant
Cheryl Menees	Clerical Assistant (to 11/17)
LaTanya Morgan-Bell	Wellness Navigator
Travis Parker	Communications Director
Lydia Pickett	Special Projects Coordinator
Jennifer Prater	REACH Data Assistant (to 5/17)
Martine Rocker	Diabetes Prevention Program Coordinator
Savannah Sims	REACH Community Liaison (to 6/16)
Rebekah Smay	REACH Community Liaison (to 9/15)
LaToya Smith	Wellness Navigator (to 12/16)
Terri Spencer	Wellness Navigator (to 9/16)
Carianne Stinson	Financial Consultant
Molly M. Stone	Executive Director
Deona Tucker	REACH Community Liaison (to 7/17)
	Data & Accounting Assistant
Christopher Varghese	Wellness Navigator (to 5/15)
Ashley Vinson	REACH Community Liaison
Judy Washington	Wellness Navigator
Charlotte White	Office Manager

BUILDING A WORKING COMMUNITY HEALTH WORKER NETWORK

> “COMMUNITY HEALTH WORKERS ARE FRONT LINE SOCIAL WORKERS & CASE MANAGERS WORKING TO BUILD RELATIONSHIPS WITH CLIENTS AND ASSIST THEM WITH THEIR HEALTHCARE NEEDS.

The best teachers and leaders for community change often must come from within the community itself. It was this thought, within the context of a need to bring healthcare access opportunities to the vulnerable populations within the REACH service area, that led to the formation of the REACH Community Health Worker intervention.

COMMUNITY HEALTH WORKERS IMPROVE LIFE EXPECTANCY IN VULNERABLE REGIONS

Community health workers (CHWs) promote health through supportive services to bridge healthcare access gaps at the community level. CHWs are used to improve life expectancy in geographical areas where there are too few medical providers and within communities vulnerable to poor health due to low education, low income, a lack of health insurance, or a combination of these factors. Employing CHWs to bring healthcare education and linkage to a community experiencing healthcare barriers is an evidence-based strategy that has been shown to improve individual and community health outcomes.

NONPROFITS RALLY TO THE CALL FOR COMMUNITY HEALTH WORKERS THROUGHOUT THE REGION

Based on a decade-long history of providing CHW services through its signature Wellness Case Management program, The Wellness Coalition (TWC) developed an intervention to establish new sites that offered CHW services. The intervention consisted of providing training to existing case managers at area nonprofit organizations that serve the REACH target population as a strategy to increase access to community health resources.

TWC approached nonprofit organizations that already provided case management services related to needs outside of healthcare (including housing, employment, and general social services) and invited their case managers to become versed on available healthcare resources and to undergo training to coach their clients on how to access them. TWC trained CHW sites to collect data related to the evaluation of the CHW services for a nine-month period. Bound by a contractual agreement to deliver the prescribed CHW services, all CHW sites agreed to continue offering the services after their contract period ended. TWC provided continuing education and networking opportunities to the members of this CHW network.

YEAR 1 CHW SITES:

- East Central Mental Health Center (Macon County)
- Friendship Mission West (Montgomery County)
- Lowndes County Mental Health (Lowndes County)
- The Wellness Coalition (Montgomery County)

YEAR 2/YEAR 2 EXTENDED CHW SITES:

- Family Guidance Center (Lowndes County)
- Friendship Mission North (Montgomery County)
- Hope Inspired Ministries (Montgomery County)
- Lighthouse Counseling Center (Montgomery County)
- Young’s Mentoring Program (Montgomery County)

YEAR 3 CHW SITES:

- Central Alabama Aging Consortium (Montgomery County)
- Council on Substance Abuse (Montgomery County)
- Family Sunshine Center (Montgomery County)
- Montgomery Community Action (Montgomery County)

YEAR 3 SUPPLEMENTAL (YEAR 4) SITES:

- Family Promise of Montgomery (Montgomery County)
- Heritage Training and Career Center (Montgomery County)
- Lending Families a Hand (Montgomery County)

At the beginning of each program year or program year extension, TWC held meetings with interested nonprofit organizations to discuss their organizational capacity to provide CHW services and determine staff training requirements. Two to four organizations became CHW sites each successive program year or program year extension after a meeting was held with the organization’s director and principal employees. After completing contractual agreements defining the REACH partnership, TWC set dates for a two-day CHW training that usually took place at the Montgomery County Health Department and involved representatives from the multiple partnering organizations as trainees.

THE PROCESS OF EXTENSIVE AND THOROUGH TRAINING

REACH community liaisons and project managers facilitated the CHW training based on TWC’s experience with Wellness Case Management and the latest information on health disparities and chronic disease from the Centers for Disease Control and Prevention, the National Partnership to End Health Disparities, the Alabama Department of Public Health, the American Diabetes Association, and the American Heart Association.

Day one of the training encompassed the need for CHW services, the reality of health disparities among communities that lack healthcare access, the many barriers to healthcare, and the complications that result for

individuals who have untreated and unmanaged chronic conditions such as obesity, hypertension, and diabetes. Initial training also examined the skills of motivational interviewing and the importance of building rapport with clients.

Day two of training provided an introduction to resources available to improve healthcare access, such as the Affordable Care Act and the Healthcare Marketplace, Medicaid, low-cost and no-cost medical homes, and medication cost assistance. Strategies for providing healthcare to people with functional and access needs, as well the ethical and legal guidelines for CHW service provision were also covered. Finally, trainees received information on best practices for documenting their provided services and became familiar with the evaluation forms used to measure the impact of their services. They also learned best practices for initial service delivery and service follow-up.

TWC staff guided CHW trainees through additional training modules for insurance coverage through the resources of the Centers for Medicare and Medicaid Services (CMS). Each trainee completed the Certified Application Counselor certification available through CMS.

On their own time, but within a set period, CHW trainees completed online training to be certified as Healthcare.gov application counselors. Once certified to counsel those seeking insurance under the supervision of TWC, trainees learned how to collect information specific to health insurance.

CHWs were trained to provide supportive roles if, in the course of a case management relationship, a client wished to tackle a health-related problem or healthcare access issue. In these supportive roles, CHWs offered possible changes or choices to their clients and then followed up with them on their progress to determine whether they required further assistance.

In addition to helping people make health-related changes, CHWs also sought to monitor their clients' hospital stays and use of hospital emergency departments. They kept track of the number of days that clients experienced reduced activity because of sickness and worked with them to decrease that number. The evaluation of CHW services compared a client's health status before and after services were delivered. CHWs used a baseline data collection form to record participant demographic information and healthcare access need information prior to the delivery of CHW services. CHWs used follow-up forms to document subsequent encounters with clients to determine any further healthcare access needs or whether the client's initial needs had been met.

Combined evaluation data for Years 1 and 2 indicated several positive changes in health status from baseline to the 90-day follow-up. These included:

- A decrease in the number of clients without health insurance (-3.6 percentage points)
- An increase in the number of clients with medical homes (+10.8 percentage points)
- An increase in the number of clients taking prescribed medications (+4.4 percentage points)
- An increase in the number of patients taking medications as prescribed (+3.6 percentage points)

The data also revealed small, non-significant declines in emergency room visits and nights hospitalized over the last three months, as well as days of reduced activity due to illness during the past week. At the 90-day follow-up, most clients felt that the CHWs had made a significant impact on their health status, including helping them to have fewer days of reduced activity due to sickness, decreased ER and hospital visits, increased linkages with community resources, more regularity in taking prescribed medications, and a medical home. Finally, the data revealed that clients, on average, had established 4.8 wellness goals at baseline and had achieved 2.0 of those goals at follow-up.

Under the REACH grant, TWC reimbursed organizations for the time that their employees spent in CHW training. Organizations were also reimbursed monthly for sharing non-identifiable data collected from encounters with each client who received CHW services.

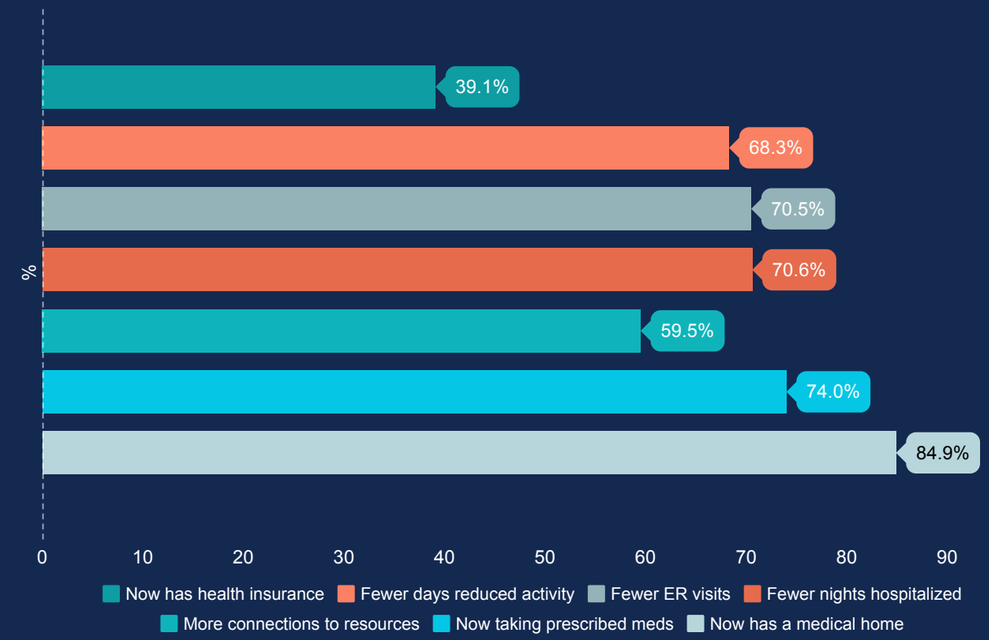
A MEASURABLE IMPACT ON HEALTH IN COMMUNITIES WITH COMMUNITY HEALTH WORKERS

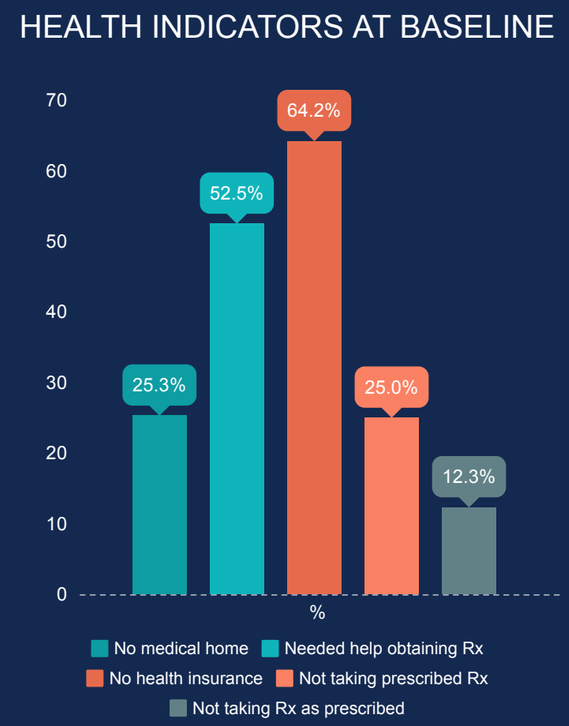
Building health autonomy, raising awareness of community resources, and educating patients contributes to the overall promotion of healthy, sustainable lifestyle behaviors that will help to combat the threat of chronic disease.

The REACH program enabled TWC to increase the efforts of CHWs in the River Region as part of a long-term strategy to improve community clinical linkages. Even though the REACH contract period with the CHW partner organizations has expired, they continue to work together as a network to improve healthcare access.

