**Prevention Goals:**

1. Increase awareness of the risk factors for cardiovascular disease including tobacco use, uncontrolled hypertension, high cholesterol, obesity, physical inactivity, unhealthy diets, and diabetes.
2. Decrease the proportion of adults and children at risk for developing type 2 diabetes.

<table>
<thead>
<tr>
<th>Health Indicators by 2019</th>
<th>QIM Measure</th>
<th>State Measure</th>
<th>Healthy People 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Decrease the prevalence of adults who report no leisure time physical activity from 16% in Crook County, 14% in Deschutes County and 17% in Jefferson County to 14%, 12%, and 15% respectively (Baseline: Oregon BRFSS, 2010-13).</td>
<td></td>
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</tr>
<tr>
<td>2. Decrease the prevalence of 11th graders and 8th graders who 0 days of physical activity from 11% and 6% to 10% and 5%, respectively (Baseline: Oregon Healthy Teens, 2013).</td>
<td></td>
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</tr>
<tr>
<td>3. Decrease the prevalence of adults who are overweight (BMI 25 to 29.9) from 33% to 31% (Baseline: Oregon BRFSS 2010-13).</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>4. Decrease the prevalence of 11th graders and 8th graders who are overweight from 14% and 16%, respectively, to 13% and 14%, respectively (Baseline: Oregon Healthy Teens, 2013).</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>5. Decrease the percentage of OHP participants with BMI greater than 30 from 31.5% to 30.9% (Baseline: Oregon State Core Performance Measure, MBRFSS 2014).</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

1. **3:30-3:35** Introductions—All
2. **3:35-3:40** Membership Update—MaCayla Arsenault
3. **3:40-3:45** Walking School Bus Update—Brian Potwin
4. **3:45-4:50** Proposal Review and Voting—Sarah Worthington & Steve Strang
   - Promoting a Healthy Environment among American Indians & Hispanic Americans Proposal Follow Up
   - Nutrition Education Volunteer Coordinator Proposal—Katie Ahern
   - Diabetes Prevention Program Proposal—Sarah Worthington
5. **4:50-5:00** Next Steps/Action Items—Sarah Worthington & Steve Strang
Grant Application
COHC Application - Standard Process

Jefferson County Public Health Department
Promoting a Healthy Environment among American Indians and Hispanic Americans in Jefferson County

<table>
<thead>
<tr>
<th>Application Snapshot</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount Requested</strong></td>
</tr>
<tr>
<td>$125,582.00</td>
</tr>
<tr>
<td><strong>Organization Contact</strong></td>
</tr>
<tr>
<td>Michael K. Baker &amp; Nansalmaa Conway</td>
</tr>
<tr>
<td><strong>Contact Phone</strong></td>
</tr>
<tr>
<td>541-475-4456</td>
</tr>
<tr>
<td><strong>Contact Email</strong></td>
</tr>
<tr>
<td><a href="mailto:nansalmaa.conway@co.jefferson.or.us">nansalmaa.conway@co.jefferson.or.us</a></td>
</tr>
<tr>
<td><strong>Organization Address</strong></td>
</tr>
<tr>
<td>715 SW 4th Street Madras, Oregon 97741</td>
</tr>
<tr>
<td>Madras, OR 97741</td>
</tr>
<tr>
<td><strong>Website</strong></td>
</tr>
<tr>
<td><a href="http://cohealthcouncil.org/">http://cohealthcouncil.org/</a></td>
</tr>
</tbody>
</table>

A3 Metric:
Decrease the number of those at risk for type II diabetes
Improve primary care response when behavioral health screening is positive
Increase awareness of risk factors for cardiovascular disease

Pillar 10 Vital Condition:
Healthy Environment
Nutritious Food
Physical Activity
Preventative Services & Policies
Proposal Overview

Investment/Project Name*
*Name of Project.

Promoting a Healthy Environment among American Indians and Hispanic Americans in Jefferson County

Name of project lead*

*Please provide the first and last name of the project lead for this funding request.

Michael K. Baker & Nansalmaa Conway

Email for project lead*

*Please provide a good email address for the project lead.

nansalmaa.conway@co.jefferson.or.us

Requestor/Agency location*

Madras

Other towns

*If you chose 'other' above, please specify where your agency is located.

Counties included in project*

*Which of the following counties will your project include?

Jefferson

Inclusion of all counties

*If your project does not include all of the counties listed above, please provide explanation.

Jefferson County has unique demography and challenges in preventing chronic disease, as revealed in the Regional Health Assessments and County Rankings

Project Description/Overview*
Please describe your project.

Jefferson County is a multi-ethnic county in Central Oregon with a population of 21,720 in 2017. Census data shows children under 18 and persons 65 and older make up nearly half of the county’s population. Historically, the county has been ranked last or next-to-last in length of life and healthy behaviors (County Health Rankings and Roadmaps report, 2014-2017), largely due to high rates of early deaths and a prevalence of health risk factors, like smoking and physical inactivity, that contribute to chronic disease. The rates of asthma, arthritis, diabetes, and certain cancers in Jefferson County are some of the highest in the state, and a disproportionate number of these chronic disease cases occur among the American Indian/Alaskan Native and Hispanic communities who constitute nearly 40% of the county’s population (US Census estimates, 2016). These health disparities not only endanger these communities but also put mothers, infants and children at risk of serious health consequences, including the potential for chronic disease earlier in their lives.

With this application we propose to apply Racial and Ethnic Approaches to Community Health (REACH) system strategies to mitigate and reduce these deleterious circumstances, focusing on the nutrition and physical activity factors that have contributed to poor health conditions among Native Americans and Hispanics/Latinos in Jefferson County. The REACH approach will help us measure, manage, and modify flawed behaviors and practices in our target populations.

We will focus our efforts on two strategic approaches: nutrition – fostering healthy eating habits and physical activity – creating opportunities for developing and maintaining a physically-active lifestyle.

This project aims at reducing and preventing chronic disease and premature death among Jefferson County’s Hispanic and American Indian residents by increasing their knowledge of prevention of the most common chronic diseases; improving their nutrition by fostering healthy eating habits; creating opportunities for physical activity; and extending community-based programs that explain the dangers of risky behaviors such as bad eating habits, physical inactivity, and tobacco use, while providing access to healthier lifestyles.

The project outcomes will include a planning model and policies to ensure an accessible healthy food supply; improved residents’ knowledge and practice of healthy eating and physical activity; increased availability of healthy foods in the communities of Warm Springs and Madras; planning to develop a built environment to encourage physical activity in the target communities; increased American Indian tribal and Hispanic community engagement and networks resulting from increasing the number and frequency of partnerships within programs.

Project Goals*

Please concisely describe the goals of this project.

Goal 1:
Extend local resources effectively to reach healthy food consumption status by applying “Sodium Reduction in Communities Program,” “High Obesity [reduction] Program,” and other guidelines in cooperation with local food producers, distributors, and communities.

Goal 2:
Engage communities to get moving by improving knowledge and encourage personal behavior patterns so our population can get adequate exercise

Goal 3.
As a long term goal, we will focus on encouraging sustainable behavioral change and reduction of the prevalence of chronic disease risk factors, and, eventually, a measurable decrease in chronic disease incidence in the project priority populations.

Ultimately, the success of this project “will serve as a model for communities across the state from which to create, implement, and sustain population-based improvements that result in improved health outcomes for all groups, regardless of racial or ethnic composition” (Harvard University, 2012-2015).

**Target Population**
*Please select all that apply.*

- Males
- Females
- Children (ages 0-17)
- Adults (ages 18-64)
- Older Adults (ages 65+)

**Target Population (continued)**
*If your project targets a more narrow subset of the population, please provide that here (ex. postpartum females; individuals diagnosed with pre-diabetes, etc).*

Particularly focused on American Indian and Hispanic residents

**Timeline - project start date**
*Please provide an estimated start date for your project.*

03/01/2019

**Timeline - project end date**
*Please provide an estimated end date for your project.*

03/01/2020

**Project duration**
*Please indicate the number of years you expect this project to span.*
Identified Need*

*Please describe the identified need for this project.*

In 2017, Jefferson County’s population self-identified as 19.8% Hispanic/Latino and 20.2% American Indian/Alaskan Native (ACS, 2012-2016). The county encompasses most of the American Indians in the Warm Springs Reservation as well as a large number of Spanish speaking, migrant agricultural workers. It is estimated that 14.7% of Jefferson County adults are uninsured and 22% of uninsured residents are Hispanics (SAHIE, 2016; U.S. Census, 2016).

A health analysis of Jefferson County using Oregon Public Health Data Tools (OPHAT, 2016) showed the age-adjusted mortality rate for American Indians (1406 per 100,000 population) was almost twice the rate for white non-Hispanics (776/100K population) in the county. What’s more, 43.2% of American Indians and 29.9% of Hispanics had a disability, compared with 24.4% for White adults in Oregon (CDC, 2016).

Many of the county residents live in low-income, sparsely-developed areas with no ready access to health care services or fresh produce and whole grains. A recent report finds 63.1% of the county population is rural and 30.1% of children under 18 live in food-insecure households (Community Needs Assessment Report, 2016; U.S. Census 2010; America Community Survey, 2012-2016). Hispanic and tribal communities face a number of barriers to access nutritious foods due to low income, lack of knowledge and skills for healthy eating, transportation, food storage, etc. Rural and particularly remote, Warm Springs communities have few sources of fresh vegetables and fruits. While Madras has two groceries offering fresh produce at typical Oregon prices, multiple tribal members have pointed out that the principal store in the town of Warm Springs carries general merchandise and groceries, but scant produce at high prices and an even more meager supply in winter.

Compounding the problem, Oregon data from the Behavioral Risk Factor Surveillance System (BRFSS, 2010-2011) show American Indians and Hispanics are more likely to be physically inactive (24.6%, 23.1%) than non-Hispanic whites (17.2%). Overall, 74% of Hispanic and 56% of American Indian 8th-grade students in Oregon schools did not meet the CDC recommendations for daily minimum physical activity. In short, inadequate produce consumption and inactivity are salient risk factors not only for American Indian and Hispanic residents of Jefferson County, but also for Central Oregon’s disproportionately unfavorable health Indicators. Addressing these conditions should, therefore, be considered a local public health and Central Oregon priority.

Community Support*

*Please describe the community support you have received for this project.*

Letters of Support for this project were received from:
- Confederated Tribes of Warm Springs
- Community Health Improvement Partnership (CHIP), Madras
- Warm Springs Community Action Team
- Latino Community Association
- Madras High school chapter of the Future Farmers of America (FFA)

**Optional: Community Support Letter #1**

*Please attach any letters of support that you have received for this project. You may attach up to 5. Letters must be uploaded separately.*

Letter from CTWS WarmSprings.pdf

**Optional: Community Support Letter #2**

Support letter of WarmSpringsActionTeam.pdf

**Optional: Community Support Letter #3**

Letter from CHIP.pdf

**Optional: Community Support Letter #4**

Letter from 509j school.pdf

**Optional: Community Support Letter #5**

Support letter from LCA (LatinoCommAss).pdf

**How will we know if the project is successful?**

We will have the following expected outcomes:

During the first six months we will have:

1. Established a group to promote a model community nutrition policy that can be incorporated into everyday life and which ensures and monitors a healthy food supply.
2. Improved residents’ knowledge and practice of healthy eating habits and physical activity choices by establishing Double-SNAP incentives
3. Fostered tribal and Hispanic community engagement by increasing the number and frequency of partnerships within existing programs such as SNAP, WIC, Lactation Assistance, chronic disease management, CocoonCare, Meals-on-Wheels, Chronic Disease Management, Warm Springs’ Diabetes Prevention, and Native Aspirations
4. Broadened American Indian and Hispanic networks by boosting their representation in various activities and events.
Intermediate (first year):

1. Increased availability of healthy foods such as fruit, vegetables in the communities of Warm Springs and Madras by providing “Double SNAP” and other incentives to local growers and encouraging farmers’ markets.
2. Increased number of healthy food consumers and increased physical activity choices.
3. Measurably changed behavior to favor the consumption of healthy foods and engage in exercise/physical activity among the targeted populations.
4. Created fresh produce supply in grocery outlets and encourage backyard and community gardening based on higher demand by consumers in Madras and Warm Springs.
5. Drafted a Jefferson County Action Plan for Chronic Disease Prevention 2020-2024
6. Decreased prevalence of chronic disease risk factors such as obesity, inadequate eating habits, physical inactivity etc. in our targeted population.

**Affiliations***

*Does your project/program have any national affiliations?*

N/A

**Best Practice***

*What, if any, are the emerging best practices and/or evidence-based guidelines upon which the project is based?*

This project will follow the REACH Logic Model to provide communities the opportunity to improve health, prevent chronic diseases, and reduce health disparities among American Indians and Hispanic Americans with the highest risk, or burden, of chronic disease (e.g., arthritis, stroke, heart disease, Type 2 diabetes, and obesity).

This model will help this project implement strategies for improved nutrition and increased physical activity (incorporated in stretch goals) with the following expected outcomes in Communities with Health Disparities for first one year:

Improvements as recommended by the Regional Health Improvement Plan (including health indicators by 2019 and 2020, health equity strategy, and policy to increase opportunities for physical activity and access to healthy foods); priorities per Central Oregon Health Indicators’ Metrics and other guidelines, including Sodium Reduction, and Prevention of Chronic Disease and Diabetes incorporated in the Central Oregon Prevention goals for cardiovascular disease, i.e., increased awareness of the risk factors for cardiovascular disease including obesity, physical inactivity and unhealthy diets.
Expansion of community networks based on supportive policy and environments to access healthy food and physical exercise to encourage not only personal behavioral change but also system change.

**Fidelity**

*If your program is evidence-based or best practice, will it be reviewed for fidelity?*

The project outcomes will be reviewed for fidelity to REACH model strategies of nutrition and physical activity and short-term outcomes for each project year by project group and staff and community advisory bodies.

**Funding Match**

*Are you seeking any funding matches or additional contributions to support your project? If so, provide the organization/entity name that will be providing the match. If you are not seeking a match, please write*

Matching funding would include other portions (0.1FTE - 0.2FTE) of Public Health Department staff and collaborators’ time that will be applied in-kind to project development, management, and execution ($43,600 contributions from 7 professional persons including the project director, public health data analyst, community health educator, WIC and family services program staff, finance & grant manager, Warm Springs OSU Extension instructor and other partners’ work contribution, etc.)

It will also consist of unmet overhead costs, and the use of Jefferson County and Confederated Tribes of Warm Springs facilities (for meetings), unaccounted-for support personnel, and other costs such as those for obtaining and maintaining vehicles, project-related meeting and activity space support for use in the frequent field interactions as proposed (approx. $10,000).

**Funding Match Amount (if not applicable, leave blank)**

$53,600.00

**Sustainability**

*Please provide the sustainability plan for this project.*

Successes with better fresh produce availability and increased physical exercise opportunities will increase a sense of community empowerment and control, and the demand for continuing the following changes:

1. There will be durable changes not only in individual behavior, personal choices, and responsibilities leading to healthier lifestyles across our targeted communities, as well as awareness for system changes.
2. There will be more locally available fresh produce, a safe outdoor environment, and supportive policies to ensure a continuation of this progress.
3. The number of healthy lifestyle enthusiasts will increase every year, demanding to create a more suitable built environment and opportunities to further improve the availability of healthy foods and beverages.
4. There will be lower rates of chronic diseases such as diabetes, heart disease, asthma, and obesity in Jefferson County.

**Evaluation**

*Please provide the evaluation plan for this project.*

For the duration of the project, we will measure and evaluate activities and outcomes in relation to baseline and incremental data. Assessments will be done through group discussions, knowledge tests (pre-, mid-, and post-training), and other tools as needed. Evaluation will consist of:

- surveys of participants on program advantages and disadvantages;
- assessment of participants’ knowledge and confidence before and after activities to document changes in understanding and practices;
- periodic observing of participants’ behaviors change and healthy choices; and
- comparing of documented outcomes versus county and state health reports and other data.

Tools for evaluation will include:
- group discussions to exchange ideas and to support self-esteem;
- self-administered questionnaires;
- analysis of survey results;
- direct observation - to verify participants’ responses, identify challenges, priorities, and opportunities, to gauge the effectiveness of REACH approaches; and
- attendance records to track participation.

Outcomes to be evaluated are:
- a frequency of buying and preparing fresh produce as part of a meal by participants before and after project;
- number of regular consumers of healthy food items before and after the project;
- number of healthy food outlets or vegetable and fruit distributors in our target communities before and after project; and
- number and size of actively-gardened plots in the community before and after the project.

**Preliminary approval**

*All applicants must go through a preliminary approval process before applications can be approved. Please select how you will receive preliminary approval from the list below.* The majority of applicants will present to a RHIP workgroup.
Present to a RHIP workgroup

**RHIP Workgroup**
*If the proposal will, or has already been presented to a RHIP workgroup, please select the workgroup from the list below.*

Cardiovascular Disease/Diabetes Prevention

**RHIP Goals**
*If your proposal has been or will be submitted through a RHIP workgroup, it must contain at least one goal (clinical or prevention) that corresponds with a workgroup. Please select the applicable workgroup goal(s) that your proposal addresses.*

- Decrease the number of those at risk for type II diabetes
- Improve primary care response when behavioral health screening is positive
- Increase awareness of risk factors for cardiovascular disease

**Pillar 10 vital condition - maximum impact**
*Please select the Pillar 10 condition(s) that you expect your project to have the most impact.*

- Healthy Environment
- Nutritious Food
- Physical Activity
- Preventative Services & Policies

**Pillar 10 vital condition lesser impact (continued)**
*Please select any additional Pillar 10 vital condition areas that you expect your project may have a lesser impact on, if any.*

- Safe Neighborhoods

**Board of Directors Approval**
*If you have been notified that your proposal must be presented to the COHC Board of Directors, your proposal must address one of the Board’s priority areas. Please select which priority area your proposal addresses.*

- N/A

**Objectives**
Objective #1

Objective 1. Explore local resources to create healthy food environments such as healthy minimarkets and grocery stores in Warm Springs and Madras.

Target for objective #1

Target for objective #1. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

Focusing on engagement, the REACH work plan will seek to inform and educate the overall community about existing resources and to explore potential partnerships with local farmers, grocery stores, master gardeners, etc. Our public health department and other partners will organize many events and interventions such as training sessions, meetings, field learning classes, other small incentives, etc. during the project period. By December 1, 2019, these activities will be integrated with the successful implementation of the project’s work plan.

Baseline data for objective #1

Please provide information that indicates where you are starting as it relates to your target (see example above).

Jefferson County has enjoyed historically strong community commitments to overcome barriers and limitations associated with living in a poor rural community. As a result, many community-based partnerships have already formed locally. One of the primary resources currently active is the Jefferson County Community Health Improvement Partnership (CHIP). The CHIP Committee is composed of local schools and daycare centers, tribal health workers, faith-based and ethnic leaders, equity and diversity coalitions, and local governments. The CHIP organizes community kitchen events periodically.

Objective #2

Objective 2. Improve the target populations’ healthy food consumption by developing supportive policy and environments and integrating health and community stakeholder initiatives

Target for objective #2

Target for objective #2. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).
By November 30, 2019 for the nutrition strategy of this objective, the health education classes will be organized based on CDC, WHO, OHA and other agencies’ recommendations and programs to provide participants with understandable and culturally appropriate health education materials which fit project priorities for preventing chronic diseases, learning basic nutrition concepts, promoting healthy choices, eating healthily in combination with improving physical activity, etc.

Before mid-April 1, 2019 (before growing season starts), additionally, community health workers (CHWs) and Community Health Volunteers (CHVs) from the Warm Springs and Hispanic communities and fifteen (15) students aged 11 to 17 years from Jefferson County School District 509-J (Madras High School and Warm Springs K-8 Academy) will be trained and recruited as trainers by trained professionals, including community health educators, nutritionists, and public health specialists throughout the project period.

By May 1, 2019, extended meetings on healthy lifestyles and fostering social connections will be organized. Local experts (15) will be invited: farmers, Warm Springs Education, Culture & Heritage Department, Oregon State University/ USDA Extension Service agents, school district officials, community leaders including policymakers, tribal and Latino community representatives, teachers, parents, child care organizations, preschool facilities, food producers, vendors, distributors, seniors, women, and young adults. The purpose of the meetings will be to spark participants’ knowledge, interest, and ideas on how to deliver fresh vegetables and fruit to our target populations.

By June 1, 2019, fresh produce will be started to be provided by local grocery outlets in Warm Springs and farmers markets will work periodically with reasonable prices in Warm Springs and Madras.

By Spring and early Summer in 2019, field learning practice will be organized by agricultural and gardening experts who will talk about establishing home gardens, greenhouses, and community gardens tended by tribal and Hispanic families. Training and ongoing coaching in gardening techniques will be implemented through Warm Springs Community Action Team and educational centers, senior gardeners, and community leaders in collaboration with landscape professionals.

Baseline data for objective #2*

Rural and particularly remote, Warm Springs communities have few sources of fresh vegetables and fruits. While Madras has two groceries offering fresh produce at typical Oregon prices, multiple tribal members have pointed out that the principal mini-store in the town of Warm Springs carries general merchandise and groceries, but scant produce at high prices and an even more meager supply in winter.

Objective #3

Improve the role of community actions to create healthy food stores/access healthy food through the implementation of discount vouchers and “double SNAP” incentive for local grocers and consumers.

Target for objective #3
Target for objective #3. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

By November 30, 2019, for the community based exploration, public outreach, and engagement strategy of this objective farmers’ market, community kitchen, and salad bar events will be organized through collaboration by the JCPHD and its community coalition partners during the project period. These events will include public health, health care professionals, nutritionists, local food producers, vendors, distributors in an effort to engage the community in a broad range of healthy food growing and consuming practices. Where possible, we will incorporate a food enterprise business model and network – such as Warm Springs Action Team, Future Farmers’ of America, Jefferson County 4H of Oregon State University Extension Service, Warm Springs Education, Culture & Heritage Department, and Oregon Farmers Markets Association.

By May 17, 2019, development of a targeted Jefferson County Double SNAP Farmers’s market and fresh produce outlet addition to the Oregon Trail Card, and other community incentives will be created. Every year, to further encourage healthy consumption, “double SNAP” incentives ($10- $20 per months) will be provided to recipients of SNAP programs, low-income adults and seniors, and disadvantaged youth.

For double SNAP intervention, up to 100 consumers among the target population of the Warm Springs tribal community will be selected every month to receive incentives (coupons) to use to buy discounted vegetables and fruit at mini-markets/convenient stores, and the farmer market in Warm Springs. In addition, reimbursement ($100) for some of those discounts and transportation costs will be made periodically to food distributors periodically when they deliver local fresh produce and fruit to local consumers. The local fresh produce and fruit deliveries, CHWs, CHAs and public health trainers to target consumers will be partly subsidized out of project funds. Such vouchers have been demonstrated to be effective in increasing purchase and consumption of fresh produce, particularly among the vulnerable groups targeted in this study (Ann Arbor, 2014 & USDA, 2014).

Project staff will follow the templates developed in other locales (http://www.oregonfarmersmarkets.org/snap-incentives/) to provide technical assistance to our coalition in applying to Oregon DHS (http://apps.state.or.us/caf/fsm/06fs-wg1.htm) and the USDA Food and Nutrition Service to develop alternative scrip and to local farmers’ markets, and interested fresh produce sellers (including existing grocers) to become authorized outlets for this local supplementation of SNAP benefits. We will also provide technical assistance and guidance in developing recipient selection criteria (and a lottery or other mechanism if demand exceeds supply), an accounting system, market day procedures, educating the participants, and advertising this new opportunity to the community.

Disabled people, low-income families and other clients referred by providers from the project target population will also be provided $10 transportation vouchers to allow them to access healthy food, physical activity centers, and community events.

By March 1, 2020, the number of residents with inadequate fresh food access will be reduced from 20% to 15%.

Baseline data for objective #3

Currently, Double SNAP incentive is not available in Jefferson County and Nearly 20% of county residents live with inadequate fresh food access.

Objective #4
Promote physical activity and physical exercise opportunity in combination with healthy food consumption by encouraging self-esteem and confidence of healthy lifestyles for our target communities

**Target for objective #4**

*Target for objective #4. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).*

In the Autumn of 2019, the activities such as after-lunch and after-school exercise hours, hiking and bicycling teams, a wide variety of active people events, and other group activities will be initiated, and by March 15, 2020, fully organized with a regular schedule, to promote physical fitness for children, youth, disabled people, and seniors in the American Indian and Hispanic communities. These events will provide information, guidance, and coaching on age-appropriate physical activity to at least 1000 individuals and 15 organizations at school campuses, daycare/kindergartens, recreation centers, civic and social gatherings, and similar facilities and events. Disabled people will be given transportation vouchers to allow them to access healthy food, physical activity centers, and community events.

Our target community representatives (25) will receive coupons, gift cards, or other funding support for the purchase of healthy food after successful completion of the project’s physical exercise goals.

By March 1, 2020, the prevalence of adults who report no leisure-time physical activity will be decreased from 17% to 13%.

**Baseline data for objective #4**

17.3% reported no leisure-time physical activity in 2013

**Objective #5**

To develop an Action Plan for Chronic Disease Prevention 2020-2024 document based on existing Jefferson County data analysis for 2014-2016 and the upcoming analysis for 2015-2017 (which will be completed by May 30, 2019) and the most recent Central Oregon Regional Health Improvement Plan 2016-2019.