TWC continues to offer periodic refresher training sessions to the CHWs, providing this network with updated information on chronic disease and its impact on community health, as well as best practices of incorporating CHW services into case management.

Watch our short film on the financial and social impacts CHWs have made in our community and the sustainability of the CHW network at thewellnesscoalition.org/about.





MOST

FREQUENTLY OCCURRING CHRONIC CONDITIONS REPORTED AMONG CLIENTS:

- HYPERTENSION (46.8%)
- DIABETES (34.5%)
- MENTAL ILLNESS (19.6%)
- OBESITY (18.1%)
- ASTHMA/COPD (15.5%)
- HEART DISEASE (12.5%)

EDUCATION AND PEER SUPPORT MAKE PREVENTION, MANAGEMENT, AND CHANGE POSSIBLE

> A SUPPORTIVE ENVIRONMENT CREATES OPPORTUNITIES TO MANAGE HEALTH RISKS, ADOPT HEALTHY BEHAVIORS, AND FOSTER WELL-BEING. INDIVIDUALS WITHOUT THESE RELATIONSHIPS ARE AT GREATER RISK OF NEGLECTING THEIR HEALTH.

THE SUPPORTIVE ENVIRONMENT OF A CHRONIC DISEASE SELF-MANAGEMENT PROGRAM

When health is not prioritized, unmanaged conditions of obesity, high blood glucose levels, and high blood pressure can cause chronic and life-shortening diseases. Prioritizing one's health may include a consideration of lifestyle changes related to nutrition, physical activity, stress reduction, and medication management, as well as health risk reduction through preventive care.

One evidence-based strategy proven to increase health-related learning and improve healthy behaviors is the Chronic Disease Self-Management Program (CDSMP). CDSMP was created and tested at Stanford University and is now overseen by the Self-Management Resource Center (SMRC), an independent agency. CDSMP is a course of peer-led classes designed to help people with chronic diseases (and their caregivers) gain confidence in their ability to control their symptoms and be in charge of how health conditions like arthritis, hypertension, diabetes, obesity, and depression affect their lives. Short lectures and facilitated, interactive discussions on action planning, problem-solving, communication strategies, medicine-free pain management tactics, and other tools of self-management are the focus of the course. Additional topics examined include best practices for working with healthcare providers, dealing with difficult emotions, and healthy lifestyle changes in the areas of nutrition and physical activity.

Since 2008, TWC has utilized CDSMP, known as Living Well Alabama within the state, in its healthcare access efforts. Since 2010, TWC has been licensed to train Lay Leaders to teach the program to others. The Living Well Alabama program consists of six classes that are held weekly and led by trained co-lay leaders who either personally have a chronic condition or care for someone who does. The program is designed to include no more than 15 to 20 participants, and this small group is asked to attend all of the 2.5 hour-long classes each week in order to receive the proven benefit of increased well-being.

AFRICAN AMERICAN CHURCHES AS CDSMP LOCATIONS AND PRESENTERS

TWC invited African-American churches located within the 21 targeted census tracts to become REACH partners and to teach Living Well Alabama as a ministerial outreach to their congregations and surrounding communities. By equipping church leaders to teach CDSMP, TWC expanded the reach of the program and enhanced the support offered by church partners. REACH church partners for CDSMP included:

LOWNDES COUNTY

- Bethlehem Christian Church
- First Missionary Baptist Church of Hayneville
- First Missionary Baptist Church of White Hall
- Rock Creek Baptist Church

MACON COUNTY

- Mary Magdalene Baptist Church
- Washington Chapel African Methodist Episcopal Church

MONTGOMERY COUNTY

- Bethany Seventh Day Adventist Church
- Better Covenant Ministries
- Hope Inspired Ministries
- Impact Christian Church
- Mobile Heights Missionary Baptist Church
- Resurrection Catholic Church
- Victory Through Faith Worship Center

Each REACH partner committed three leaders to four, eight-hour days of Lay Leader training. Once trained, these leaders were asked to teach three rounds of CDSMP classes and to collect non-identifiable data from the program participants prior to their involvement in the program, and then after their completion of the program. Churches were reimbursed for training time, supplies, and data collection.

TWC's goal in this intervention was to develop a partnership with one church in each of the REACH counties each program year. Interested pastors and church leaders were invited to attend an initial meeting in order

to learn about the compliance requirements of the REACH partnership. Because a limited number of partnerships were to be funded, church pastors were invited to apply for these opportunities. The viability of each application was considered, and the strongest candidates were chosen.

Upon completion of Lay Leader training, each church planned dates to offer the program. A certified Lay Leader from the TWC staff accompanied the newly trained Lay Leaders as they offered their initial round of CDSMP. This guidance ensured program compliance and prepared the Lay Leaders to make CDSMP a sustainable part of each church's health programming. TWC also provided support in publicizing the program in surrounding communities.

Over the course of the REACH program, 13 churches were trained as new CDSMP sites, and a total of 34 rounds of CDSMP classes were held within the identified counties serving the targeted census tracts. Two of the 34 cycles of Living Well Alabama were held at the Montgomery Area Mental Health Authority, and one cycle was conducted at the Montgomery County Health Department.

EVALUATING CDSMP

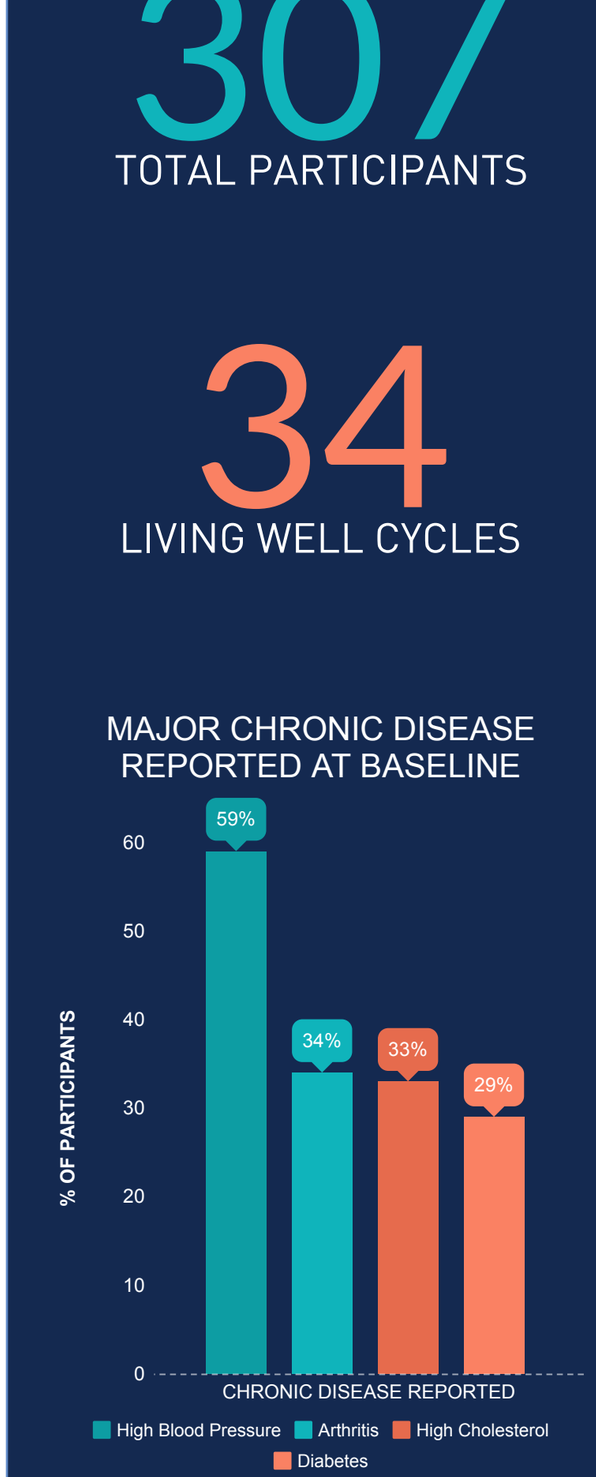
At the beginning of each cycle of Living Well Alabama classes, Lay Leaders asked participants to share information about their health and their self-management practices. According to these assessments, chronic diseases occurring with the most frequency were high blood pressure, high cholesterol, arthritis, and diabetes.

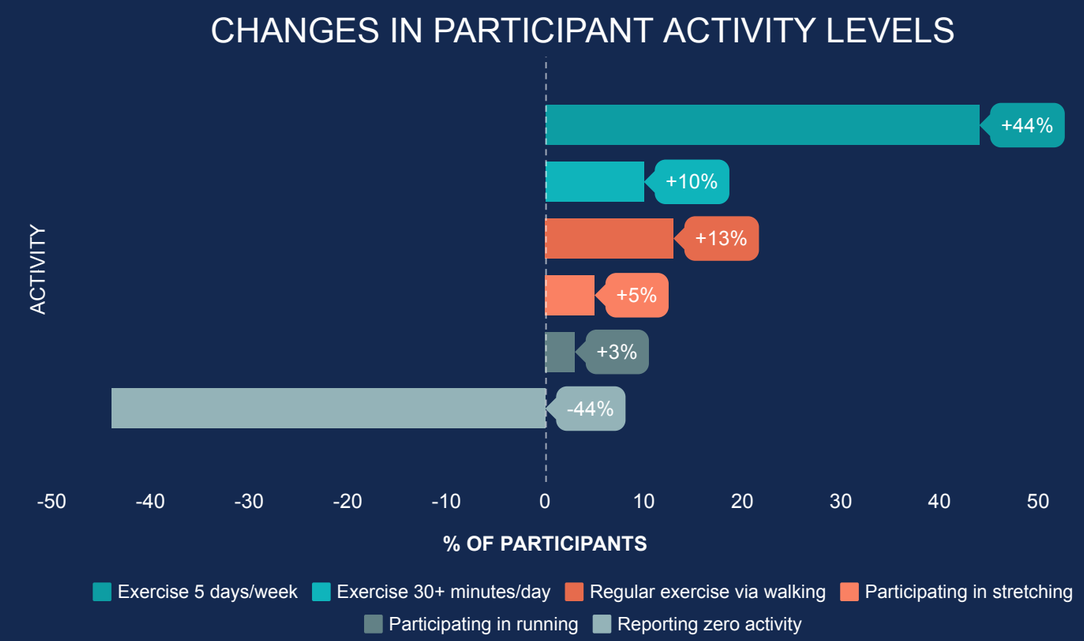
By the end of each course, 29% of the participants rated their general health as either "excellent" or "very good" versus 22% at baseline. More participants paid attention to their salt intake (an increase of 14 percentage points in those who thought about their salt intake at either "every" or "most" meals), and participants recorded an increase in both the average number of days per week during which physical activity occurred (0.6) and minutes per day spent in physical activity (a 10 percentage-point gain in the proportion spending 30 minutes or more). In addition, it appears that participants' daily consumption of fruits and vegetables increased slightly, as did those reporting no emergency room visits over the last six months (a gain of four percentage points from pre-assessment to post-assessment), no nights spent in the hospital (an increase of four percentage points), and the number of days they ate breakfast (a drop of three percentage points in the number of persons eating breakfast one day per week and a corresponding increase of three percentage points in the number having breakfast two times a week). Nearly three-fourths of all CDSMP participants said that they were "very likely" to continue to set weekly self-management goals after completing the program.

CDSMP became a vital part of outreach. Its positive impacts were felt among church leaders and members, and it inspired other health and wellness-related church activities. Routine exercise classes, healthy Wednesday night suppers, accountability groups, health fairs, and scheduled neighborhood walks are examples of existing and new healthy programming offered at the REACH partner churches.