**Target for objective #5**

*Target for objective #5. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).*
By September 30, 2019, the Jefferson County Public Health Department (JCPHD) will collaboratively establish this plan in collaboration with the Jefferson County Community Development Department, the Board of County Commissioners, and community coalitions such as the Community Health Improvement Partnership (CHIP).

Baseline data for objective #5

Only strategic plan but no Action Plan for Chronic Disease Prevention.

Objective #6

Measure the food consumption and physical activity-related chronic disease outcomes

Target for objective #6

Original target for objective #6

For 2020, Jefferson County's diabetes, heart disease hospitalization rates and premature deaths will be, respectively, decreased to 134.0, 830.0 and 8900 per 100,000 population.

Baseline data for objective #6

Prevalence of the county's diabetes, heart disease hospitalization rates and premature deaths are 138.5, 851.2 and 9,363 in 2016.

Objective #7

Target #7

Baseline data for objective #7

Objective #8

Target #8

Baseline data for objective #8

Objective #9
Target #9

Baseline data for objective #9

Financial Information

Project Budget*

*Please download the Health Council’s budget document, found here. After downloading and completing the budget document, please upload it below.

Revised Budget (Jefferson County PHD).xlsx

Amount requested*

*Total amount of funds requested from the Health Council for this project.

$125,582.00

Funding request - year one

$125,582.00

Funding request - year two

[Unanswered]

Funding request - year three

Follow-up questions and/or supplemental information

Follow-up questions and/or supplemental information

This section is to be used ONLY if you received follow-up questions following your presentation to a workgroup or to the Board of Directors. Please use this space to provide the answers to all questions you may have received post-presentation.

- Please make every effort to type or copy the answers into the text box below.
- In the event that you have documentation such as flow-charts or graphics that you would like to provide that will not copy into a text box, you may use the file upload to attach.
- If you have multiple attachments, they will need to be scanned together and uploaded as one file.
Jefferson County Public Health Department

COHC Application - Standard Process


Question 1. How are the chronic disease rates in American Indians and Hispanic residents in Jefferson County compared with other states’ counties with these ethnic groups?

Jefferson County American Indian (AI) and Hispanic residents’ age-adjusted death rates and many chronic disease rates such as Arthritis, Asthma, Diabetes, heart disease etc. are much higher than other counties’ rates in Oregon. In comparison to Jefferson County, these indicators are similarly high in western counties with Indian reservations and Hispanic persons, e.g. such as Okanogan County, WA (home of the Colville Reservation, 12.9% AI, 19.5% Hispanic), and Fremont County, WY (Wind River Reservation, 21.8% AI, 6.9% Hispanic). All of these counties exhibit elevated diabetes prevalence of 10%-12%, obesity prevalence of 30%-35%, and elevated risk factors such as food insecurity, 14% in each, physical inactivity ranging from 19%-26% among these three counties, and elevated premature death rates ranging from 7,000 (OK county, WA) to 9,100 (JE County, OR) to 12,800/100,000 population for FR County, WY.

Question 2. How will REACH approach help your project?

REACH approach will help our project to create the opportunity for our communities to improve health and prevent chronic diseases. This informs our project strategy to foster nutrition improvements & physical activity per our goals and measure/evaluate project outcomes. This will also help us to better parse out and measure what should be done in short-term (diffusion and dissemination of key information to the community), intermediate-term (further diffusion early adoption) and long (continuing adoption and resulting changes in health status beyond the project period).

Question 3. Do you know other examples which are adaptable to your project?

We found many good examples. For example, schools, in collaboration with local Education and Public Health Departments in Mississippi and South Carolina created “Smart Snack’ interventions using healthy eating guidelines and successfully fundraised for a policy to supplant junk food by supplying better alternatives at schools. Moreover, as a project to reduce sugary soda drinks consumption in California; the Healthy Corner Store Initiative promoted by the Philadelphia Public Health Department; innovative public health policies in New York schools; incentives for healthy food outlets in a Michigan Community Health Department; and voucher approaches for nutrition and physical activity in Canadian Public Health organizations in many provinces. These projects have been helpful in creating supportive environments to improve the nutritional and physical health of their populations.

Question 4. Is there any matching funding for this project? Total – $53,600

Matching funding would include other portions (0.1FTE - 0.2FTE) of Public Health Department staff and collaborators’ time that will be applied in-kind to project development, management and execution ($43,600 contributions from 7 professional persons including project director, public health data analyst, community health educator, WIC and family services program staff, finance & grant manager, Warm Springs OSU Extension instructor and other partners’ work contribution, etc.)

It will also consist of unmet overhead costs, and the use of Jefferson County and Confederated Tribes of Warm Springs facilities (for meetings), unaccounted-for support personnel, and other costs such as those for obtaining and maintaining vehicles, project related meeting and activity space support for use in the frequent field interactions as proposed (approx. $10,000).

Question 5. What innovative/unique activities will occur as a result of this project?
• Community outreach, instruction, coaching, and access to seeds, gardening implements, and natural compost/fertilizer for community gardening
• Nutritional outreach and encouragement for change (such as community events and tastings) toward consumption of more fresh produce vegetables and fruit
• Development of SNAP (and, funding permitting, Double Snap) for farmers’ market(s) in Jefferson County
• Durable changes not only in individual behavior, personal choices, and responsibilities leading to healthier lifestyles across our targeted communities, but also awareness for system changes to continue sustainable improvement with supportive policy awareness among decision makers.
• The major intervention of this project, promoting healthy nutrition, will be complemented by interventions for physical activity.

Question 6. Would it be possible to convene stakeholders and develop the Jefferson County Action Plan before applying for funds? The workgroup would like to know specifically what the money would go towards. We have met with, introduced, and discussed the Action Plan for this project implementation in collaboration with the leaders of project partners, engaging them in budget decisions for the most common activities. The resulting/revised project plan is attached. The budget distribution for this project will be:
1. Personnel: 59% (broken down: 63.8% of that for Jefferson County Public Health Department, 25.4% of that for Warm Springs and 10.8% of that for Hispanic community in Madras)
2. Group meetings and public events 5%
3. Regional and local travel to organize project events and educate people 8.5%
4. Double SNAP and other incentives for purchasing and delivering fresh produce 16.7%
5. Survey and office supplies 0.9%
6. Overhead costs for Jefferson County Government 9.84-9.9%
Justification: Jefferson County is a low-SES county. We anticipate needing grant funds to support the individuals who will take the most active role in the planning process (i.e., project staff for Jefferson County, the Confederated Tribes of Warm Springs, and the Central Oregon Hispanic Coalition). Without support for such professional staff, the development of a thorough, well grounded, and applicable action plan for this project would be tenuous at best.

Question 7. Would you be able to disclose who the personnel are that would be working on this project?
Key staff list to be involved in this project:
1. Project director (In-kind contribution)- Michael Baker (Director, Jefferson County Public Health Department) - responsible for project management, administration, and supervision
2. Overall project coordinator (Chronic disease epidemiologist 0.5 FTE) - Nansalmaa Conway (Jefferson County Public Health Department) - responsible for project planning & reports, objective, outcome measurement, evaluation, survey data analysis, project coordination, evaluation and project activity consulting
3. Warm Springs project co-coordinator (0.15 FTE) - Valerie Switzler, (Manager, The Confederated Tribes of Warm Springs Education, Culture and Heritage Department) - responsible for training, planning, and coordination in Warm Springs
4. Community health assistant (Hispanic speaking) (0.2 FTE) - Jess Mendoza (Jefferson County PHD) - responsible for Hispanic community outreach and training
5. Nutrition/Physical Exercise Educator (0.1 FTE) - Radine Johnson, (coordinator, The Confederated Tribes of Warm Springs Education, Culture and Heritage Department)  
- responsible for training, educating Warm Springs community and outreach
6. Community health assistant (0.1 FTE) - Deanie Smith, (Elder Teacher Project manager, The Confederated Tribes of Warm Springs - responsible for Warm Springs community outreach
8. Project funding and budget coordinator (In-kind contribution),- Karla Hood, Financial and grants manager, Jefferson County PHD - responsible for project funding coordination
9. Project partners (In-kind contribution): Dustin Seyler (Warm Springs Community Action Team), Rosanna John (Warm Springs OSU Extension program), Sara Vollmer (Madras High School 509J), Beth Ann Beamer (CHIP), Tami Kepa’a (WIC) and Carolyn Harvey (health education) etc - responsible for organizing gardening activities/events, school outreach, double SNAP intervention/other incentive coordination, and public health/community health education and training

Question 8. Has LCA confirmed that they have enough capacity to partner in this project?
We discussed this with Mr. Brad Porterfield, Executive Director of the Central Oregon Latino Community Association. He reiterated their interest in collaborating on this project. He confirmed that they have the capacity to serve as a productive partner in this project, through their branch office located in Madras. They will help us to connect to the local Hispanic community and organize project-related events. Their support letter is attached.
In addition, Jefferson County Public Health Department has a capacity of Hispanic speaking workers who can contribute meaningfully as community health assistants.

Question 9. Would Jefferson County be willing to do one aspect of this project for $125,000? If so, would you be willing to modify your proposal with a $125,000 budget and submit it by January 14 for the workgroup to review on January 22?
Yes. We have attached the revised 1-year budget and project proposal with greater concentration on alleviating the fresh produce desert condition in Warm Springs, Jefferson County, and beginning a planning process for improving exercise opportunities for county residents.

Workgroup Approval

Did you complete all portions of the application?
Was your project solicited by a RHIP workgroup as part of an A3 process?
Did you include a proposed budget?

RHIP Workgroup Approval*
Have you already presented and been given preliminary approval by a RHIP workgroup?

Yes, I presented and have been given preliminary approval
Process Following Submission
Application Files

Applicant File Uploads

- Letter from CTWS WarmSprings.pdf
- Support letter of WarmSpringsActionTeam.pdf
- Letter from CHIP.pdf
- Letter from 509j school.pdf
- Support letter from LCA (LatinoCommAss).pdf
- Revised Budget (Jefferson County PHD).xlsx
To Whom It May Concern:

On behalf of the Confederated Tribes of the Warm Springs Reservation of Oregon (CTWS) Culture and Education Department, I am writing to express our enthusiasm for and commitment to partner on a proposed project, to incorporate Tribal foods and the gathering of such as healthy basis of nutrition. The CTWS Culture and Heritage are excited to build on our partnership with Jefferson county Community Health and Educator Program. We believe the project supports the educational empowerment of Native American students by encouraging them to learn about the science that surrounds food.

These activities will have positive long-term effects, including increasing the number of tribal members who seek careers protecting our natural, cultural resources, and food sciences. The proposed project will be tailored to meet the needs of Native American students in a culturally responsive manner while simultaneously helping students acquire the skills and knowledge most critical for success.

As a partner, CTWS Culture and Education Department agrees to:
• Assist in the recruitment of elementary and middle school youth from the Confederated Tribes of the Warm Springs Reservation of Oregon;
• Promote leadership opportunities for high school and college students to serve as mentors to elementary students;
• Provide guidance on curriculum, activities and presenters when we host a program.

We are very interested in providing opportunities for tribal youth to develop skills that will help them protect natural and cultural food resources and to provide technical assistance in the future. If you have any questions, please feel free to contact me at (541) 553-3290.

Sincerely,

Valerie Switzler, Manager
Education, Culture and Heritage Department
PO Box C Warm Springs OR 97761
(541) 553-3290
valerie.switzler@wstripes.org
Dear Dr. Conway, Dr. Baker, and other colleagues,

I was very pleased to hear that you were considering applying for the Racial and Ethnic Approaches to Community Health grant opportunity from the Central Oregon Health Council. I understand that your proposal will focus on providing increased access to healthy groceries for children, adults, and disabled people, and will provide them with technical and practical assistance in developing community and home gardens. I was also pleased to hear of your plans to collaborate with food distributors, producers, vendors, and a broad community coalition to improve distribution and increase consumption of healthy foods, and to train children and adults to consume more fresh produce and increase physical activity.

Our organization, Warm Springs Community Action Team, is a 501(c)3 organization promoting community development on the Warm Springs Reservation by empowering individuals and groups of people to realize their potential, become self-reliant, and affect positive change for themselves, their families, and their community. We provide a bi-weekly outdoor summer market for community members, with vendors including produce and value-added food vendors, arts and crafts vendors, and many others. We have worked in the community to provide agricultural training and assistance to tribal members, and have provided IDA matched savings accounts enabling community members to purchase cattle, fishing boats, food carts, agricultural tools, and other capital assets enabling them to enhance our food system and earn money for themselves and their families. We own two tractors, a rototiller, and significant gardening tools and supplies, and have the know-how to assist tribal and community members on the reservation.

We will look forward to collaborating on this project with you, are happy to assist with community outreach, and will do our utmost to provide technical assistance in gardening, agricultural development, and improving the fresh produce supply chain among Confederated Tribes of Warm Springs tribal members. Please feel free to contact Dustin Seyler, WSCAT's Small Business Coach, or me at 541-553-3148 if you have further questions.

Sincerely,

Chris Watson
Executive Director
Warm Springs Community Action Team
To: Cardiovascular Disease and Diabetes Prevention Workgroup

Central Oregon Health Council

Dear Colleagues,

Our community based organization, Community Health Improvement Partnership (CHIP), helps communities to develop an integrated vision for improving population health by facilitating partnership engagement across multiple stakeholders.

The project support for Racial and Ethnic Approaches to Community Health program from Central Oregon Health Council conforms to our priorities and could help to usefully apply our community outreach to Native Americans and the Hispanic population in our region. Our roles in this project would include:

1. Have an active involvement with coordinating and organizing project events such as workshops, meetings and other activities
2. Play a coordination role, to connect the project community and interventions through existing community outreach partners from members of the Confederated Tribes of Warm Springs and Hispanic people living in Jefferson County.
3. Have a motivational role in mobilizing communities to improve their physical activity and nutrition health based on our community kitchen.
4. Have an influential role in planning efforts to developing the opportunities, policies and environment for our communities to improve access to physical exercise and healthy foods.

Sincerely,

Beth Ann Beamer, RN, BSN
Coordinator,
Community Health Improvement Partnership
Madras, Oregon
Jefferson County Public Health Department, OR  

Dear Central Oregon Health Council,  

Dec 04, 2018  

As faculty advisor to the Madras High school FFA chapter, an agricultural leadership organization, I was very pleased to hear of the Racial and Ethnic Approaches to Community Health grant opportunity from the Central Oregon Health Council.

Many of our FFA members are enrolled members of the Warm Springs Tribe (as is our chapter President), and we have multiple Hispanic FFA members involved as well. We will look forward to assisting with community and home garden development, by providing instruction and assistance in planning, soil preparation, cultivation, planting, insect control, harvest, and marketing of vegetables. As we discussed, I hope to organize two trips per week by our FFA members and agricultural classes to Madras throughout the school year in this service role.

We will also look forward to our members learning more about chronic disease prevention, and engaging themselves in the community to encourage the purposeful exercise that (along with fresh produce) benefits all gardeners.

Sincerely,

Sara Vollmer  
Madras High School, 509J  
Madras, Oregon  
svollmer@509j.net  
mobile 541-815-3341
January 10, 2019

Dear Central Oregon Health Council,

The Latino Community Association (LCA) works across central Oregon serving the needs and aspirations of our immigrant Latino families. We offer our services from four offices, including our Madras office serving Jefferson County where nearly all of our clients are Latino and from families with at least one first-generation immigrant present.

We are very pleased to work in collaboration with Jefferson County Public Health Department (JCPHD), where our Madras office is housed, because there is a pressing need to work with families to generate the motivation, interest and opportunities to improve their health and change behaviors such as physical inactivity and poor eating habits.

The “Promoting a Healthy Environment among American Indians and Hispanic Americans in Jefferson County” project of the JCPHD aims to reduce health disparities and prevent chronic disease among these target groups, which are worthy goals we can get behind. As a potential partner in this project, we foresee contributing in some or all of the following ways to help the project succeed:

- Mobilize the Latinx community broadly to participate in the project activities and support them to improve their knowledge and experience in healthy living.
- Coordinate and organize many activities to increase their healthy choices in nutrition and physical activity in alignment with our family empowerment, healthy families and youth rising programs.
- Distribute interpreted education materials addressing chronic disease prevention.
- Educate people on how to improve their physical activity, healthy food choices and ways to access local health resources.

We hope you will agree that this project’s value deserves funding support from the Central Oregon Health Council as we work together to reduce health disparities and increase access to education and affordable activities to improve the health of Latino and American Indian families in Jefferson County.

If you have any questions about our role and commitment to this project, do not hesitate to call me at 541.550.6297.

Sincerely,

Brad Porterfield

Empowering our Latino Families to Thrive!

28
## Project Budget

<table>
<thead>
<tr>
<th>Personnel Costs: Name</th>
<th>Position (FTE)</th>
<th>Salary</th>
<th>Benefits</th>
<th>Total Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project coordinator as Chronic Disease Epidemiologist (Jefferson County Public Health Department)</td>
<td>0.5</td>
<td>36,393</td>
<td>10,918</td>
<td>47,311</td>
<td>47,311</td>
</tr>
<tr>
<td>Warm Springs Local Project Collaborator/co-coordinator (The Confederated Tribes of Warm Springs Education, Culture and Heritage Department)</td>
<td>0.15</td>
<td>9,982</td>
<td>1297.7</td>
<td>11,280</td>
<td>11,280</td>
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<tr>
<td>Community Health Assistant (CHA) from Hispanic community (Jefferson County Public Health Department)</td>
<td>0.2</td>
<td>6,655</td>
<td>1330.9</td>
<td>7,986</td>
<td>7,986</td>
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<tr>
<td>Nutrition/Physical Exercise Educator in Warm Springs (The Confederated Tribes of Warm Springs Education, Culture and Heritage Department)</td>
<td>0.1</td>
<td>3,327</td>
<td>432.6</td>
<td>3,760</td>
<td>3,760</td>
</tr>
<tr>
<td>Community Health Assistant in Warm Springs (The Confederated Tribes of Warm Springs)</td>
<td>0.1</td>
<td>3,327</td>
<td>432.6</td>
<td>3,760</td>
<td>3,760</td>
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</tbody>
</table>

Sub-Total: Personnel $ 59,684.52 $ 14,411.63 $ 74,096.15 $ 74,097.00

<table>
<thead>
<tr>
<th>Materials &amp; Supplies</th>
<th>Total Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Supplies including binders, file folders, printer paper, toner, etc.</td>
<td>600</td>
<td>600</td>
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</table>

Sub-Total: Materials & Supplies $ 600.00 $ 600.00

<table>
<thead>
<tr>
<th>Travel Expenses</th>
<th>Total Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project director (regional &amp; local travel costs including daily subsistence)</td>
<td>1503</td>
<td>1503</td>
</tr>
<tr>
<td>Chronic disease epidemiologist (regional &amp; local travel costs including daily subsistence)</td>
<td>2048</td>
<td>2048</td>
</tr>
<tr>
<td>Warm Springs local collaborators (local travel costs including daily subsistence)</td>
<td>2048</td>
<td>2048</td>
</tr>
</tbody>
</table>

Total Requested Project Funds from COHC: $ 125,582.00
<table>
<thead>
<tr>
<th>Category</th>
<th>Total Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHWs &amp; CHVs (local travel costs including daily subsistence)</td>
<td>2593</td>
<td>2593</td>
</tr>
<tr>
<td>Community Health Educator/WIC, Home visiting nurses (local travel costs including daily subsistence)</td>
<td>2593</td>
<td>2593</td>
</tr>
<tr>
<td><strong>Sub-Total: Travel Expenses</strong></td>
<td>$10,785.00</td>
<td>$10,785.00</td>
</tr>
<tr>
<td>Consultants &amp; Contracted Services</td>
<td>Total Cost</td>
<td>Amount Requested</td>
</tr>
<tr>
<td><strong>Surveys/group discussions (50 persons /each time for 10 times)</strong></td>
<td>500</td>
<td>500</td>
</tr>
<tr>
<td><strong>Sub-Total: Consultants &amp; Contracted Services</strong></td>
<td>$500.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>Meeting Expenses</td>
<td>Total Cost</td>
<td>Amount Requested</td>
</tr>
<tr>
<td>Education materials, meals and coffee/tea break for 35 persons during 12 events/site visits/gardening practice/public events</td>
<td>6300</td>
<td>6300</td>
</tr>
<tr>
<td><strong>Sub-Total: Meeting Expenses</strong></td>
<td>$6,300.00</td>
<td>$6,300.00</td>
</tr>
<tr>
<td>Professional Training and Development</td>
<td>Total Cost</td>
<td>Amount Requested</td>
</tr>
<tr>
<td><strong>Sub-Total: Professional Training and Development</strong></td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Other Budget Items</td>
<td>Total Cost</td>
<td>Amount Requested</td>
</tr>
<tr>
<td>Incentives, e.g., Double SNAP scrip/other Vouchers ($10/ person/family x 12 cycles) for up to Warm Springs tribal member/Hispanic American SNAP eligible (100) and non-eligible (25) low income individuals/families per cycle</td>
<td>15000</td>
<td>15,000</td>
</tr>
<tr>
<td>Transportation cost support for local fresh produce distributors and healthy grocery outlets connected to Warm Springs</td>
<td>6000</td>
<td>6,000</td>
</tr>
<tr>
<td>Overhead costs for Jefferson County Government by 9.84% ~9.9%</td>
<td>$12,300.00</td>
<td>$12,300.00</td>
</tr>
<tr>
<td><strong>Sub-Total: Other Budget Items</strong></td>
<td>$33,300.00</td>
<td>$33,300.00</td>
</tr>
<tr>
<td><strong>Total Project Budget</strong></td>
<td>$125,581.15</td>
<td>$125,582.00</td>
</tr>
</tbody>
</table>
**Project Implementation Action Plan**

| **Project name:** “Improving the Health Environment (Food and Exercise) for American Indians and Hispanic Americans in Jefferson County” | **Outcome Measure:** Decreased rates:  
Inadequate fresh food access: from 20% to 15%.  
No leisure time physical activity -from 17% to 13%.  
Diabetes and heart disease hospitalization rates: to 134.0 and 810.0 per 100,000 population |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Period of Performance Outcome:</strong> 1 year (March 1, 2019 - March 1, 2020)</td>
<td></td>
</tr>
<tr>
<td><strong>Strategies and Activities</strong></td>
<td><strong>Outcome Measure</strong></td>
</tr>
<tr>
<td><strong>Nutrition Strategy:</strong> Establish well-designed supply chains for healthy foods and extend community partner engagement in Madras and Warm Springs, Jefferson County, Oregon.</td>
<td>Pre- and post-Knowledge and Attitude surveys show significant increases in knowledge, skills, and behavior for 80% of trainees.</td>
</tr>
<tr>
<td><strong>Training, advocacy and learning practice:</strong> Train 4 Community Health Workers (CHWs) and 15 (total) peer trainers, advocates, and master gardeners to educate the community on healthy nutrition choices, focusing on the target populations (families, schools, workplaces, health care organizations, and community groups)</td>
<td>Meetings yielded progression of resources for effective project actions—e.g., identifying resources, recruiting partners, and increasing the number of food distributors, producers and consumers for healthy nutrition (especially for fresh produce). Improved supply chain and distribution outlets for fresh produce at reasonable cost.</td>
</tr>
<tr>
<td>Gardening practice to develop skills to create and expand home gardens, greenhouses, and community gardens among tribal and Hispanic families.</td>
<td>Information successfully disseminated about fresh produce availability. Increased number of skilled gardeners among our targeted populations.</td>
</tr>
<tr>
<td>---</td>
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</tr>
</tbody>
</table>

**Community based public outreach and engagement:**

Organize “Farmers’ Market” and “Salad Bar”, Community Kitchen events through collaboration with partners in Madras, Warm Springs and Metolius. These events will focus on encouraging consumption of local food resources and expanding community engagement in a broad range of fresh produce of outlets for consuming and distributing healthy food.

<table>
<thead>
<tr>
<th>Community based public outreach and engagement:</th>
<th>Increased number of places offering healthy foods in many places in Madras and Warm Springs. Increased network supply for fresh produce by 50 % and increased number of consumers from target communities by 30%.</th>
<th>Public Health Department, County Government, CTWS Education, Culture &amp; Heritage Department, CHIP, Latino Community Association, Warm Springs Community Action Team, Madras High School, 509J</th>
</tr>
</thead>
</table>

Create a food enterprise business model and network

<table>
<thead>
<tr>
<th>Create a food enterprise business model and network</th>
<th>Increased number of food vendors</th>
<th>All partners</th>
<th>Project period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Double SNAP and Incentives:</strong> Demonstrate to be effective in increasing purchase and consumption of fresh produce among the project priority population.</td>
<td></td>
<td></td>
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<tr>
<td>---</td>
<td></td>
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</tr>
<tr>
<td>Create Jefferson County Double SNAP Farmers’ market and fresh produce outlet addition to the Oregon Trail Card.</td>
<td>Established working group and joined Oregon “double SNAP” network.</td>
<td>Public Health Department, CTWS Education, Culture &amp; Heritage Department, Warm Springs Community Action Team</td>
<td>May 17, 2019</td>
</tr>
<tr>
<td>Provide “double SNAP” incentives ($10 per person) to one hundred (100) recipients of SNAP programs every month.</td>
<td>Increased number of healthy food (fresh produce, vegetables, greens and whole grains) consumers.</td>
<td>Public Health Department, Warm Springs Community Action Team</td>
<td>February 15, 2020</td>
</tr>
<tr>
<td>Provide other incentives such as coupons, gift cards ($5-10 per person) to twenty five (25) low-income seniors, disadvantaged youth, and disabled people in our target communities for accessing healthy foods every month.</td>
<td>Increased number of healthy food (fresh produce, vegetables, greens and whole grains) consumers among disabled people and project priority populations.</td>
<td>Public Health Department, Warm Springs Community Action Team</td>
<td>February 15, 2020</td>
</tr>
<tr>
<td>Provide transportation cost ($100 monthly per distributor) support for 5 local fresh produce distributors and healthy grocery outlets connected to Warm Springs</td>
<td>Increased fresh produce supply in Warm Springs</td>
<td>Public Health Department, Warm Springs Community Action Team</td>
<td>Project period</td>
</tr>
</tbody>
</table>
Encouraged to develop broader community support for double SNAP scrip from farmers, vendors, and community organizations to any interested individual/family community members, along with background information on healthy food choices and recipes.