307
TOTAL PARTICIPANTS

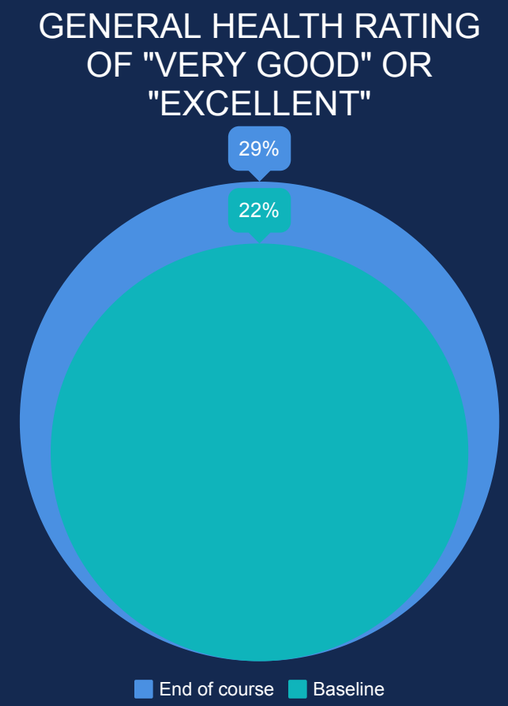
34
LIVING WELL CYCLES





29%

Increase in the percentage of participants reporting having three to five servings of fruits and vegetables daily



THE GREEN PRESCRIPTION: A BACK-TO-BASICS REVOLUTION

> IN AN ERA OF HEALTHCARE REFORM, LOCAL PRIMARY CARE PROVIDERS ARE WORKING TO IMPROVE PATIENT ACCESS TO HEALTHCARE SERVICES AND THE QUALITY OF THOSE SERVICES AS A SIGNIFICANT PERCENTAGE OF THE RIVER REGION'S POPULATION FACES THE GROWING BURDEN OF PREVENTABLE AND UNMANAGED CHRONIC DISEASES.

INTRODUCING THE GAME-CHANGING GREEN PRESCRIPTION

A REACH strategy to improve opportunities for chronic disease prevention, risk reduction, and self-management involved partnering with primary care providers on a new system designed to enhance patient/provider communications concerning nutrition and activity goals. This tailored intervention, called "Green Prescription", aimed to increase the involvement of primary care providers in the promotion of patient behavior change related to nutrition and exercise.

A Green Prescription is a written prescription for nutrition and exercise changes given by a doctor or other medical provider. It is an emphasis on behavior modification tailored to the individual patient. Based on the patient's level of exercise and fruit and vegetable intake, the medical provider gives the patient a prescription for behavior change. The provider follows-up with the patient during future office visits to determine if the prescription is being followed. Changes in health indicators, including patient weight, Body Mass Index (BMI), cholesterol, glucose, blood glucose (A1C), and blood pressure are tracked in relationship to the Green Prescription.

Making a lifestyle change that affects diet and longevity is challenging for most people. Yet, lifestyle choices related to nutrition and exercise determine the quality and length of an individual's life and the degree of complications related to chronic conditions. The Green Prescription intervention provides a communication vehicle and tracking tool for primary care providers, enabling them to address and follow-up on the behavior change necessary to better manage and reduce the risks that are associated with conditions like obesity, hypertension, and diabetes.

PROVIDER PARTNERS MAKE GREEN PRESCRIPTIONS A REALITY

Over the course of the project, three River Region healthcare providers incorporated Green Prescriptions into their healthcare delivery systems, including:

- Health Services Incorporated (HSI)
- Medical Outreach Ministries (MOM)
- Montgomery Area Mental Health Authority (MAMHA)

Each of these providers serves the target population of low-income African Americans from the 21 census tracts in Lowndes, Macon, and Montgomery counties.

The Wellness Coalition (TWC) recruited and worked with one primary care provider network each program year from 2015 to 2017, assisting these REACH partners to incorporate and sustain the practice of giving Green Prescriptions to all patients as a part of an ongoing care plan. These contracted partnerships involved training clinicians to perform the intervention and to adapt their paper or electronic patient record keeping systems in order to permanently integrate the Green Prescription intervention. In return for incorporation of the system prompt within their healthcare delivery process, each provider received a one-time stipend. For a designated period of time, and after staff training and incorporation of the intervention, each of these REACH partners submitted non-identifiable monthly data-collection reports regarding their Green Prescription patients.

INTEGRATION INTO CARE AND MEASURING THE IMPACT

Clinicians at these institutions followed up with their Green Prescription patients after 90 days of the prescription and then, again, after 180 days in order to track and assess patient behavior changes. Because not all of the REACH Green Prescription partners used electronic records, TWC developed carbonized paper forms that could be included in paper files or scanned into electronic records. One of these forms was the Green Prescription itself: a tailored set of instructions on green paper for cardio and/or strengthening activities; weight loss goals; increases in fruit, vegetable, and water servings each day; and daily reductions in sugar-sweetened beverages and fried foods. This form served as an action plan to be followed until the patient's next medical appointment. It also served as a referral for other supportive services related to patient goals, such as diabetes classes and Chronic Disease Self-Management (CDSMP) classes. Each medical provider kept a copy of the Green Prescription in the patient file for clinician referral when the patient returned to the office for follow-up visits.

In addition to the Green Prescription form, TWC designed an interview form that the clinical staff completed when the patient first received their Green Prescription and then again when the patient returned for follow-up visits. Clinical staff used this interview form to record the cardio exercise, strength-building activity, and fruit and vegetable intake of each patient prior to receiving the Green Prescription. At every Green Prescription follow-up visit, clinical staff used this same form to assess any changes in patient activity and nutrition, as well as any changes to their intake of fried foods, sugar-sweetened beverages, and water. In addition to these questions, the follow-up interview for each Green Prescription patient documented the patient's feelings associated with changes in activity and nutrition levels and the patient's pursuit of supportive programming related to the management of chronic disease.

These TWC-designed forms were used for the primary care provider's record keeping as well as for the REACH evaluation of the intervention. In addition to the information contained on these forms, TWC collected data on patient demographics (age, race, gender, and zip code) and basic health indicators (weight, height, blood pressure measurements, cholesterol levels, and A1C readings) at each Green Prescription-related visit. Green Prescription patients were given the choice to release this information for the TWC evaluation. Once each REACH Green Prescription partner completed their data collection obligation for the program year, they were free to use whatever forms they desired in order to continue their use and tracking of the Green Prescription intervention.

RESULTS OF THE GREEN PRESCRIPTION INTERVENTION

MOM was the REACH Green Prescription partner for Year 1 and an extension of Year 1. This Montgomery-based clinic serves patients without insurance who live in Autauga, Elmore, and Montgomery counties. From August 2015 to August 2016, MOM's clinicians and nurses issued Green Prescriptions to 740 participants.

HSI, encompassing 10 clinics within Autauga, Chilton, Elmore, Lowndes, and Montgomery counties, was the REACH Green Prescription partner for Year 2 and an extension of Year 2. HSI is a federally-qualified health center and a patient-centered medical home in the River Region, and six of its clinics are in the REACH population target areas. REACH staff trained nurses at all 10 clinics to offer the Green Prescription and, from March 2016 to May 2017, 3,360 Green Prescriptions were issued.

MAMHA was the REACH Green Prescription partner for Year 3 and an extension of Year 3 from January 2017 to November 2017. MAMHA is a public nonprofit provider of mental health services and medication management for residents of Autauga, Elmore, Lowndes, and Montgomery counties, and two of the clinics are within the REACH population target area. During a nine-month period, MAMHA provided 262 Green Prescriptions to its patients.

Green Prescription patients evaluated by the REACH program were predominantly female, predominantly African American with an average age of 48.8 years, and reside principally in Montgomery County portion of the REACH target area.

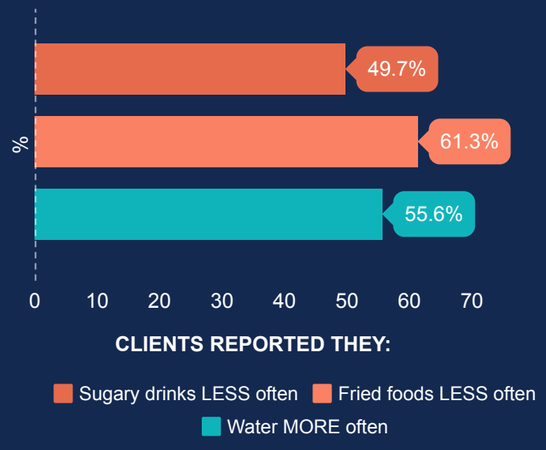
REACH evaluators combined the data collected from all three Green Prescription partners and analyzed matched-case samples. The results demonstrated an improvement in vegetable consumption, from an average of 1.3 servings per day at baseline to 1.4 at 90 days to 1.5 at 180 days (456 matched cases). The results also indicated that Green Prescription patients were drinking sugar-sweetened beverages "less often" at the 90-day follow-up than at baseline (50%; n=1,280), eating fried foods "less often" (63%; n=1,284), and drinking water "more often" (52%; n=1,283). Concerning participant weight, there was a slight increase in the obese category from baseline to the 90-day follow-up (using only those cases [n=1,147] where baseline weight was classified as "overweight" or "obese"), but the proportion of overweight persons dropped by 3.4 percentage points and the number of persons with normal weight reached 19. Beyond the weight of Green Prescription patients, evaluated results revealed improvements in blood pressure readings, blood sugar levels, and cholesterol levels.

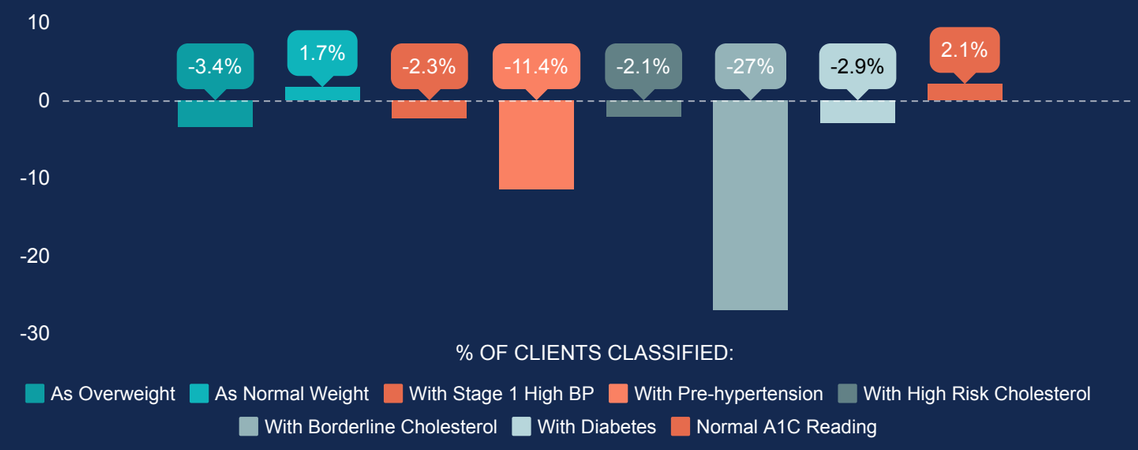
While the proportion of patients with Stage 2 high blood pressure (HBP) increased slightly from baseline to the 90-day follow-up, it declined for all other categories (considering only those cases [n=1,083] where baseline blood pressure was classified as prehypertension, Stage 1, or Stage 2). The decrease was 2.3 percentage points for those with Stage 1 HBP and 11.4 percentage points for those with prehypertension. Furthermore, 11.4% of the study group now recorded "normal" blood pressure, and 0.5% were characterized as "low" blood pressure. The 180-day matched sample (n=374) posted improvements as well, most notably a 12.3 percentage point drop among those with prehypertension and a movement of 39 people (10% of the study group) into the normal blood pressure range.