<table>
<thead>
<tr>
<th>Increased number of donors and fundraisers to support double SNAP</th>
<th>All partners</th>
<th>Project period</th>
</tr>
</thead>
</table>

**Physical Activity**: Encourage physical activity and physical exercise opportunity in combination with healthy food consumption by encouraging self-esteem and confidence in healthy lifestyles for our target communities

**Key approaches:**

Develop physical activity interventions such as “After Lunch and After School Hours,” “Hiking Groups,” “Bicycle Group,” and other opportunities to promote physical activity for children, youth, disabled people, adults, and elderly people in American Indian and Hispanic populations.

| Increased number of young children, students, adults, and seniors choosing active lifestyle and increasing physical activity | Public Health Department, Schools, Education Centers, CTWS Education, Culture & Heritage Department, CHIP, Latino Community Association, Madras High School, 509J | March 01, 2020 |

| Increased number of people to play and exercise in- and outdoors. | Public Health Department, CTWS, CHIP, Latino Community Association, Warm Springs Community Action Team | Project period |

Promote cultural acceptance of walking, running, dancing and other physical activity pattern.

Provide the disabled and project priority people with vouchers, coupons and other types of incentives to access wellness therapy sessions, physical exercise places, and community events.
**Assessment and Report:** Survey, group discussion, gathering information of self-reported behavior change and other community outreach activities will be used to evaluate survey findings. Existing baseline data at the beginning and findings at the end of the project will be compared to measure project outcomes.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Responsible Organization</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct surveys, group discussions, assessments, data analysis</td>
<td>Analyzed comparative findings and project outcomes</td>
<td>Public Health Department</td>
<td>June 30, October 31, 2019 / February 28, 2020</td>
</tr>
<tr>
<td>(using baseline data sources of this project’s survey findings and other</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>above-mentioned reports)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create Chronic Disease Data Assessment for project priority population</td>
<td>Recognized pathway to identify the highest priority interventions to reduce and prevent chronic diseases.</td>
<td>Public Health Department</td>
<td>February 28, 2020</td>
</tr>
<tr>
<td>for last three years.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish long term action plan for Chronic Disease Prevention</td>
<td>Completed Action Plan for Chronic Disease Prevention for 2020-2024. Created supportive and integrated policies</td>
<td>County Public Health</td>
<td>September 30, 2019 (drafted) / January 31, 2020 (finalized)</td>
</tr>
<tr>
<td>to develop chronic disease assessment and strategy; explore and include</td>
<td>with input strategies from representatives and stakeholders from many sectors of the food system to serve</td>
<td>Government, the</td>
<td></td>
</tr>
<tr>
<td>broad initiatives, ideas, culturally specific experience, efforts, and</td>
<td>our target populations.</td>
<td>Confederated Tribes</td>
<td></td>
</tr>
<tr>
<td>involvement from local farmers, food distributors, producers, the</td>
<td></td>
<td>for Warm Springs</td>
<td></td>
</tr>
<tr>
<td>education sector, other partner resources, and priority communities.</td>
<td></td>
<td>Reservation (CTWS)</td>
<td></td>
</tr>
<tr>
<td>Evaluate project outcome measure, propose further continued action plans</td>
<td>Evaluated and posted project outcome</td>
<td>Public Health Department</td>
<td>March 01, 2020</td>
</tr>
<tr>
<td>to Jefferson County Commissionaires and report project outcomes to</td>
<td>Reported project results to funding organization and received feedback evaluation for project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Oregon Health Council</td>
<td>implementation.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Responses to committee questions: “Improving the Health Environment Among American Indians and Hispanic Americans in Jefferson County, Oregon” proposal

Is there any matching funding for this project?

Answer: Yes, totaling $53,600

- Matching funding would include other portions (0.1FTE - 0.2FTE) of Public Health Department staff and collaborators’ time that will be applied in-kind to project development, management and execution ($43,600 contributions from 7 professional persons including project director, public health data analyst, community health educator, WIC and family services program staff, finance & grant manager, Warm Springs OSU Extension instructor and other partners’ work contribution, etc.)
- It will also consist of unmet overhead costs, and the use of Jefferson County and Confederated Tribes of Warm Springs facilities (for meetings), unaccounted-for support personnel, and other costs such as those for obtaining and maintaining vehicles, project-related meeting and activity space support for use in the frequent field interactions as proposed (approx. $10,000).

What innovative/unique activities will occur as a result of this project?

Answer:

- Community outreach, instruction, coaching, and access to seeds, gardening implements, and natural compost/ fertilizer for community gardening
- Nutritional outreach and encouragement for change (such as community events and tastings) toward consumption of more fresh produce vegetables and fruit
- Development of SNAP (and, funding permitting, Double Snap) for farmers’ market(s) in Jefferson County
- Durable changes not only in individual behavior, personal choices, and responsibilities leading to healthier lifestyles across our targeted communities, but also awareness for system changes to continue sustainable improvement with supportive policy awareness among decision makers.
- The major intervention of this project, promoting healthy nutrition, will be complemented by interventions for physical activity.

Would it be possible to convene stakeholders and develop the Jefferson County Action Plan before applying for funds? The workgroup would like to know specifically what the money would go towards.

Answer:

- We have met with, introduced, and discussed the Action Plan for this project implementation in collaboration with the leaders of project partners, engaging them in budget decisions for the most common activities. The project plan is attached. The budget distribution for this project will be:
<table>
<thead>
<tr>
<th>N</th>
<th>Expenses</th>
<th>Budget distribution (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Personnel:</td>
<td>59% (broken down: 63.8% of that for Jefferson County Public Health Department, 25.4% of that for Warm Springs and 10.8% of that for Hispanic community in Madras)</td>
</tr>
<tr>
<td></td>
<td>- Chronic Disease Epidemiologist, 0.5 FTE (Jefferson County Public Health Department)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Local project coordinator 0.15 FTE (The Confederated Tribes of Warm Springs Education, Culture and Heritage Department)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Community Health Assistant from Hispanic community 0.2 FTE (Jefferson County Public Health Department)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Nutrition/Physical exercise educator 0.1 FTE (The Confederated Tribes of Warm Springs Education, Culture &amp; Heritage Department)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Community Health Assistant from Warm Springs community 0.1 FTE (The Confederated Tribes of Warm Springs)</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Group meetings and public events</td>
<td>5%</td>
</tr>
<tr>
<td>3.</td>
<td>Regional and local travel to organize project events and educate people</td>
<td>8.5%</td>
</tr>
<tr>
<td>4.</td>
<td>Double SNAP and other incentives for purchasing and delivering fresh produce</td>
<td>16.7%</td>
</tr>
<tr>
<td>5.</td>
<td>Survey and office supplies</td>
<td>0.9%</td>
</tr>
<tr>
<td>6.</td>
<td>Overhead costs for Jefferson County Government</td>
<td>9.84-9.9%</td>
</tr>
</tbody>
</table>

- Justification: Jefferson County is a low-SES county. We anticipate needing grant funds to support the individuals who will take the most active role in the planning process (i.e., project staff for Jefferson County, the confederated Tribes of Warms Springs, and the Central Oregon Hispanic Coalition). Without support for such professional staff, the development of a thorough, well grounded, and applicable action plan for this project would be tenuous at best.
Would you be able to disclose who the personnel are that would be working on this project?

Answer:

- Yes: Key staff list to be involved in this project:

<table>
<thead>
<tr>
<th>N</th>
<th>Project title</th>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Project director (In-kind contribution)</td>
<td>Michael Baker (Director, Jefferson County Public Health Department)</td>
<td>Project management, administration and supervision</td>
</tr>
<tr>
<td>2.</td>
<td>Overall project coordinator (Chronic disease epidemiologist 0.5 FTE)</td>
<td>Nansalmaa Conway (Public health data analyst, Jefferson County Public Health Department)</td>
<td>Project planning &amp; reports, objective, outcome measurement, evaluation, survey data analysis, project coordination, evaluation and project activity consulting</td>
</tr>
<tr>
<td>3.</td>
<td>Warm Springs project co-coordinator (0.15 FTE)</td>
<td>Valerie Switzler, (Manager, The Confederated Tribes of Warm Springs Education, Culture and Heritage Department)</td>
<td>Training, planning, and coordination in Warm Springs</td>
</tr>
<tr>
<td>4.</td>
<td>Community health assistant (Hispanic speaking) (0.2 FTE)</td>
<td>Jess Mendoza (Jefferson County PHD)</td>
<td>Hispanic Community Outreach</td>
</tr>
<tr>
<td>5.</td>
<td>Nutrition/Physical Exercise Educator (0.1 FTE)</td>
<td>Radine Johnson, (coordinator, The Confederated Tribes of Warm Springs Education, Culture and Heritage Department)</td>
<td>Training, educating Warm Springs community and outreach</td>
</tr>
<tr>
<td>6.</td>
<td>Community health assistant (0.1 FTE)</td>
<td>Deanie Smith, (Elder Teacher Project manager, The Confederated Tribes of Warm Springs)</td>
<td>Warm Springs community outreach</td>
</tr>
<tr>
<td>8.</td>
<td>Project funding and budget coordinator (In-kind contribution)</td>
<td>Karla Hood, Financial and grants manager, Jefferson County PHD</td>
<td>Project funding coordination</td>
</tr>
<tr>
<td>9.</td>
<td>Project partners (In-kind contribution)</td>
<td>Dustin Seyler (Warm Springs Community Action Team), Sara Vollmer (Madras High School 509J), Beth Ann Beamer (CHIP), Tami Kepa’a (WIC) and Carolyn Harvey (health education) etc.</td>
<td>Organize gardening activities/events, school outreach, double SNAP intervention/other incentive coordination, and public health/community health education and training</td>
</tr>
</tbody>
</table>
Has LCA confirmed that they have enough capacity to partner in this project?

Answer:

- We discussed this with Mr. Brad Porterfield, Executive Director of the Central Oregon Latino Community Association. He reiterated their interest in collaborating on this project. He confirmed that they have the capacity to serve as a productive partner in this project, through their branch office located in Madras. They will help us to connect to the local Hispanic community and organize project-related events.
- In addition, Jefferson County Public Health Department has capacity of Hispanic speaking workers who can contribute meaningfully as community health assistants.

Would Jefferson County be willing to do one aspect of this project for $125,000? If so, would you be willing to modify your proposal with a $125,000 budget and submit it by January 14 for the workgroup to review on January 22?

Answer: Yes.

- We have attached the revised 1-year budget and project proposal with greater concentration on alleviating the fresh produce desert condition in Warm Springs, Jefferson County, and beginning a planning process for improving exercise opportunities for county residents.
Grant Application

COHC Application - Standard Process

Oregon State University - Cascades
OSU Extension Nutrition Education Program Volunteer Coordinator

A3 Metric:
Decrease the number of those at risk for type II diabetes

Pillar 10 Vital Condition:

Education
Healthy Environment
Nutritious Food
Note: * indicates required questions

Proposal Overview

**Investment/Project Name***
Name of Project.

OSU Extension Nutrition Education Program Volunteer Coordinator

**Name of project lead***
Please provide the first and last name of the project lead for this funding request.

Katie Ahern

**Email for project lead***
Please provide a good email address for the project lead.

katherine.ahern@oregonstate.edu

**Requestor/Agency location***

Bend
La Pine
Madras
Prineville
Redmond
Warm Springs

**Other towns***
If you chose 'other' above, please specify where your agency is located.

**Counties included in project***
Which of the following counties will your project include?

Crook
Deschutes
Jefferson

**Inclusion of all counties***
If your project does not include all of the counties listed above, please provide explanation.
We do not serve Northern Klamath from Central Oregon. Our Klamath Falls unit would serve this area.