Of 146 matched cases with blood glucose levels of 125+ at baseline, there was a 12 percentage point decrease at 90 day follow-up. And of those with a glucose level of 100-125 at baseline, there was a 3% drop in blood glucose levels at follow-up. In addition, 15% had overcome their baseline condition of "prediabetes" or "diabetes," moving into a "normal" glucose category at their follow-up appointment.

Using 141 matched cases, evaluators found a significant decline in the percentage of patients with "borderline" cholesterol levels from baseline to the 90-day follow-up (i.e., 27 percentage points) and a corresponding increase in those with cholesterol levels in the "good" category (29% at the 90-day follow-up of those who were either "borderline" or "high risk" at baseline).

Patients receiving Green Prescriptions made healthy adjustments to their diet over time, and their health indicators improved at follow-up visits with their primary care providers. Their care was successfully enhanced due to the willingness of providers to incorporate Green Prescriptions into their system of healthcare delivery. This is good news for providers seeking to lessen the burden of cardiovascular disease and diabetes in their patient population and who want to take a positive step toward the elimination of health disparities in the community.





REDUCING COST AND INCREASING ACCESS TO FITNESS CENTERS

> REGULAR EXERCISE IMPROVES THE QUALITY OF LIFE, LENGTHENS LIFESPANS, AND IS A BENEFICIAL WAY TO HELP MANAGE HEALTH CONDITIONS WHILE POTENTIALLY REDUCING ONE'S MEDICAL COSTS.

PRIORITIZING EXERCISE AS A WAY TO COMBAT HEALTH DISPARITIES

Prioritizing regular exercise can be a challenge for many individuals facing health disparities. In an effort to address this problem, The Wellness Coalition (TWC) considered existing opportunities for exercise in the REACH target area and partnerships that could be developed to improve health outcomes through increased physical activity.

During REACH Year 1, TWC invited the Wellness Centers of Health Services, Inc. (HSI) to offer low-cost memberships to individuals living within the 21 census tracts served by REACH. TWC implemented this initiative at two of HSI's locations–River Region Wellness Center (Montgomery County) and Hayneville Wellness Center (Lowndes County). Although each of these fitness centers is located near the offices of HSI's primary care providers, they operate as separate facilities.

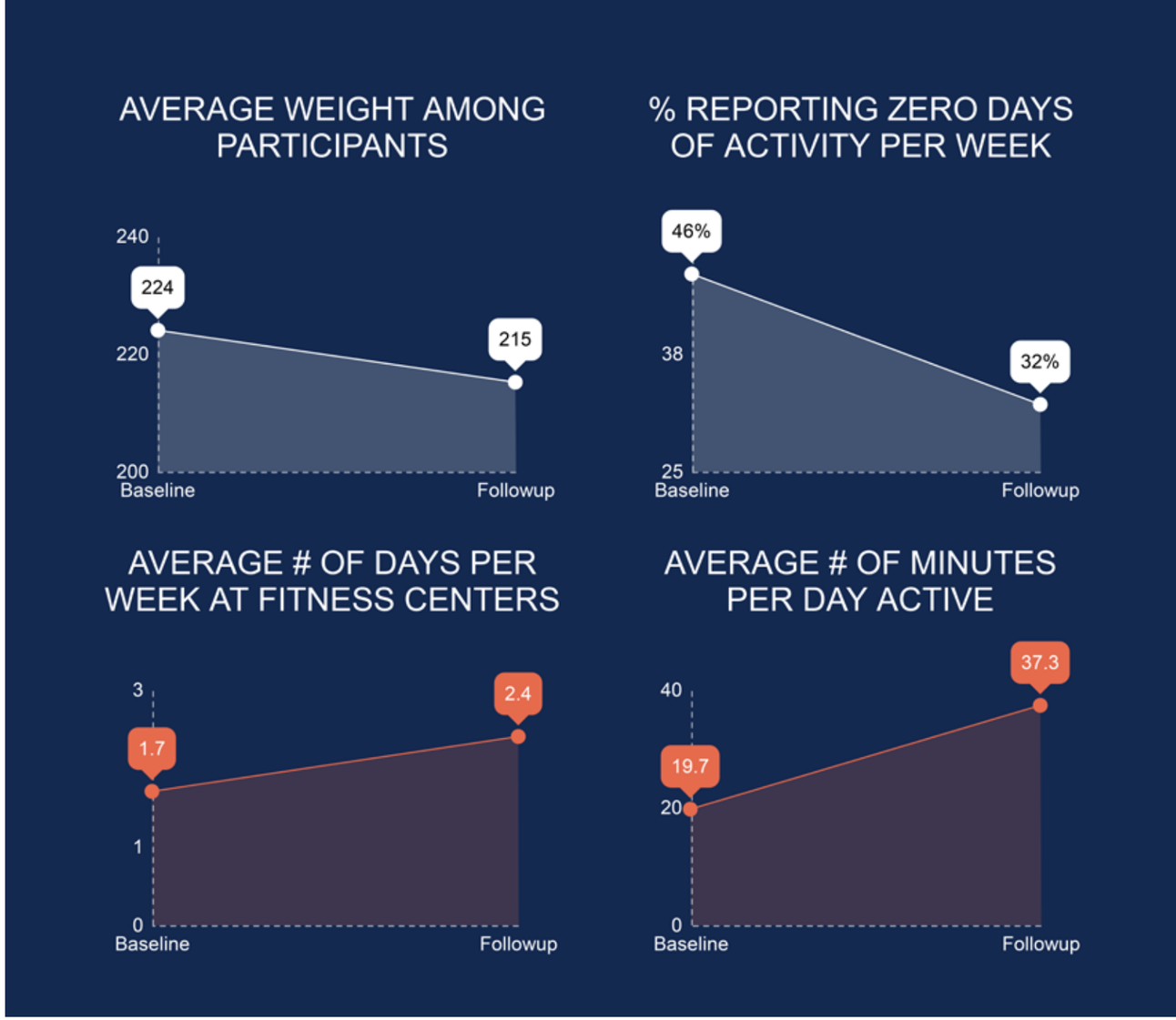
The HSI Wellness Centers offer a clean workout environment with accessibility to weight-resistance machines, free weights, treadmills, bikes, ellipticals, and more. Each facility provides designated rooms for personal workouts and a variety of aerobic classes. Members are encouraged to discuss, learn, and practice exercise routines with available trainers who can guide and support them on their wellness journey.

These fitness centers agreed to waive their customary $10 registration fee and to discount monthly $12 membership fees for residents living in the REACH census tracts. HSI staff also referred patients from the Green Prescription program to receive discounted rates at the wellness centers. In order to monitor the benefits of these discounted rates, fitness center staff collected data on the initial visit for these members and at a follow-up visit to the gym that occurred at least three months later. In exchange for these data, the fitness centers received a monthly data collection incentive.

RESULTS OF THE FITNESS CENTER INTERVENTION

With the implementation of this program, the fitness centers experienced an increase in enrollment. There were 106 membership enrollments at a discounted rate. 88% of the memberships represented new enrollees, and 5% of them were REACH Green Prescription recipients.

Data based on 29 matched cases indicated that 63% of the participants lost at least some weight and that the average loss per person was at least 9.3 pounds. Evaluated members also increased the average number of days per week that they engaged in physical activity (41%), and also increased the number of minutes per day that they were physically active (89%).



SUCCESSES, CHALLENGES, AND OBSTACLES

This intervention yielded positive results, but it is important to emphasize that the matched cases of collected data were small. Membership enrollments did increase at reduced-cost fitness centers, and some Green Prescription patients followed through on an action plan to increase exercise by joining a gym.

However, one-third of the matched-case sample of 29 enrollees did not engage in follow-up physical activity during the course of the intervention. For this reason, the intervention was suspended at the conclusion of Year 1, and REACH resources were focused on other interventions.

We filmed a series of exercise videos, in partnership with HSI, for those who may have limited mobility or a chronic condition. Watch them at thewellnesscoalition.org/resources.

THE CHANGING ROLE OF THE CORNER STORE

> THROUGH THE HEALTHY CORNER STORE PROGRAM, URBAN AND RURAL CONVENIENCE STORES WERE INVITED TO STOCK THREE DIFFERENT FRUITS AND THREE DIFFERENT VEGETABLES OF THEIR CHOOSING WITH THE DISTRIBUTION SUPPORT OF A PRODUCE VENDOR.

Neighborhood stores have historically been vital to the communities around them. Often locally owned, small urban and rural stores, especially in areas without access to grocery stores, met the needs of the community by stocking small-scale amounts of produce, meats, candy, tobacco, beverages, and local newspapers. More recently, these stores have continued to serve the community, but with an emphasis on fast foods and other convenience items, with little attention to healthy foods.

This change can be attributed to few sources of local produce and a lack of reliable distribution systems for supplying produce to smaller stores. Consequently, those who rely on these smaller stores as sources of food lack access to healthy options. Inaccessibility to fresh fruits and vegetables contributes to the rise in chronic conditions for residents of urban and rural communities in the River Region.

INCREASING ACCESS TO HEALTHY FOOD AT CORNER STORES

Through the Healthy Corner Store program, The Wellness Coalition (TWC) enlisted urban and rural convenience stores to stock three different fruits and three different vegetables of their choosing with the distribution support of a produce vendor. The produce was to be prominently displayed in six baskets that were restocked on a weekly basis, and the availability of fresh produce at the store was to be advertised through provided signage.

The stores were responsible for reporting sales and profit data in exchange for a monthly stipend. In addition, they were asked to provide access to their customers for survey purposes. REACH partners conducted these pre- and post-implementation surveys with random store customers through a set schedule including weekdays, weekends, and specified time frames. TWC collaborated with the Central Alabama Regional Planning and Development Commission (CARPDC) to provide the stores guidance throughout the process. CARPDC played a vital role in identifying and introducing the opportunity to 15 convenience stores over a three-year period (2015-2017). CARPDC considered stores that were located in or near the targeted REACH census tracts and selected stores based on their accessibility and use by the target population. CARPDC selected five stores per year within the REACH counties:

LOWNDES COUNTY:

- Casey's Store
- Kwik Stop
- Shopper Stop

MACON COUNTY:

- Chevron
- Texaco Store 87
- The Yellow Store

MONTGOMERY COUNTY:

- BJ's Grocery Store
- Chevron (now Eagle Express)
- Citgo
- Kwik Shop #107
- Kwik Shop #124
- Petro Mart
- Raceway
- Shell
- Variety Shopping Mart

HEALTHY OPTIONS FIND DEMAND AT CORNER STORES

Based on findings from Years 1–3 pre- and post-implementation surveys, TWC and REACH partners identified that the most frequently sold items were snacks, alcohol, tobacco, and gasoline. At pre-implementation, 90% of store customers responded that they would be interested in buying fresh produce including apples, bananas, oranges, grapes, collards/turnips greens, lettuce, and tomatoes. At post-implementation, 81% responded that they wanted the corner stores to continue selling fresh fruits and vegetables.

In the first three years of the program, stores sold over 20,000 units - Year 1 (9,727), Year 2 (6,257), and Year 3 (4,204) - of fresh produce . That number reflects 26 types of fresh fruits and vegetables. Bananas were the biggest seller, followed by plums, apples, and oranges. In addition, other products such as onions, lemons, limes, and tomatoes were popular. The gross profit from REACH produce sales was $4,469.66 (32%). Over the three years, stores discarded only 13% of the items due to spoilage.

MAINTAINING PROGRAM SUCCESS

To build sustainability of the healthy food initiative, in Year 4, TWC partnered with Farmscape Solutions to provide technical assistance (TA) to REACH corner stores. In the nascent stages, REACH staff contacted all identified stores to discuss interest in receiving assistance with continued program implementation.

Out of the 15 original healthy corner stores, one permanently closed and seven desired TA. Of the seven remaining stores that declined TA, six were still selling fruits such as apples, bananas, and oranges, and some were also offering an array of vegetables. Out of the seven that desired TA, six were also still selling some fresh produce, yet they desired a relationship with Farmscape as a new produce vendor. Analysis and maintenance of this program revealed its continued successes and strengthened its evolution.

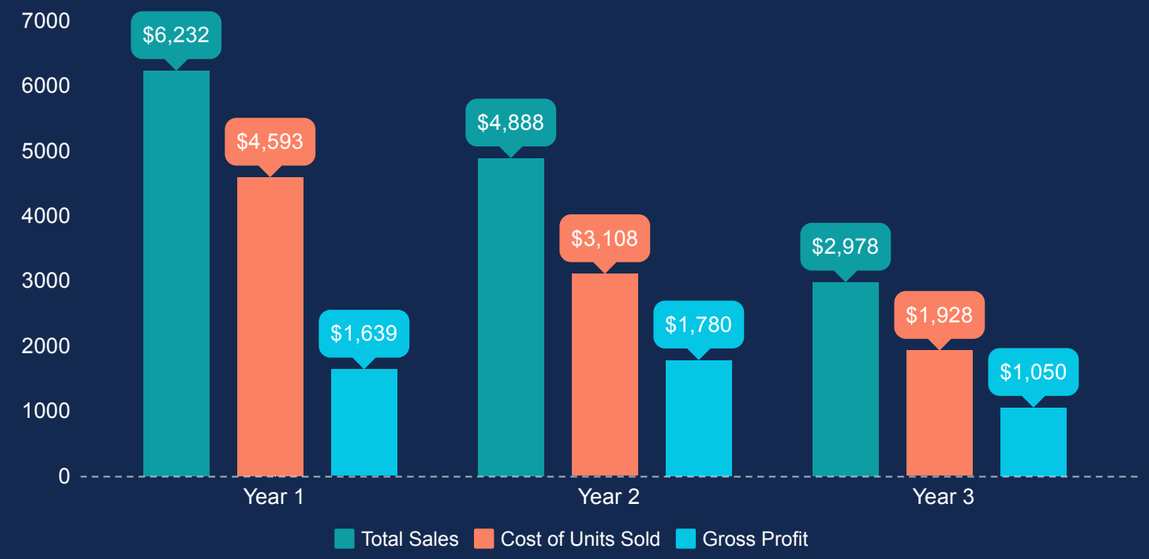
Having available healthy food choices proves beneficial to communities. During a delivery with Farmscape to one of the stores, project staff placed fresh fruits in the baskets, and the plums caught the attention of a paying customer. He had already purchased his morning snack and drink, yet he reached back into his pocket for money to purchase two plums. That moment alone demonstrated the benefit of offering healthy options at corner stores. Increased accessibility to fresh fruits and vegetables is an important step toward healthy lifestyle choices for residents of low income urban and rural areas.

20,188
PIECES OF FRESH PRODUCE SOLD

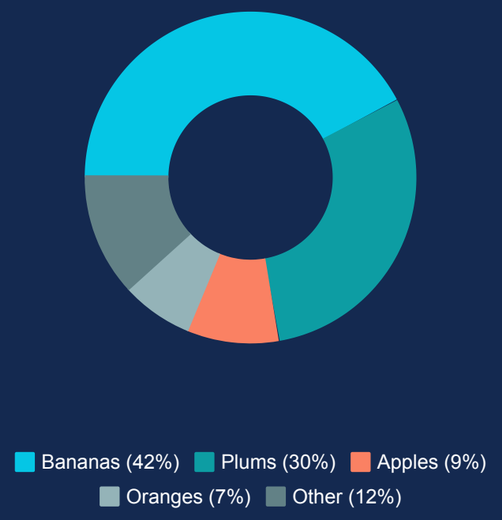
$14,098
WORTH OF FRESH PRODUCE SOLD

	TOTAL YEAR 1		TOTAL YEAR 2		TOTAL YEAR 3		TOTAL	
	UNITS SOLD	% OF SALES	UNITS SOLD	% OF SALES	UNITS SOLD	% OF SALES	UNITS SOLD	% OF SALES
APPLES	767	7.9%	628	10.0%	317	7.5%	1,712	8.5%
BANANAS	3,977	40.9%	2,130	34.0%	2,441	58.1%	8,548	42.3%
BELL PEPPERS	-	-	6	0.1%	-	-	6	<.1%
CABBAGE	-	-	2	<.1%	-	-	2	<.1%
CANTALOUPE	-	-	2	<.1%	-	-	2	<.1%
COLLARD GREENS	6	0.1%	-	-	-	-	6	<.1%
CORN	30	0.3%	-	-	-	-	30	0.1%
CUCUMBERS	-	-	3	<.1%	-	-	3	<.1%
GRAPEFRUIT	-	-	30	0.5%	15	0.4%	45	0.2%
GRAPES	-	-	2	<.1%	-	-	2	<.1%
LEMONS/LIMES	213	2.2%	222	3.5%	14	0.3%	449	2.2%
LETTUCE	-	-	20	0.3%	-	-	20	0.1%
MANDARINS	-	-	-	-	74	1.8%	74	0.4%
NECTARINES	164	1.7%	-	-	-	-	164	0.8%
ONIONS	261	2.7%	193	3.1%	39	0.9%	493	2.4%
ORANGES	717	7.4%	512	8.2%	231	5.5%	1,460	7.2%
PEACHES	57	0.6%	86	1.4%	-	-	143	0.7%
PEARS	28	0.3%	46	0.7%	30	0.7%	104	0.5%
PLUMS	3,068	31.5%	2,061	32.9%	997	23.7%	6,162	30.3%
POTATOES	90	0.9%	73	1.2%	21	0.5%	184	0.9%
SQUASH	9	0.1%	-	-	-	-	9	<.1%
STRAWBERRIES	2	<.1%	4	0.1%	-	-	6	<.1%
SWEET POTATOES	115	1.2%	43	0.7%	23	0.5%	181	0.9%
TOMATOES	223	2.3%	185	3.0%	2	<.1%	410	2.0%
WATERMELON	-	-	9	0.1%	-	-	9	<.1%
TOTAL	**9,727**	**100.0%**	**6,257**	**100.0%**	**4,204**	**100.0%**	**20,188**	**100.0%**

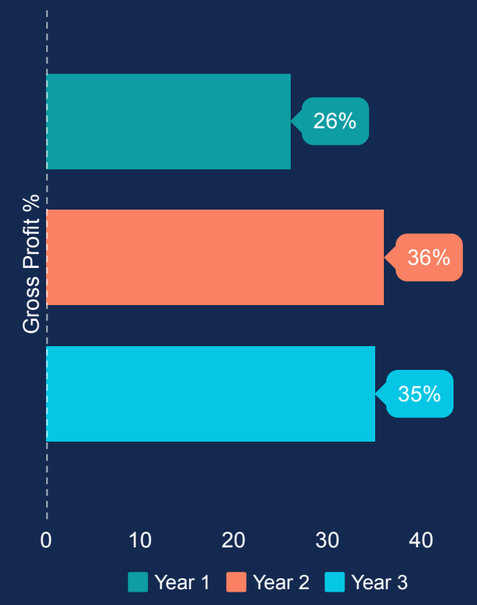
HEALTHY CORNER STORE SALES



TOP PRODUCE SOLD



GROSS PROFIT %



COMMUNITY GARDEN TRAINING REVITALIZES A FOCUS ON A DIET OF FRESH FOODS

> IT IS IMPORTANT TO RETURN TO THE HEALTH BENEFITS OF GARDENING THE FRUITS AND VEGETABLES THAT OTHERWISE HAVE BECOME DIFFICULT TO ACCESS.

Alabama provides an optimum geography and climate for agriculture for both large and small gardens. The historic practice of keeping a home garden, however, is no longer common. Most Alabamians have become disconnected from the seasonal effort of growing their own fruits and vegetables as transportation and technological advances have made it economical to purchase produce that has been shipped from all over the world to local grocery stores.

These advances have freed generations to become occupied with pursuits other than the cultivation of a home or community garden, yet they have also contributed to a disconnect between local food vendors and local consumers. Alabamians are now in the midst of a crisis of diet-related diseases, as those in rural and some impoverished urban communities find themselves served only by stores that are not on fresh produce distribution routes.

Complicating this crisis is the overabundance of fast and ready-made food options stocked at convenience stores. Processed and preserved, these foods have high concentrations of fat, sugar, and low-nutrient carbohydrates. It is important to return to the health benefits of gardening the fruits and vegetables that otherwise have become difficult to access.

COMMUNITY GARDEN TRAINING PROGRAM AS A REACH STRATEGY

Through the REACH cooperative agreement, The Wellness Coalition (TWC) implemented the Community Garden Training program to increase the availability of fresh produce for communities within the 21 targeted census tracts. The goal of this intervention was to collaborate with faith-based organizations as sites where community-accessible gardens could be created and regular trainings could be offered for those who wanted to build and maintain home gardens.

TWC partnered with the Central Alabama Regional Planning and Development Commission (CARPDC) and EATSouth to offer this intervention. Professionals from these organizations used REACH funding to build raised and irrigated garden beds at selected churches within the REACH target area. CARPDC and EATSouth shared their gardening expertise with leaders from each church partner to equip them with knowledge that they could then pass on to those in their congregations or surrounding communities who wanted to start their own home gardens.

Over the course of three years, 12 faith-based organizations developed Community Garden Training programs: three in Lowndes County, four in Macon County, and five in Montgomery County. Each REACH partnership was funded for a year, with an average of four partnerships per year.

LOWNDES COUNTY

- First Missionary Baptist Church of White Hall
- Snow Hill Christian Church
- St. Paul Christian Methodist Episcopal Church

MACON COUNTY

- First Tuskegee Seventh-day Adventist Church
- Greenwood Missionary Baptist Church
- Notasulga United Methodist Church
- Washington Chapel African Methodist Episcopal Church

MONTGOMERY COUNTY

- Capitol Heights United Methodist Church
- Restoration Baptist Church
- St. Peter African Methodist Episcopal Church
- Stonetank Antioch Baptist Church
- The Episcopal Church of the Holy Comforter

THE PROCESS OF PARTNER IDENTIFICATION AND SELECTION

TWC chose these churches through a detailed evaluation process focused on each church's capacity to have a garden, to provide training, and to serve the REACH target population. For Year 1 church selections, TWC sent a mass mailing advertising the opportunity to all of the churches in the 21 census tracts.

As churches expressed interest, CARPDC scheduled and conducted site visits to assess the capacities of the church leadership, the availability of water supply, and adequacy of space for garden beds. The assessments allowed CARPDC and TWC to select optimal partners for the program. In Years 2 and 3, the selection process was modified to be more effective and efficient. Prospective church partners attended a community gardening workshop conducted by EATSouth. Interested church representatives then applied for the opportunity to partner to develop gardening training programs at their own churches. CARPDC and EATSouth representatives then conducted site assessments in order to select the best church partners for the program.

TWC asked each of the selected churches to organize a garden committee comprised of representatives from within the church and surrounding community. It was the committee's responsibility to manage the garden area, plant new seeds or plants, harvest produce, and schedule meetings with CARPDC and EATSouth for monthly or bi-weekly evaluations and educational workshops. After assembling its committee, each church determined a date for a gardening training event. Training events were advertised by the churches, TWC, and CARPDC as open events, inviting everyone in the surrounding community to attend and participate.