**Project Description/Overview***

*Please describe your project.*

OSU Extension Nutrition Education/SNAP-Ed Program serves the SNAP eligible Oregonians and the nutrition education and obesity prevention component of SNAP (Supplemental Nutrition Assistance Program) through evidenced-based, community level programming. The goal of our program is to improve the likelihood that persons eligible for SNAP will make healthy food choices within a limited budget and choose physically active lifestyle consistent with the current Dietary Guidelines for Americans. These actions can lead to improving chronic conditions in adults. Research shows chronic conditions such as obesity and diabetes are more prevalent in adults living below the federal poverty level in Oregon by 7% for obesity and 4% for diabetes as well as in rural areas by 4% more diabetic adults than their urban counterpart and 6% more obese adults (Oregon Behavioral Risk Factor Surveillance System (BRFSS), 2016). Moreover, in Central Oregon, the OSU SNAP-Ed program provided educational programming reaching under-served diverse audiences. In 2018, the contacts for this audience include 11,361 people that identified themselves as Latinx & 7,554 contacts with people that identified themselves as an American Indian or Alaskan Native (FFY 2018).

OSU Extension Nutrition Education Volunteer Program is a community-based volunteer program led by the OSU Extension Nutrition Education/SNAP-Ed Program. Trained volunteers from the county assist the Extension programs in expanding the reach to serve a greater number of SNAP eligible residents in our communities. Central Oregon programming includes educating the public with evidenced-based information at emergency food pantries through recipe demonstrations utilizing the Oregon State University Food Hero social marketing campaign of healthy recipes. Volunteers also assist OSU Extension staff with after-school nutrition education programming, family hands-on nutrition classes, farmers markets & community events. Volunteers are required to participate in 6 hours of initial training that includes background check, civil rights learning module, food safety, food resource management, classroom management, and nutrition information according to the Dietary Guidelines for Americans. Continual research-based updates and training by faculty and staff occurs monthly.

The funding provided for a Nutrition Education Volunteer Coordinator will be used to:

- Complete updates for the training curriculum and evaluation adaptable to the needs of each Central Oregon County and the Confederated Tribe of Warm Springs.
- Expand marketing/recruitment to reach potential volunteers.
- Create a system for volunteer sign up and demonstration or event planning.

With these efforts, community outreach and education will increase. Please see goals for details.

**Project Goals***

*Please concisely describe the goals of this project.*

The Volunteer Coordinator will provide necessary updates to the Central Oregon OSU Extension Nutrition Education Programs by:
• Developing and evaluating trainings
• Create marketing materials
• Recruit volunteers for trainings
• Scheduling volunteers for events
• Office procedures (including food safety guidelines)

The trained volunteers will extend our nutrition education to SNAP eligible adults at food pantries, community events and other adult education events. Volunteer education will increase food confidence in preparing healthy foods (according to the Dietary Guidelines for Americans) and recipes (from foodhero.org) which will result in the increase and willingness for participants to try healthy foods and learn to shop on a budget.

Community outreach and education delivered by trained volunteers will increase by:
• 8 additional volunteer trainings per year (4 in Deschutes, 2 in Jefferson (including Warm Springs), 2 in Prineville) resulting in approximately 50 volunteers trained per year.
• New volunteers are required to deliver 6 healthy recipe demonstrations in exchange for the training, resulting in 300 additional healthy recipe demonstrations per year.
• Volunteers assisting in community events at various settings (examples include 6 WIC Baby Showers, 10 farmers market events, Warm Spring Pi-Ume-Sha Health Fair, Festival of Cultures, Discover Nature Festival, Commute Options Open Streets, 4 National Night Outs, 3 County Fairs).
• Volunteers assisting in family hands-on, nutrition-enhanced cooking classes (4 schools, 8 classes reaching at least 48 families per year).
• Other direct education options will be available for volunteers to assist with staff that include after school nutrition-enhanced cooking classes, nutrition-enhanced garden education programming, and Head Start and Housing Works parent classes.

Regional and county based community partners include NeighborImpact Food Bank, Head Start, three WIC County Health Services, six school districts, Housing Works units, La Pine Parks and Recreation, four grocery stores, and the Family Resource Center.

**Target Population***

*Please select all that apply.*

- Males
- Females
- Adults (ages 18-64)
- Older Adults (ages 65+)

**Target Population (continued)**

*If your project targets a more narrow subset of the population, please provide that here (ex. postpartum females; individuals diagnosed with pre-diabetes, etc).*

- SNAP Eligible residents of Central Oregon, Latinx population and members of the Confererated Tribe of Warm Springs.
Timeline - project start date*
*Please provide an estimated start date for your project.
04/01/2019

Timeline - project end date
*Please provide an estimated end date for your project.
04/01/2021

Project duration*
*Please indicate the number of years you expect this project to span.
2

Identified Need*
*Please describe the identified need for this project.

Actively engaged adults can adopt and focus on healthy strategies to decrease chronic diseases that include diabetes and obesity (Central Oregon Regional Health Improvement Plan, 2016-2019). The prevalence of diabetes has doubled over the past 20 years to 9% of all Oregon adults (Oregon Health Authority, 2015). The obesity rate for Jefferson County is over 40%, much above the state average with Crook County at 25.1% and Deschutes County just below the state average at almost 22% (Accessed from the Communities Reporter Tool on 1/13/18). Additional factors contributing to this health data include the poverty rates ranging from almost 14% to 20% in Central Oregon (US Census Bureau: Decennial Census (1990, 2000); American Community Survey (2005-09 forward)) and over 20% to 28% of our renting households spending half or more of their income on rent. The statistics depict the critical need to teach residents how to prepare healthy meals on a budget, how to shop with limited food dollars and how to prepare a wide variety of fruits and vegetables for their families to enjoy is an approach in combating obesity.

Furthermore the data shows that in the general Central Oregon population, only 11.7% in Deschutes, 7.7% in Crook and 22.6% in Jefferson consume five or more servings of fruits and vegetables per day as recommended by the Dietary Guidelines for Americans (Oregon Health Authority: Adult Behavior Risk Factor Surveillance System (BRFSS) 2015). Our trained volunteers along with Food Hero website messaging provide tips and strategies to increase healthy food consumption in the target population.

Community Support*
**Please describe the community support you have received for this project.**

OSU Extension Nutrition Education/SNAP-Ed Program has had a positive partnership with NeighborImpact Food Bank for over 12 years. Director Carly Sanders wrote in her letter of support, “Currently, the NeighborImpact food bank does not have the capacity to provide nutrition education to pantry clients so our program relies heavily on partnerships to assist with this imperative aspect of feeding folks experiencing food insecurity.” The individual food pantries also work well with our volunteers to match ingredients from the demonstrated recipes for clients to take home and prepare the food. All three county WIC departments are long standing partners with the OSU Extension Service Nutrition Education program. Volunteers provide Taste of WIC or Quick WIC demonstrations, encourage redemption of the summer voucher program and attend the regional ‘baby showers’. Other community agencies that support our volunteer program are Head Start, Housing Works and family/after-school nutrition enhanced classes at elementary schools that include but not limited to Juniper and Bear Creek Elementary Schools. Volunteers assist in family community events with agencies including to Children’s Forest of Central Oregon, Commute Options, and the Warm Springs health fair. Please see the attached letters of support

**Optional: Community Support Letter #1**
*Please attach any letters of support that you have received for this project. You may attach up to 5. Letters must be uploaded separately.*

Letter of support HS.pdf

**Optional: Community Support Letter #2**

letter of support HW.docx

**Optional: Community Support Letter #3**

Letter of support NI.pdf

**Optional: Community Support Letter #4**

Letter of support WIC Jeff.docx

**Optional: Community Support Letter #5**

Letter of support WIC.pdf

**How will we know if the project is successful?**
Data will be measured quantitatively through survey results from volunteer trainings and outreach events/demonstrations. Parents attending family classes will complete a SNAP-Ed adult survey. Data will also be measured quantitatively by the number of volunteers trained as well as the number events delivered by the volunteers, hours of volunteer service and number of contacts reached. Both volunteers and education participants will be asked to provide additional comments with all surveys used.

**Affiliations***
*Does your project/program have any national affiliations?*

N/A

**Best Practice***
*What, if any, are the emerging best practices and/or evidence-based guidelines upon which the project is based?*

OSU Extension Nutrition Education program is required to deliver evidence-based curricula, messages and materials appropriate for the target audience. The training curricula will be reviewed by SNAP-Ed state team members to assure alignment with the Dietary Guidelines and overall content abiding with the SNAP-Ed guidance. Learner-centered teaching strategies are the cornerstone of extension education.

**Fidelity***
*If your program is evidence-based or best practice, will it be reviewed for fidelity?*

To ensure fidelity with the training, the evaluation will be based on program design, educator training and program delivery for the volunteers. To ensure fidelity with outreach, selected adult participants will take a brief survey and participant numbers, and hours will be collected on all events, classes and demonstrations.

**Funding Match***
*Are you seeking any funding matches or additional contributions to support your project? If so, provide the organization/entity name that will be providing the match. If you are not seeking a match, please write*

We are not seeking matching funds. The OSU Nutrition Education Program will provide needed in-kind dollars and has the funds in our budget necessary for this position to advance the program.

**Funding Match Amount (if not applicable, leave blank)**

**Sustainability***
*Please provide the sustainability plan for this project.*
After developing a training curriculum, evaluation and marketing strategy as well as a system for volunteer event procedures, unit faculty and/or trained volunteers will continue to maintain this program.

**Evaluation***

*Please provide the evaluation plan for this project.*

After completing the training curriculum, the coordinator will consult with Dr. Marc Braverman, OSU Extension Service Evaluation Specialist to develop an appropriate training evaluation. Furthermore, a three question survey will be distributed to participants (published in English and Spanish) after completing a contact with a volunteer at select public educational settings. Adults attending direct education family events will complete a SNAP-Ed adult survey.

**Preliminary approval***

*All applicants must go through a preliminary approval process before applications can be approved. Please select how you will receive preliminary approval from the list below. The majority of applicants will present to a RHIP workgroup.*

Present to a RHIP workgroup

**RHIP Workgroup***

*If the proposal will, or has already been presented to a RHIP workgroup, please select the workgroup from the list below.*

- Cardiovascular Disease/Diabetes Prevention

**RHIP Goals***

*If your proposal has been or will be submitted through a RHIP workgroup, it must contain at least one goal (clinical or prevention) that corresponds with a workgroup. Please select the applicable workgroup goal(s) that your proposal addresses.*

- Decrease the number of those at risk for type II diabetes

**Pillar 10 vital condition - maximum impact***

*Please select the Pillar 10 condition(s) that you expect your project to have the most impact.*

- Education
- Healthy Environment
- Nutritious Food
Pillar 10 vital condition lesser impact (continued)

*Please select any additional Pillar 10 vital condition areas that you expect your project may have a lesser impact on, if any.*

Equity, Social Connection & Civic Muscle
Physical Activity

**Board of Directors Approval**

*If you have been notified that your proposal must be presented to the COHC Board of Directors, your proposal must address one of the Board's priority areas. Please select which priority area your proposal addresses.*

N/A

**Objectives**

**Objective #1**

Complete volunteer training curriculum and materials. Create a training survey and evaluation of volunteer impact from participants (submit to IRB).

**Target for objective #1**

*Target for objective #1. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).*

May, 15, 2019, 50 training manuals completed. Two surveys developed and IRB approved.

**Baseline data for objective #1**

*Please provide information that indicates where you are starting as it relates to your target (see example above).*

Currently training curriculum is partially completed in forms of modules. Six total modules will be developed.

**Objective #2**

Develop a promotion and media campaign in all counties to promote trainings that includes but not limited to flyers, press release, articles and social media posts.

**Target for objective #2**
Target for objective #2. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

June 1, 2019, Increase media outlet hits by 50% with help from the OSU Extension and Experiment Station Communications office.

Baseline data for objective #2*

Currently we use a public news release to newspapers and radio stations throughout Central Oregon for each training reaching thirty media outlets per training.

Objective #3

Deliver volunteer trainings throughout Central Oregon.

Target for objective #3

Target for objective #3. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

June, 2019 to March, 2021; Deliver 8 trainings in Deschutes County (Redmond, Bend, and La Pine), 4 trainings in Jefferson County (including Warm Springs) and 4 trainings in Crook County for the two year grant cycle.

Baseline data for objective #3

Currently an average of 3 trainings per year are delivered in Redmond, a central location. Training materials need to be updated, resources are available to add and update materials for 50 training manuals per year.

Objective #4

Record and report back evaluation results and volunteer outreach.

Target for objective #4

Target for objective #4. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

Every six months of the grant cycle, report that volunteers increased their knowledge of food labels, balanced diets, food safety, and strategies to stretch food dollars at home after receiving all volunteer training modules by a ‘good deal of knowledge’ or ‘great deal of knowledge’. Newly trained volunteers will complete all six required events within six months of being trained extending our reach.
Baseline data for objective #4

Regionally, in FFY 2018, volunteers delivered programming at 69 events reaching 4,266 residents totally 205 volunteer hours. One year after the first training, volunteers will extend this reach by 300 events with an additional 600 hours of volunteer service reaching over 15,000 more contacts per year in Central Oregon.

Objective #5

Participants that attend an education events with a volunteer will increase healthy food preparation/meals and increase confidence with shopping on a budget.

Target for objective #5

Target for objective #5. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

Participants will complete a brief survey. 100 surveys will be completed each year.