GARDEN TRAINING PROGRAMS IN YEARS 1–3

The garden events offered participants a chance to receive interactive experience with small-scale agriculture. Under the guidance of CARPDC and EATSouth, attendees planted a variety of vegetables, fruits, herbs, and flowers, including collards, tomatoes, basil, oregano, eggplants, watermelons, onions, kale, peppers, sunflowers, okra, and marigolds. Several churches took these events a step further by organizing cooking demonstrations using produce that would eventually be harvested from the gardens. These demonstrations showcased different ways of preparing and incorporating vegetables and herbs into meals and the benefits of doing so. Education and awareness were the most vital part of these events.

Watch our gardening video to learn how to grow fresh produce in a variety of containers on your porch or wherever you can at thewellnesscoalition.org/about.

Participants gained insight on how to create their own garden beds, design irrigation systems, deter pests to keep plants organically healthy, and seasonal planting. Apart from the planting sessions, the educational discussions often took place inside of the church buildings where the garden specialists from CARPDC and EATSouth elaborated on their efforts and answered any garden or nutrition-related questions.

Sign-in sheets were created for each event in order to document participants' names, zip codes, counties of residence, ages, church or organizational affiliations, and their methods of learning about the program. From 2015 to 2017, 645 participants attended these events. There were 267 participants documented at the Year 1 gardening trainings, 227 participants at Year 2 trainings, and 151 at Year 3 trainings.

EVALUATION OF THE INITIAL YEARS OF THE PROGRAM

Although the trainings may have differed slightly based on requests from church to church, they all followed the same guidelines to ensure that the objectives of the REACH program were addressed. The success of the garden trainings was measured through 120 telephone interviews with participants who had signed in at the various events. Designed and conducted by the REACH evaluation team, this telephone survey was used to assess the impact of the garden workshops, subsequent participation in the community gardening project, influence on planting vegetables at home, and any changes in vegetable consumption. 88% of the training event participants found the workshops "very valuable." 54% of the respondents started a garden at home because of the "great deal of influence" of the trainings. The trainings also influenced many to increase their intake or servings of healthy foods.

After the initial gardening workshops, representatives from CARPDC returned to the churches on a bi-weekly basis during the growing and harvesting phase of the community gardens. The goals of the visits were to evaluate the program through regular inspections of the gardens' health and to provide further education to the community as needed.

The CARPDC garden specialist completed evaluation reports by noting observations of the garden beds and other planted areas, and conducted an informal interview with a member of the garden committee. Information collected in these reports included the type, size, and number of garden plots planted; vegetables planted; care

of plants relative to watering, pest control, weeding, and cultivation; gardening productivity; and community engagement in tending the garden. This information allowed TWC to understand the church's engagement with the gardens and whether the church garden committee needed further technical assistance. The major findings in the inspection reports were that the gardens were generally "well cared for" and that harvested fruits and vegetables were used for church meals, given to church members, used in church food pantries, and shared with community and neighborhood residents.

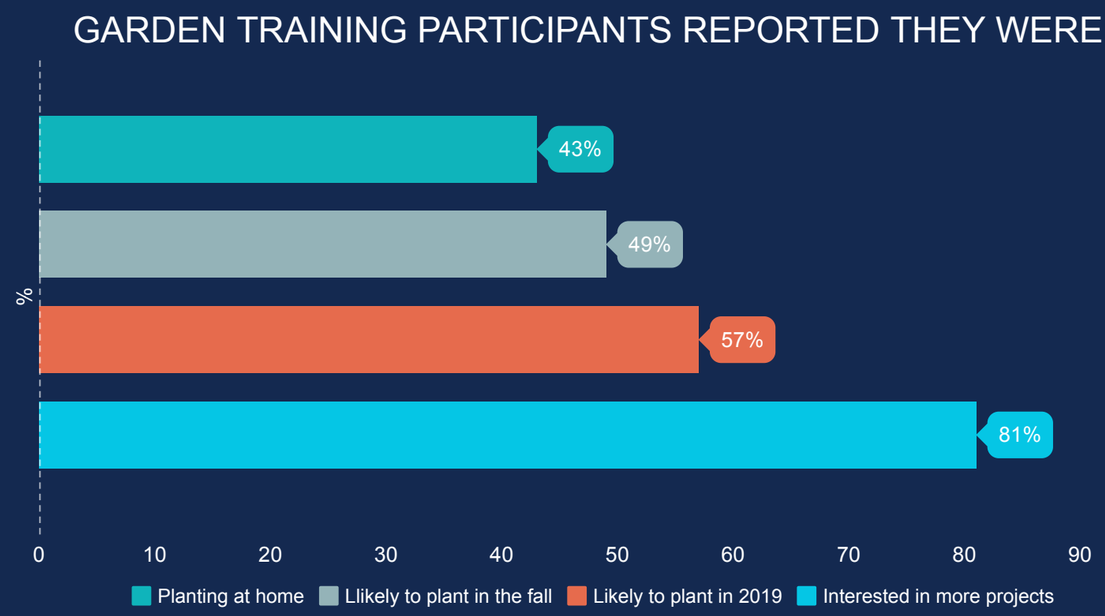
TECHNICAL ASSISTANCE TO THE PROGRAMS IN YEAR 4

In order to increase the sustainability of the Community Gardening Training program at participating churches, TWC started a technical assistance (TA) program with a professional partner, Farmscape Solutions, in 2018. Nine of the 12 churches that implemented the training program in Years 1–3 accepted TA from Farmscape. Their collaboration began with garden visits and baseline evaluation surveys. Of these garden sites, five were dormant, and four were planted.

Of the four sites that were planted, one was in the mid-growing stage, and three were in the late growing stage. Farmscape generally rated the productivity of the gardens as "highly productive" or "fairly productive" and their overall assessment of the gardens was rated as "good." Farmscape conducted the surveys with the garden committee leader at each of the nine community gardens and then collaborated with the committee to plan a spring garden workshop event that was to be advertised to the public.

Utilizing the existing garden bed structures, Farmscape consulted with each church on plant choices, demonstrated planting methods, and continued an ongoing, positive learning experience related to gardening. TWC joined these workshops, providing healthy recipes and other information related to the incorporation of fresh produce into daily nutrition. Farmscape scheduled follow-up site visits with each church garden committee in order to meet with the church partners on garden growth issues and planting choices for the upcoming season.

The overall vision for the Community Garden Training program was to create sustainable access to healthy food options and gardening instruction in underserved communities within REACH census tracts. Through partnerships with faith-based organizations located within a targeted geographical area, the REACH coalition increased access to fresh produce at a community level and provided education to church garden committees and those intending to create home gardens for themselves and their families. This training program is expected to continue into the future with ongoing benefits to community health.



57%

REPORTED THEY AND/OR THEIR HOUSEHOLD WERE EATING MORE FRESH FRUITS AND VEGETABLES AS A RESULT OF THE GARDEN TRAINING.

One church reported the community garden training helped bridge the gap between different generations.

THE REALITIES OF PRODUCE DISTRIBUTION

In the River Region, there are few local growers of fruits and vegetables and even fewer avenues for distribution of this produce. Consequently, there is a disconnect between local residents and locally grown produce. Fruits and vegetables, most imported from outside the state, are available at grocery stores and wholesale distributors in urban areas where there is evident wealth. There are few mechanisms, however, for widely distributing highly perishable produce to smaller stores in less prosperous rural and urban areas.

COMPONENTS OF THE FOOD SYSTEM

A healthy food system is a regenerative cycle of growers providing work for processors who package produce for distributors, who then stock the marketplace for consumers, who then recycle waste as compost for growers. The REACH community action plan, with an emphasis on sustainable healthy food access interventions, considered all of these components of the food system in a collaborative effort to increase access to fresh fruits and vegetables for the residents of the targeted census tracts.

STRENGTHENING PRODUCE DISTRIBUTION AS A REACH STRATEGY

As a supportive intervention to the Healthy Corner Store program, it became a REACH goal in program Years 1–3 to increase the number of produce vendors or distributors available to supply the corner stores with produce for sale. The Central Alabama Regional Planning and Development Commission (CARPDC) was the lead partner in this endeavor for each program year. CARPDC developed relationships with potential food vendors, including food cooperatives and produce procurement companies, by inviting them to expand their markets to include and distribute produce to the stores participating in the Healthy Corner Store program.

In Year 1, five different partners served as food vendors to five healthy corner stores, allowing store owners to choose the vendor that best suited their needs:

- CMB Foods #107, based in Montgomery County
- CMB Foods #124, based in Montgomery County
- Gibbons Farm, based in Elmore County
- Nathan Segall Co., based in Montgomery County
- Wright's Produce, based in Montgomery County

In Year 2, two partners implemented the objective as distributors to continuing Year 1 stores as well as an additional group of five corner stores that had become REACH partners:

- Harvest Tyme Food Ministries, based in Montgomery County
- Opelika Farmers Market, based in Lee County

In Year 3, Lula Martin became the sole distributor to five additional stores that joined the Healthy Corner Store program during that program year.

BARRIERS AND ACCOMPLISHMENTS

All of the partners that served as food vendors to the Healthy Corner Store program during Years 1–3 eventually met economic barriers that led to the suspension of their distribution services to the corner stores. Most vendors desired to sell a greater quantity of produce to the corner stores than the store owners wanted to purchase. The subsequent small profit for these food vendors, combined with the cost of traveling the healthy corner store distribution circuit, meant the service could not be sustained. After two years with this challenge and a constant need to serve as a substitute food vendor, CARPDC was granted the ability to offer mileage reimbursement to the food vendor partner in Year 3.

Over the course of three years, fulfillment of this objective to distribute produce to Healthy Corner Store programs provided access to healthy food options for more than 50,000 people in the REACH target area.

Beyond this accomplishment, CARPDC developed a resource packet for local produce vendors in an effort to cultivate entrepreneurship related to local produce distribution. CARPDC also organized two seminars, one held in Year 2 and another in Year 3, inviting the food vendors, as well as farmers, local officials, investors, students, and educators to learn about the efforts that other regional coalitions have made toward fortifying their own local food cycles. These interactive seminars led to the formation of three different action groups that met during the course of Year 3 to work toward long-term goals on the following topics:

- Healthy Foods Accessibility
- Healthy Foods Feasibility and Sustainability
- Healthy Foods Programs and Partners

These seminars and action groups fostered discussions concerning the steps necessary to improve the local food system in order to reconnect local farmers to local buyers.

EXPANDING OUR REACH WITH STRATEGIC COMMUNICATIONS

USING COMMUNICATIONS AS A CONSTANT REMINDER

The Wellness Coalition (TWC) developed a comprehensive communications strategy to capture the attention of residents in the 21 census tracts. In Year 1, a unique marketing campaign was created for each program intervention. While the public responded positively, TWC employed a new tactic in Year 2 in an effort to increase the impact of all communications efforts. This new tactic was the creation of the character, "Constant Reminder," a positive and energetic spokesperson who reminded the public to make healthy choices.

Constant Reminder became an iconic figure for the majority of REACH communications. From TV to radio, and even on the side of city buses and on healthy corner store signage, he appeared to let people know about each of the REACH programs in a fun and humorous way. It was the widespread use of this character that helped unify the REACH programs into a single identity of wellness that resonated with people across the region.

MAKING COMMUNITY HEALTH WORKERS THE FOCUS

In addition to aligning the messaging under the umbrella of the Constant Reminder character, TWC sought to simplify the point of contact for anyone responding to the ads. By Year 2, nearly all calls to action on REACH advertising directed people to contact community health workers (CHWs) at TWC. By connecting people directly with CHWs, it became possible to promote the wide variety of REACH programs without having to showcase each service individually.