Baseline data for objective #5

N/A

Objective #6

[Unanswered]

Target for objective #6

Original target for objective #6

Baseline data for objective #6

Objective #7

Target #7

Baseline data for objective #7

Objective #8
Target #8

Baseline data for objective #8

Objective #9

Target #9

Baseline data for objective #9

Financial Information

Project Budget*

*Please download the Health Council's budget document, found here. After downloading and completing the budget document, please upload it below.

COHC-Project-Budget-Final OSU Extension Nutrition Education Cordinator.xlsx

Amount requested*

*Total amount of funds requested from the Health Council for this project.

$30,000.00

Funding request - year one

$15,000.00

Funding request - year two

$15,000.00

Funding request - year three

Follow-up questions and/or supplemental information

Follow-up questions and/or supplemental information
This section is to be used **ONLY if** you received follow-up questions **following your presentation** to a workgroup or to the Board of Directors. Please use this space to provide the answers to all questions you may have received post-presentation.

- Please make every effort to type or copy the answers into the text box below.
- In the event that you have documentation such as flow-charts or graphics that you would like to provide that will not copy into a text box, you may use the file upload to attach.
- If you have multiple attachments, they will need to be scanned together and uploaded as one file.

**Workgroup Approval**

Did you complete all portions of the application?

Was your project solicited by a RHIP workgroup as part of an A3 process?

Did you include a proposed budget?

**RHIP Workgroup Approval***

*Have you already presented and been given preliminary approval by a RHIP workgroup?

No, I have not presented yet but I am on the agenda to present at a workgroup in the next 3 months.

**Process Following Submission**
Application Files

Applicant File Uploads

- Letter of support HS.pdf
- letter of support HW.docx
- Letter of support NI.pdf
- Letter of support WIC Jeff.docx
- Letter of support WIC.pdf
- COHC-Project-Budget-Final OSU Extension Nutrition Education Coordinator.xlsx
January 11, 2019

Dear Central Oregon Health Council,

I support OSU Extension Nutrition Education proposal to provide greater volunteer capacity for SNAP eligible adults in our region.

NeighborImpact Head Start has partnered with OSU Extension for over 12 years. As part of this partnership, OSU Extension has trained our teachers to deliver a research-based curriculum, implemented food safety trainings, and taught nutrition related topics to our parents. Nutrition Education Volunteers have assisted with the parent class as well as delivered healthy snack samples in the classrooms.

OSU Extension Nutrition Education Programs in Central Oregon supports the increase consumption of fruit and vegetables, food safety and healthy recipe assembly to our children, adults and families increasing the probability of people making the healthy choice the easy choice.

Please feel free to contact me with any questions.

Thank you,

Dyan Kuehn, Health Services Manager NeighborImpact
2303 SW 1st Street Redmond, Oregon 97756
Phone: 541-323-6526
January 9, 2019

Dear Central Oregon Health Council,

I support OSU Extension Nutrition Education’s proposal for a Nutrition Education Volunteer Coordinator position.

OSU Extension provides family and adult nutrition-enhanced cooking classes and garden related programming at many of our complexes. Currently we are partnering together to start a community garden at our Aspen Villas property in Redmond. In the past we have also done nutrition education where the volunteers assist with large classes and with our annual National Night Out events. The volunteers provide extra support for the adults to have a successful experience preparing a healthy meal together, answering questions and creating confidences with managing food dollars.

We have partnered with this program for over 10 years with staff and volunteers providing a valuable community resource for our residents.

Please feel free to contact me with any questions.

Sincerely,

Amorita S. Anstett
Resident Services Coordinator
Housing Works
541 323 7419
aanstett@housing-works.org
January 9, 2019

Dear Central Oregon Health Council,

I am writing on behalf of the NeighborImpact Food Bank in support of OSU Extension Nutrition Education Program’s proposal to fund the OSU Extension Nutrition Education Volunteer Coordinator position. This position will increase volunteer capacity in our region, improving healthy eating and food preparation skills of regional food banks clientele. We strongly support this grant application and the focus on reducing health disparities among the SNAP eligible adult population and their families by increasing delivery of evidence-based interventions.

As an organization, we strive to provide healthy food options to economically disadvantaged residents of Central Oregon and the partnership with OSU Extension Nutrition Education Program for over twelve years supports our mission. This partnership helps our adult clients and their families learn how to prepare the healthy foods received from the pantry, learn seasonal food safety messages, taste and discover fresh fruits and vegetables in a friendly environment. Furthermore, OSU Extension has executed healthy pantry assessments to help our pantries improve services.

Currently, the NeighborImpact food bank does not have the capacity to provide nutrition education to pantry clients so our program relies heavily on partnerships to assist with this imperative aspect of feeding folks experiencing food insecurity.

Last year, volunteers delivered 30 pantry demonstrations reaching 914 participants. These volunteers provide the missing link between receiving food and preparation. This ultimately leads to a healthier community. I fully support this program and this grant proposal.

Please feel free to contact me with any questions.

Thank you,

Carly Sanders
Food Program Director
January 11, 2019

Regional Health Improvement Plan,

We have worked closely with the Oregon State University Extension Nutrition Department in Jefferson County and have seen first-hand the positive impact of their programming. Recipes, nutrition information, and their expertise are resources that help our clients meet their nutrition and healthy lifestyle goals.

We have collaborated through several local avenues such as our monthly WIC classes, farmer’s market, pre-school family nights, and community events throughout the year. Our clientele is very diverse, yet in every class, OSU Nutrition has translated recipes and materials, while offering reinforcements and information relevant to our clients.

When the opportunity comes, we are always happy to collaborate with OSU Extension Nutrition.

Always a Pleasure,

Tami
January 8, 2019

Central Oregon Health Council:

The Deschutes County WIC Program has been a long-standing partner with OSU Extension (SNAP-Ed) Nutrition Education Program. We are grateful that Extension volunteers promote healthy food choices and nutrition messages at our monthly “A Taste of WIC” events and at our recent Community Baby Shower. As well, they provide education at farmer’s market tours for our participants, which garner rave reviews from all who attend! Their program aligns with our commitment to support and improve the health of our children, their families and our community.

I am pleased to support OSU Extension Service (SNAP-Ed) Nutrition Education Program’s proposal. Nutrition education volunteers complement our messaging to support the increased consumption of nutrient-rich foods such as fruits, vegetables and whole grains. My staff, our participants and I appreciate their presence at our events and we look forward to our continued partnership.

Thank you for your consideration of their proposal as it will allow OSU Extension to continue their valuable work with our WIC program.

Sincerely,

Laura Spaulding, RDN
WIC Supervisor/Coordinator
Deschutes County Health Services
2577 NE Courtney Dr.
Bend, OR 97701
541.322.7450
laura.spaulding@deschutes.org
# Project Budget

## Total Requested Project Funds from COHC:

<table>
<thead>
<tr>
<th>Personnel Costs: Name</th>
<th>Position (FTE dedicated to this project)</th>
<th>Salary</th>
<th>OPE 27.90%</th>
<th>Total Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff: year 1</td>
<td>0.36</td>
<td>11,741</td>
<td>3,276</td>
<td>15,018</td>
<td>15,000</td>
</tr>
<tr>
<td>Staff: year 2</td>
<td>0.36</td>
<td>11,741</td>
<td>3,276</td>
<td>15,017</td>
<td>15,000</td>
</tr>
<tr>
<td>Supervision</td>
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<td>0</td>
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</tbody>
</table>

Sub-Total: Personnel $ 23,482.00 $ 6,552.00 $ 30,034.71 $ 30,000.00

All Project funds already in SNAP Ed budget:

<table>
<thead>
<tr>
<th></th>
<th>Total Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer, office space and office supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Total: Materials &amp; Supplies</td>
<td>$ -</td>
<td>$ -</td>
</tr>
</tbody>
</table>

Travel Expenses

<table>
<thead>
<tr>
<th>Mileage: Madras  88 RT: Warm Springs 118 RT at .58 per mile &amp; Vc</th>
<th>Total Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mileage: Prineville 70 m. RT at .58 per mile and vicinity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mileage: Bend, Redmond La Pine at .58 per mile</td>
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</table>

Sub-Total: Travel Expenses $ 2,537.00 $ -

Training Expenses

<table>
<thead>
<tr>
<th>Folders ($2.00 each)</th>
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</thead>
<tbody>
<tr>
<td>Food handlers card for volunteers and Cordinator</td>
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<td></td>
</tr>
<tr>
<td>Copies</td>
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</table>

Sub-Total: Training Expenses $ 510.00 $ -

Event Expenses

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<thead>
<tr>
<th>Copies</th>
<th>Total Cost</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructional supplies/food/teaching supplies $25 per event</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking equipment &amp; supplies</td>
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<td></td>
</tr>
</tbody>
</table>

Sub-Total: Event Expenses $ 8,500.00 $ -

Other Budget Items

Sub-Total: Other Budget Items $ - $ -

Total Project Budget $ 41,581.71 $ 30,000.00
Grant Application
COHC Application - Standard Process

Deschutes County Health Services
Prevent Diabetes Central Oregon

<table>
<thead>
<tr>
<th>Application Snapshot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount Requested</td>
</tr>
<tr>
<td>Organization Contact</td>
</tr>
<tr>
<td>Contact Email</td>
</tr>
<tr>
<td>Organization Address</td>
</tr>
<tr>
<td>Website</td>
</tr>
</tbody>
</table>

A3 Metric:
Decrease the number of those at risk for type II diabetes

Pillar 10 Vital Condition:
Nutritious Food
Physical Activity
Proposal Overview

Investment/Project Name*

Name of Project.

Prevent Diabetes Central Oregon

Name of project lead*

Please provide the first and last name of the project lead for this funding request.

Sarah Worthington

Email for project lead*

Please provide a good email address for the project lead.

sarahw@deschutes.org

Requestor/Agency location*

Bend

Other towns

If you chose 'other' above, please specify where your agency is located.

Bend

Counties included in project*

Which of the following counties will your project include?

Crook
Deschutes
Jefferson

Inclusion of all counties

If your project does not include all of the counties listed above, please provide explanation.
La Pine Community Health Center serves Northern Klamath. There are not cohorts offered in Gilchrist or Crescent as part of this proposal. However, the clinic is interested in offering a telehealth option when they have capacity.

**Project Description/Overview**

*Please describe your project.*

- The primary activities conducted for this proposal are regional coordination and implementation of the Diabetes Prevention Program (DPP) across all three counties within the Central Oregon. DPP has recently been rebranded with the name Prevent Diabetes Central Oregon (PDCO). PDCO is a collaborative effort among several partners to ensure this one-year long lifestyle intervention program is available to Central Oregonians.

- Trained Lifestyle Coaches (LC) deliver 16 weekly hour-long sessions, followed by bi-monthly sessions in a group setting for the remainder of the year. All participants are assigned two primary goals to achieve and maintain: a weight loss of 5-7% of their initial body weight and at least 150 minutes of moderate physical activity per week.

- Lifestyle Coaches use group facilitation techniques, educational instruction, and demonstrations to teach strategies for incorporating physical activity and healthy eating into daily life. Participants also work to manage common challenges like stress, setbacks, and negative thoughts. Sessions are provided in a variety of locations, senior centers, churches, group meeting rooms in order to meet community need.

- This proposal seeks to specifically support nine, year-long cohorts in Bend (2), La Pine (3), Madras (1), Prineville (2), Sisters (1). In addition to regional cohort implementation, this proposal includes high-level support and program implementation by the regional coordinator.

These activities are further defined here:

- Technical assistance to partner Lifestyle Coaches and staff
- Develop tools for data collection; collect and compile data from all DPP sites
- Convene Quarterly Learning Collaborative Meetings for LC’s. These gatherings are an opportunity to share and learn from each other; identify and test solutions to common challenges
- Arrange trainings for new LC’s
- Participate in statewide networking calls and meetings; disseminate program updates and resources to partners and LC’s
- Participate in and disseminate continuing education opportunities/resources to improve program quality and retention
- Procure and manage inventory and distribution for program supplies
- Submit program data to the CDC for Program Recognition
- Ongoing outreach to providers: visit clinics to promote the program and increase referrals
- Develop and disseminate free and paid marketing materials, including fliers, brochures, info cards, press releases, social marketing and newspaper ads
- Plan, market, and implement DPP cohorts in Bend
- Provide backup as a LC as needed
- Develop and manage contracts with program partners
- As a member of both the Clinical and Prevention-focused Diabetes RHIP workgroups, provide informed input to community-based efforts to reduce the burden of diabetes in Central Oregon
Participants in PDCO will benefit from making positive lifestyle changes with the support of structured workshops and the trained LC. Those who succeed in losing 5-7% of their body weight will benefit from a significant reduction in their risk of diabetes and corresponding improvements in their health. All participants benefit from making small but significant changes to their eating habits and increasing their physical activity levels.