Pooling resources into this type of strategy also allowed CHWs to take center stage as a key resource for the community by connecting people with even more REACH programs than for what they originally called. The work of a CHW is key in connecting people with the resources they need, and it is their work that will ensure sustainability of the REACH program for years to come.

CONTINUOUS EVALUATION KEEPS TACTICS SHARP

The number one communications goal was to get people interested in REACH programs. To ensure the effectiveness of all communications, TWC continuously evaluated marketing creative via phone surveys, focus groups, and feedback from program partners and clients. By getting a steady stream of qualitative data, TWC was able to ensure the messaging was resonating with those whom they needed to engage most. Additionally, TWC evaluated the results of ad buys and no-cost media reporting quarterly in order to find ways to reach more people without surpassing set budgets.

Thanks to feedback from focus groups and the evaluation of Year 1 results, TWC began using different types of media in Year 2 (while omitting some previously used ones) to increase the number of times messages were seen by almost 63.9%. From there, continued evaluation and strategy adjustments led to a 13.9% increase of impressions from Year 2 to Year 3. Overall, REACH messages were seen more than 43 million times, making the REACH communications plan as expansive at it was specifically targeted to ones who would reap the greatest benefits from the programs.

> "HIGHLY VISIBLE ADS ON TV, BILLBOARDS, AND ADS ON RADIO ARE EXTREMELY EFFECTIVE. HOWEVER, SOCIAL MEDIA AND DIRECT MAIL REMAIN TWO OF THE MOST IMPORTANT TOOLS WE HAVE TO CONNECT WITH THE COMMUNITY.

43,601,043

TOTAL NUMBER OF TIMES REACH MESSAGES WERE SEEN

$152,886

VALUE OF FREE ADVERTISING FROM VENDORS

	IMPRESSIONS (NUMBER OF TIMES MESSAGES WERE SEEN OR HEARD)			
	YEAR 1	YEAR 2	YEAR 3	YEAR 4
PUBLIC RELATIONS / MEDIA	37,183	176,917	364,449	239,330
TELEVISION COMMERCIALS	-	4,268,543	7,075,256	2,795,024
ADS IN THEATERS	-	44,007	-	-
RADIO COMMERCIALS	512,000	3,184,624	1,452,258	1,494,000
DIGITAL / WEB ADS	821,797	813,960	-	-
FACEBOOK	378,987	487,926	547,145	597,411*
YOUTUBE	-	2,039	788	632*
TWITTER	79,066	117,029	39,144	150,331*
PRINT/NEWSPAPER ADS	390,045	19,000	29,400	41,000
BILLBOARDS	5,825,907	4,082,865	5,853,510	-
TRANSIT / CITY BUSES	354,000	588,882	291,892	193,687
E-BLASTS	1,044	3,576	5,234	4,671*
DIRECT MAIL	15,639	5,446	50,694	173,705
TOTALS	**8,415,668**	**13,794,814**	**15,709,770**	**5,689,791***

*As of August 31, 2018

The Wellness Coalition filmed a total of 8 commercials and 6 instructional videos. You can watch them all at youtube.com/c/TheWellnessCoalitionMontgomery.

UNDERSTANDING THE NEED FOR CHANGE VIA THE C.H.A.N.G.E. TOOL

> “THE RROTF OUTLINED A PLAN OF POTENTIAL POLICY AND ENVIRONMENTAL CHANGES TO REDUCE OBESITY RATES AND IMPROVE THE LIFE EXPECTANCY OF RESIDENTS.

High prevalence of chronic disease, specifically obesity and its related conditions, has been well documented throughout the state of Alabama, and the River Region counties bear a high burden in this regard. In response to the high obesity rate, Montgomery Mayor, Todd Strange, appointed Michael Briddell, the City’s Director of Public Information and External Affairs, to be its “Health and Fitness Czar” in 2012. Mr. Briddell recruited community leaders and representatives from 85 agencies throughout the River Region (Autauga, Elmore, Lowndes, Macon, and Montgomery counties) to form the River Region Obesity Task Force (RROTF) in order to address population health and barriers to healthy behaviors. The RROTF outlined a plan of potential policy and environmental changes to reduce obesity rates and increase the life expectancy of community residents.

THE RIVER REGION OBESITY TASK FORCE AND THE CHANGE TOOL

Mr. Briddell and the RROTF recruited partnering agencies and individuals to join the mission of making the River Region a healthier community. To assess the area’s limitations that contribute to chronic disease, the RROTF implemented a survey recommended by the Centers for Disease Control and Prevention (CDC) in 2012. The Community Health Assessment and Group Evaluation (CHANGE) Tool was administered to 80 community members to gauge their perspectives on environmental and social conditions that contribute to obesity. The long-format survey took a day’s time to be completed in focus groups and resulted in a detailed needs assessment of healthcare resources and impediments to healthy lifestyles. Eight main barriers were identified:

- Lack of worksite policy and environment support for physical activity
- Less than 60 minutes of required physical activity education per day at schools
- Unsatisfactory standards of nutrition education at healthcare organizations
- Lack of initiative among community institutions to improve environmental policies related to health
- Inadequate physical infrastructure for the promotion of physical activity
- Lack of obesity and chronic disease prevention education
- Inaccessibility to healthy foods, chronic disease management, and other health programs
- Lack of substantial leadership within the community to promote change

CHANGE TOOL RESULTS LEAD TO REACH STRATEGIES

The barriers identified by the 2012 CHANGE Tool survey formed the basis for the work implemented through the 2014 REACH Cooperative Agreement. The RROTF combined with the members of The Wellness Coalition (TWC) formed the community alliance needed to plan, coordinate, and implement the REACH interventions. To further assess community needs and to evaluate the success of the REACH activities, the RROTF administered a reformatted CHANGE Tool in 2017. This questionnaire featured 16 demographic questions and 40 questions about health barriers. The updated health barrier questions pertained to four categories: (1) tobacco use, (2) physical activity, (3) proper nutrition, and (4) access to healthcare. The RROTF promoted and advertised the survey through social media, television, speaking engagements, and partner organizations, resulting in 311 electronic and 189 paper surveys completed. Demographic characteristics of the 2017 survey respondents were as follows:

- 61% were female
- 14% were students
- 20% were 60 or older
- 73% were African American
- 25% were white
- 1% were Asian
- 1% were multiracial
- 39% were unemployed or retired
- 15% worked in the healthcare sector
- 25% lived in rural areas
- 71% visited the doctor regularly
- 17% did not have a hospital in their community

CHANGE TOOL TRACKS EVOLVING HEALTH PRIORITIES

Based on the survey responses, the RROTF developed an updated list of priority strategies to shape future work:

- Increase education concerning the importance of incorporating fruits and vegetables in the diets of WIC and EBT recipients
- Increase educational outreach regarding preparation of healthy meals and snacks
- Increase the number of public facilities available to nursing mothers
- Remain engaged with leaders regarding the enhancement of safety where people exercise and ensure that leaders follow-up on issues such as bike lanes and walkable routes to schools
- Encourage healthcare providers to implement additional evening and weekend office hours
- Evaluate health indicators over time to see if the advice that healthcare providers are giving regarding good nutrition and physical activity is being implemented
- Encourage schools to include healthy living in their mission statements
- Encourage work sites to implement various wellness strategies such as healthy cooking classes, discounted gym memberships, showers, locker rooms, and/or other facilities that will enable employees to exercise before, during, or after work

THE CHANGE TOOL CONTINUES TO DRIVE CHANGE

By identifying areas that need special focus, the RROTF raised awareness of opportunities to improve community health. Mr. Briddell presented CHANGE Tool findings at local government and community meetings with an aim to influence policy and environmental improvement and to encourage investment in health. The RROTF continues to pursue partnerships with organizations across the region to grow the task force and plan future projects. The RROTF declares that change is coming and, with the results from the CHANGE Tool and the community interventions implemented by REACH, the RROTF can show that progress is being made toward a healthier River Region.

HEALTH MINISTRIES AND THE ROLE OF FAITH-BASED SETTINGS IN THE SOUTH

> THROUGH HEALTH PROGRAMS CENTERED ON COMMUNITY AND CONGREGATIONAL NEEDS, FAITH-BASED ORGANIZATIONS CAN OFFER A VARIETY OF SERVICES TO IMPROVE HEALTH AND ENCOURAGE HEALTHY BEHAVIORS.

As an unofficial geographic designation across 14 southern states, the Bible Belt is widely recognized as an area where faith wields a heavy influence on daily living. Located in the heart of this region, Alabama boasts a high percentage of residents who identify as Christian. 86% of the state's adults are members of Christian denominations, while approximately 1% belong to other faith communities. Despite the differences in observance by each faith group or denomination, studies show that faith-based settings serve as safe havens for people who share common interests and are ideal environments to provide assistance in many forms.

HEALTH MINISTRIES AND THEIR IMPACT ON INDIVIDUALS AND COMMUNITIES

Through health programs centered on community and congregational needs, faith-based organizations can offer a variety of services to improve health and encourage healthy behaviors over the lifespan. A culmination of these programs in a faith community is commonly referred to as a "health ministry." Reverend Deacon Stephanie Ulrich, a renowned leader and developer of health ministries in the Episcopal Church, describes these programs as "strategic opportunities for the community to strengthen their wholeness and health, while accentuating disease prevention, wellness, and health promotion." These programs enhance an individual's physical, mental, and spiritual well-being and positively influence the health of the community.

Studies have shown that health ministries reduce unhealthy biometric measurements (i.e., cholesterol, blood pressure, weight, and A1C), increase utilization of cancer screening services, improve psychological states, and reduce health disparities among ethnic groups. The most notable elements that make church health ministries conducive to health improvements include inherent connections to social networks and engagement, the role of prayer and beliefs, and opportunities for healthy nutrition.

HEALTH MINISTRY DEVELOPMENT AS A REACH SUPPORTIVE STRATEGY

The Wellness Coalition (TWC) incorporated health ministries into its REACH strategies by first advertising training and funding to develop such programs by sending mailings to churches in the 21 REACH census tracts. After developing partnerships with local churches in previous REACH years, TWC was able to build on its established reputation within the area to recruit church partners for health ministry projects. Representatives from 12 churches participated in a training session conducted by REACH staff at the Montgomery County Health Department.

The training provided attendees with information about the REACH cooperative agreement, research on the benefits of health ministries, best practices in implementation, and the development of a strategic plan. Upon conclusion of the presentations, representatives worked with the trainers to devise a strategic plan for the creation or improvement of their health ministry. Using a guide provided by TWC, representatives were asked to submit a preliminary plan for the upcoming six months.

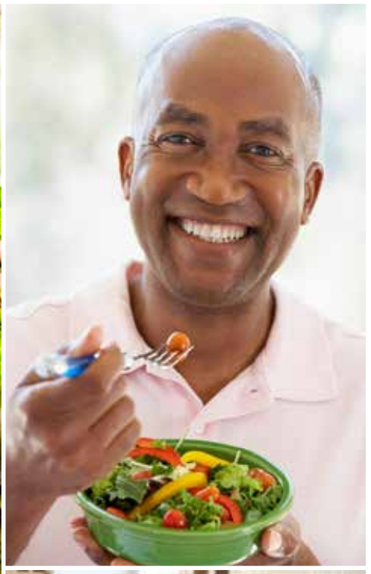
Three Montgomery County churches submitted comprehensive plans: St. Peter AME Church, King Hill Missionary Baptist Church, and Shiloh Missionary Baptist Church. Each of the churches tailored its plan to incorporate existing resources available in its congregation.

St. Peter AME Church was a partner in the Community Garden Training program in Year 3, so its plan was structured around the continuation of the garden's success. St. Peter's pastor and health ministry leader Valtoria Jackson proposed weekly 15 minute "Smart Eating" activities, promoting the adoption of healthier eating habits. St. Peter also planned to connect with health professionals to offer trainings on health and wellness topics for its congregation and local community.

King Hill Missionary Baptist Church began by recruiting church members to serve on a planning committee. King Hill also focused on the creation of a community garden to educate individuals on growing healthy foods and utilizing the harvest to prepare healthy snacks and meals.

Shiloh Missionary Baptist Church focused its health ministry efforts on general health and community events that would complement church-based programs such as Sunday School and Vacation Bible School. This approach allowed for all age groups — seniors, adults, and children — to participate. Shiloh's main focus areas were exercise classes, stress reduction programs, and health and nutrition education. The church planned to disseminate health and wellness information through presentations, posters, skits, organized walks, and cooking demonstrations.

Each of the three participating churches identified three activities for implementation. Each church applied lessons learned in the health ministry training and established a structure that included involvement of multiple generations. With planning in place, these churches are able to leverage their connections to offer more programs and health resources for their congregations. Through continued efforts to advance their health ministries, these houses of worship are serving as reliable and sustainable healthcare resources for underserved communities.



ASSESSING THE STATE OF NUTRITION IN THE STATE OF ALABAMA

> ALABAMA IS RANKED IN THE TOP FIVE STATES FOR OBESITY, DIABETES, AND HYPERTENSION. THE POPULATION'S DISCONNECTION FROM HEALTHY FOOD SOURCES MAY BE A MAJOR CONTRIBUTING FACTOR.

A nutrient-filled diet is essential to the healthy development of the human body, mind, and soul. Lack of access to fresh fruits and vegetables limits an individual's ability to benefit from the valuable nutrients that the body needs. Therefore, impoverished communities are left to consume processed foods that are more readily available than fresh produce. Processed food products that are high in fat, salt, and sugar expose the body to detrimental issues and contribute to the chronic disease epidemic. Alabama is ranked in the top five states for obesity, diabetes, and hypertension, and the population's disconnection from healthy food resources could be a major factor in this problem.

ASSESSING AND UNDERSTANDING THE LOCAL FOOD SYSTEM

To understand avenues to overcome the inaccessibility of healthy food options, The Wellness Coalition (TWC) partnered with the River Region Food Policy Council (RRFPC) to undertake a community food assessment for the 21 REACH census tracts. As a nonprofit agency, the RRFPC advocates for policy reform concerning healthy food resources by engaging and educating community stakeholders on the topic of local food sources. The primary objective of the assessment was to collect survey information that would identify the major constraints to healthy food access and its connection to population health from a community perspective. The secondary intent of the assessment was to identify how each component of the food system may be a potential avenue through which to make healthy food more accessible.

DATA PROVIDED BY CONSUMER PERSPECTIVES

The food assessment consisted of a brief survey which asked community members to state their (1) date of birth, (2) zip code, (3) "go-to" meal when they do not have money or feel tired, and (4) rankings of six potential food problems in their community. Of the 293 randomly-selected participants (average age was 49 years), 68% stated that they resided in low-income census tracts served by REACH. Over 80% of the participants responded to the open-ended question concerning their "go-to" meal, providing 338 different answers varying from healthy to unhealthy food selections. Classification of the food items identified "Unhealthy fast or junk food items" as the "go-to" meal by 34% of responses, compared to only 22% of responses that gave a variation of healthy food products (i.e., fruits, vegetables, and salads). Additionally, 97% of the respondents provided a ranking of potential food problems in the community, conclusively identifying "People are hungry/ don't have enough food to eat" as the highest ranked issue.

IDENTIFIED OPPORTUNITIES FROM FOOD SYSTEM VENDORS

RRFPC also interviewed 17 different vendors, each of whom represented food system-related businesses within the REACH census tracts. Collectively, the interviewees identified numerous opportunities to improve the food system and each aspect of its cycle: production, processing, distribution, consumption, and resource/ waste recovery. These vendors prioritized the following potential improvements to the local food cycle: (1) building partnerships with community organizations, (2) embedding relationships in the community, and (3) improving education on healthier food services.

In order to sustain a healthy local food system, the vendors stressed that these barriers be addressed: (1) lack of access to healthy food, (2) lack of strong organizational infrastructure, and (3) sparse government funding.

FOOD ASSESSMENT CONCLUSIONS

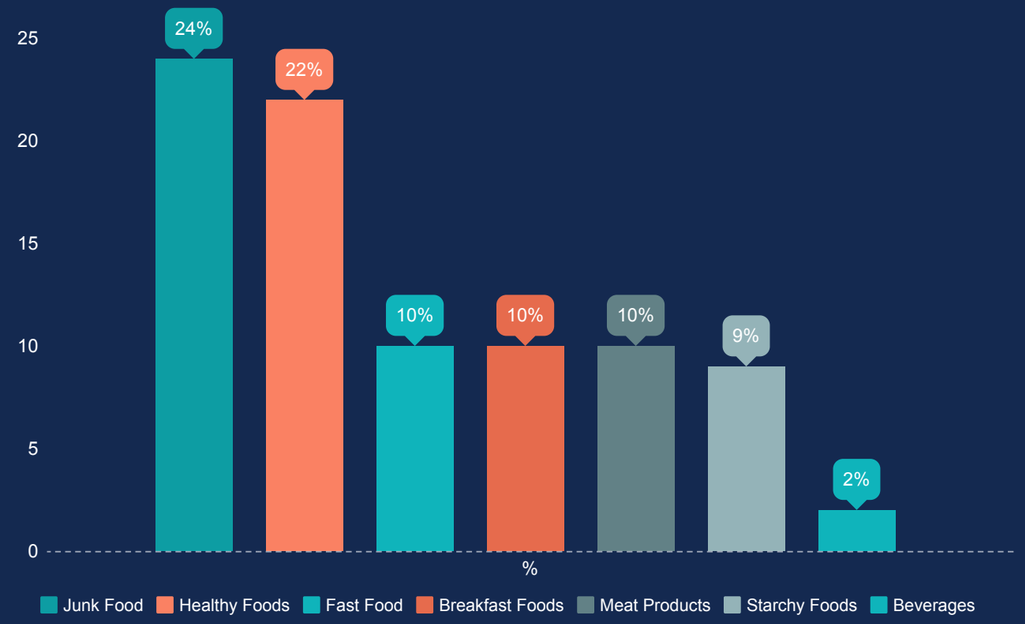
The data reveal that most consumers in REACH census tracts believe that the underlying issue is an insufficient supply of food which results in less nutritious meals. Their opinion is supported by local vendors who concur that insufficient partnerships among community stakeholders, together with a lack of investment in consumer education, has contributed to a deficiency in healthy food options. Numerous social, environmental, and economic variables dictate how, when, and what an individual may eat, potentially steering them toward harmful eating habits.

Despite current realities, it is promising that 22% of survey respondents desire to consume healthy food options and that they rank "fresh and healthy food is not tasty" as a statement that represents the least of their food-related problems. This survey indicates that, if fresh produce became more accessible to these communities, nearly a quarter would be ready to take advantage of it and work to sustain the availability of healthy food.

REACH partners are working to sustain positive social, environmental, and economic shifts necessary to improve the local food system. With faith-based organizations, REACH interventions resulted in the creation of community garden programs to grow and cultivate fresh produce and improve education on the best practices of maintaining and growing a garden. Additionally, TWC collaborated with corner stores to implement an initiative that offers customers the opportunity to purchase fruits and vegetables in local neighborhoods.

These are significant steps toward improving access to healthy food options and reducing rates of chronic disease. However, continued partnerships and education at the community level are needed to ensure a sustainable progression toward a healthier River Region.

WHEN ASKED, "WHEN YOU ARE TIRED, LAZY, BROKE, OR IN A RUSH, WHAT IS YOUR GO-TO MEAL?", RESPONSES INCLUDED:



TOP 6
FOOD PROBLEMS

- People are hungry/don't have enough food to eat.
- School food is not nutritious.
- Not enough fresh/local food available.
- People don't know how to cook/don't cook.
- Limited access to transportation to get food.
- Fresh/healthy food is not tasty.

2-1-1 CONNECTS: A RESOURCE FOR ANSWERS

THE SERVICES OF 2-1-1 CONNECTS

As a REACH nonprofit partner, HandsOn River Region directs individuals to the most critical health and human resources based on their location and need through its program, 2-1-1 Connects. Callers can simply dial 2-1-1 or visit the 2-1-1 online homepage to be connected to enthusiastic and supportive representatives who will take the time to consider callers' needs and suggest appropriate assistance. Representatives apply best practices to search, identify, and list reliable resources and organizations within their database. 2-1-1 Connects assists with linking individuals to numerous agencies in areas such as:

- Basic human needs resources
- City, county, state government services and programs
- Health and mental health resources
- Employment support
- Support for older Americans and persons with disabilities
- Support for children, youth, and families
- Volunteer opportunities and donations
- Military and family support
- Hobby groups and civic/service clubs

CONNECTING CALLERS WITH REACH RESOURCES

In partnership with The Wellness Coalition (TWC), 2-1-1 Connects screens callers for their health needs and refers clients to wellness-based programs focused on case management, chronic disease education, and linkage to community or clinical resources. Referrals made by phone are connected to TWC's Wellness Navigators for further assistance. During the REACH program years from 2014-2018, 2-1-1 Connects served as a supportive partner by expanding their services to collect data on referrals made to TWC programs and partners, such as:

- Community health worker services at nonprofit locations
- Green Prescriptions at medical clinics or hospitals
- Chronic Disease Self-Management Program classes at churches
- Community Garden Training programs at faith-based organizations

2-1-1 Connects endeavors to reduce barriers to healthcare and social service needs, connecting individuals from diverse backgrounds to appropriate resources. The collaboration between 2-1-1 Connects and REACH helped to raise health and wellness awareness among community members and local agencies. This has resulted in the increased utilization of 2-1-1 services over the program years.

	REFERRALS TO ALL AGENCIES	
	TOTAL	%
AFFORDABLE CARE ACT INFO	135	4%
AIDS/HIV CLINICS/COUNSELING	1	<1%
AUTISM THERAPY	19	1%
BLOOD DONATION/BANKS	10	<1%
COMMUNITY CLINICS	399	12%
DENTAL CARE	337	10%
DISEASE/DISABILITY INFO	32	1%
EARLY INTERVENTION	55	2%
EYE CARE/GLASSES	60	2%
HEALTHCARE SUPPORT GROUPS	15	<1%
HEALTH INSURANCE ASSISTANCE	2	<1%
HOME HEALTHCARE	23	1%
HOSPITALS	50	1%
INDEPENDENT LIVING SKILLS	53	2%
MEDICAL CARE EXPENSE ASSISTANCE	85	3%
MEDICAL EQUIPMENT/SUPPLIES	161	5%
MENTAL HEALTH/ADDICTIONS	377	11%
NUTRITION EDUCATION	2	<1%
ORIENTATION AND MOBILITY CARE	2	<1%
OTHER	206	6%
PHYSICIAN REFERRALS	2	<1%
PRESCRIPTION EXPENSE ASSISTANCE	583	17%
WEIGHT LOSS ASSISTANCE	1	<1%
WELLNESS PROGRAMS	762	23%
TOTAL	**3,372**	**100.0%**

	REFERRALS TO TWC	
	TOTAL	%
AFFORDABLE HEALTHCARE INFO	51	4%
DISEASE/DISABILITY INFO	18	2%
PHYSICAL FITNESS	13	1%
PRESCRIPTION ASSISTANCE	350	29%
PROSTHETIC DEVICES	1	<1%
GENERAL	75	6%
WEIGHT LOSS	3	<1%
WELLNESS PROGRAMS	681	57%
TOTAL	**1,192**	**100.0%**

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