**Project Goals**

*Please concisely describe the goals of this project.*

- **Weight Loss and Increased Physical Activity:** The goal of the PDCO is to reduce the risk of developing diabetes and cardiovascular disease in high-risk individuals in Central Oregon through a coordinated intensive lifestyle intervention that leads to weight loss and increased physical activity.

- **Maximize use of resources and align efforts to increase the scope of PDCO across the region:** This project will be focused on regional coordination and implementation of PDCO, working in conjunction with partners who will be providing and supporting this service. Diabetes is a priority in the Central Oregon Regional Health Improvement Plan and implementing a Diabetes Prevention Program is an identified strategy to address the Diabetes Prevention Goal to decrease the proportion of adults and children at risk for developing type 2 diabetes.

- **Reduce burden of healthcare costs related to diabetes by preventing or delaying onset:** A significant impact of diabetes is the health care costs it generates; health care expenditures for people with diabetes are estimated to be 2.3 times higher than for people without diabetes, amounting to an additional $7,888 per year per person. The total cost of diabetes in Oregon is estimated at nearly $3 billion annually in medical expenditures and reduced productivity.

- **Demonstrate the value of shifting our healthcare focus toward prevention:** Having a regional effort to prevent diabetes supports the RHIP workgroup’s efforts to focus on prediabetes interventions in the clinical setting by ensuring there are community-based resources for providers to refer patients to.

- **Build on our experience and successes/learnings to increase the quality, scope, reach, and local awareness of PDCO in Central Oregon:** This is a multi-jurisdictional effort and we are learning and improving as we go. Because these entities meet together in learning collaborative, workgroup meetings and have regular interaction with the Regional Coordinator, quality improvement is at the forefront and on-going. For example, low referral rates have at times been a challenge. It is difficult to keep DPP on busy providers’ radar screens. While outreach to clinics and providers is ongoing, we have recently partnered with Pacific Source to send mailings to beneficiaries based on prediabetes diagnosis. Moving this process upstream a bit has proven highly effective in generating enrollments from patients with demonstrated risk factors. This collaboration was largely brought about thanks to contacts made through the RHIP Clinical Diabetes workgroup.

- **Pave the way for billing Medicare and Medicaid in 2021 in Bend, La Pine, and Crook County:** DCHS will be testing newly developed electronic health referrals with Mosaic Medical in 2019, and working with our billing department to establish protocols for billing Medicare (once we have become eligible) and Medicaid. Both Crook County Health Department and La Pine Community Health Center are working toward this as well.
**Target Population**
*Please select all that apply.*

- Males
- Females
- Adults (ages 18-64)
- Older Adults (ages 65+)

**Target Population (continued)**
*If your project targets a more narrow subset of the population, please provide that here (ex. postpartum females; individuals diagnosed with pre-diabetes, etc).*

- Adults with prediabetes or other indicators of diabetes risk

**Timeline - project start date**
*Please provide an estimated start date for your project.*

01/01/2020

**Timeline - project end date**
*Please provide an estimated end date for your project.*

12/31/2020

**Project duration**
*Please indicate the number of years you expect this project to span.*

1

**Identified Need**
*Please describe the identified need for this project.*

- The burden of diabetes is huge and is rising. Nationally and state-wide the prevalence of type 2 diabetes is rising drastically. From 1993-2013, the prevalence of diabetes in Oregon doubled- an increase of 124%. Diabetes is disproportionately higher among racial and ethnic minorities and low-income populations. An estimated 19% of OHP members have been diagnosed with this condition. The cost to Oregon is nearly $3 billion per year in medical costs and loss of productivity.
Prediabetes is highly prevalent. It is estimated that 1 million Oregon (1 out of 3 US) adults have prediabetes, and most of them are unaware. Unless they make changes, people with prediabetes are likely to develop type 2 diabetes within 3-5 years.

Living with diabetes impacts every aspect of life. Individuals with diabetes must manage medication needs, potential complications, and often diminished quality of life. This is preventable! The time to take action is now, while it can possibly be delayed or prevented.

Many common comorbidities and risk factors are impacted. The shared risk factors for cardiovascular disease and type 2 diabetes, include overweight, obesity, physical inactivity, high blood pressure and high blood lipids. Successful participants in PDCO will see beneficial changes to these related risk factors. This is significant because 17-49% of adults report high blood pressure and 29-32% of adults report high blood cholesterol in Central Oregon. A recent graduate of PDCO recently reported, “My blood glucose levels have stabilized between 95 and 105, and A1Cs have been in the 4.5 range. My HDLs, LDLs, cholesterol levels are great, blood pressure, too. Each of my health care providers—General Practitioner, dental hygienist, chiropractor, pulmonary doctor.—have commented on improvements since I’ve lost weight.”

Regional Coordination provides several benefits to stakeholders. Collective marketing makes providers aware of all of sites in the region. This matters because many patients travel for healthcare; additionally providers are faced with a challenge of keeping current knowledge of community resources- streamlining this information helps minimize that burden. Nationally, a public awareness campaign is underway to increase awareness of prediabetes. As a regional offering PDCO shows community members that health officials and providers are working to tackle this problem locally by providing affordable resources. The structure of regional coordination in PDCO allows for local sites to tailor delivery to their community needs while also maintaining quality programming.

PDCO is gaining momentum. The last three years have seen a significant investment of RHIP funds alongside support from local organizations and providers. During this time we have learned, adapted, and improved on implementation/delivery to develop the robust program and partnerships we have today. We are poised to begin billing payers to offset delivery costs, but this will take time. Funding through 2020 will allow us to work on this without losing ground through interrupted programming. A year-long program requires planning ahead well in advance.

**Community Support**

*Please describe the community support you have received for this project.*

- There is solid, growing interest and support for a community-based resource like PDCO. With each new batch of program launches, we generate interest from clinics and contacts we had not previously reached. As more graduates complete the program, word of mouth is growing and leads to increased interest, awareness and new registrations.

- PDCO is delivered through multiple partnerships with health care and community agencies. Each site has some distinguishing features for how they deliver the program and work collaboratively with the coordinator and...
each other. Learning Collaborative meetings provide a way for LC’s to share updates with each other on successes, challenges, emerging needs and promising strategies.

Current active partners include: Central Oregon Council on Aging (COCOA), Crook County Health Department (CCHD), Central Oregon Health Council (COHC), Deschutes County Health Services-Public Health Division, La Pine Community Health Center (LPCHC), St. Charles Health Systems (SCHS) and Mosaic Medical (MM).

- LPCHC is about to kick off their 6th program. This health center offers PDCO to patients using an approach similar to how Living Well self-management programs. The majority of participants are referred from the clinic; this reduces the recruitment burden on staff. Additional marketing in the community broadens the cross section of people that enroll. LPCHC is working towards Medicare Diabetes Prevention Program certification, and will soon be billing for this service.

- CCHD: Kylie’s role as the Diabetes Prevention Coordinator in Crook County involves tailoring the program to the specific needs of Crook County, making connections with local community partners, and seeking ways to reach the community through media campaigns, and targeted community outreach. Last year she conducted a campaign called the Crook County Diabetes Challenge. It reached thousands of people in the Crook County area, through print and digital media. She has established relationships with local health care clinics, pharmacies, and volunteer organizations to increase the awareness of diabetes care, diabetes prevention and the DPP. In early 2019, CCHD is partnering with SCHS to offer a DPP in Prineville.

- MM: In addition to supporting all locations through patient referrals to DPP, MM has provided staff time and support to lead cohorts in the Madras clinic. Electronic referrals are in development for PDCO between DCHS and MM. As we establish systems for billing, DCHS will transition to make LC’s part of the care team, allowing them to update patient’s EHR to reflect participation/progress in the program.

- COCOA: A health educator on staff is a trained LC and an enthusiastic advocate for PDCO with seniors, leading groups at the Redmond Senior Center. Program marketing, participant registration, data compilation, and CDC reporting from these cohorts are managed by the regional coordinator.

- SCHS: St. Charles has supported cohorts in Prineville and Madras with staff support of dietitians who are trained as LC’s. With limited capacity, they fill in where needed and available. SCHS is also partnering with CCHD to offer a weight-loss focused/branded DPP in Prineville, modeled after a program at a hospital in Harney County.

Optional: Community Support Letter #1

*Please attach any letters of support that you have received for this project. You may attach up to 5. Letters must be uploaded separately.*

COA Letter of Support 1-19.pdf

Optional: Community Support Letter #2

Optional: Community Support Letter #3

RHIP DPP LOS CCHD.pdf

Optional: Community Support Letter #4

Optional: Community Support Letter #5

How will we know if the project is successful?*

Measures of Success to date: After learning through 3 years of implementation, Prevent Diabetes Central Oregon is well positioned to knock it out of the park in 2020. When compiling all completed cohorts to date, 110 participants lost 810 pounds, averaging 7 pounds per person. When we include current, uncompleted cohorts, a total of 1,253 pounds have been lost, for an average of 8 pounds per participant.

According to the CDC Recognition Standards for the DPP, the weight loss goal is a minimum of 5% of initial body weight. However, multiple subsequent translational studies have demonstrated weight loss in community settings to be on the range of 3.00-4.73%. The original DPP clinical trial concluded that every kilogram of weight lost during the program can be equated to a 16% reduction of risk. This suggests that any amount of weight lost, even if it falls below 5%, conveys significant health benefits.

PDCO completed cohorts lost an average of 4.8% of their starting body weight. When current uncompleted cohorts are included, the average is 3.7% weight lost per participant. These are strong results, and we anticipate they will only improve as we continue to streamline our program implementation and gain more experience with each cohort.

We have also collected multiple testimonials from participants that report reduced A1C along with improvements in blood lipids and blood pressure. We often hear reports from participants that their provider is pleased/proud to know they are involved in the program, and this frequently coincides with favorable blood test results. In this way, whether or not a participant was referred by their provider, PDCO is building community-clinical linkages that provide two-way support to the patient-provider relationship. Patients are empowered to change their behavior to improve their health, while providers see firsthand how this community-based resource can significantly improve the health of at-risk patients.

Attaining CDC Recognition is an indicator of quality program delivery and can be considered a proxy for achieving health outcomes- i.e. reducing risk for diabetes.

We will continue to measure weight loss as described above. However, data limitations should be noted. It can be challenging to tell the whole story of how DPP impacts health. There is great variability in individual responses to DPP; COMPASS portal does not collect data beyond CDC requirements; and most cohorts happen in community settings with no clinical EHR access.
COMPASS does not compile information such as A1C, blood lipids, blood pressure, or positive mental health changes. We have been developing tools and methods for collecting this data so that health benefits are captured and reported.

**Affiliations**

*Does your project/program have any national affiliations?*

Centers for Disease Control National Diabetes Prevention Program

**Best Practice**

*What, if any, are the emerging best practices and/or evidence-based guidelines upon which the project is based?*

The National Diabetes Prevention Program was developed by the Centers for Disease Control (CDC) as a way to broadly disseminate the findings of the robust body of research described below.

The DPP was developed as a randomized clinical trial to compare the relative effectiveness of an intensive lifestyle intervention (ILS) with medication (Metformin) in delaying the onset of diabetes in individuals at risk for the disease. Participant demographics included 45% minority groups, 68% women, and 20% age 60 or older. Participants enrolled in ILS had a goal of 7% weight loss through reducing caloric and fat intake and exercising for at least 150 minutes a week.

The initial trial of over 3000 individuals found that, compared with placebo, participation in the DPP ILS reduced the incidence of diabetes by 58% and Metformin reduced incidence by 31%. For participants at least 60 years of age, the lifestyle intervention was even more effective; compared with placebo, their risk of diabetes was reduced by 71%. These effects were evident for all participants regardless of race, age, sex, or socioeconomic status. Cardiovascular disease risk factors including high blood pressure and triglyceride levels also decreased significantly more in the ILS group than metformin or placebo. The effects were so powerful that the study was concluded one year early.

This body of evidence supports lifestyle intervention as the first-line of defense for prediabetes and as a key preventive strategy to reduce the risk of diabetes and cardiovascular disease. The DPP research study has shown that the lifestyle intervention works for virtually anyone with prediabetes. Those individuals who participated in the original trial of DPP continued to have a lower incidence rate of diabetes in a 10-year follow-up study, demonstrating the lasting effects of this intervention in preventing or delaying diabetes onset.

Beyond health benefits and quality of life improvements, DPP provides “good value for the money spent” according to extensive research demonstrating cost-effectiveness as well as return on investment. Studies have found average savings over 10 years ranging from $4250 to $6300 per participant. The Montana Department of Public Health estimated an annual return on investment of $1,132,394 assuming 700 people with prediabetes enrolled in DPP and DPP leads to a 58% risk reduction in type 2 diabetes incidence over 3 years follow up as the research indicates.
**Fidelity**

*If your program is evidence-based or best practice, will it be reviewed for fidelity?*

Attainment of CDC recognition status is the most universal/meaningful indicator of program fidelity. The CDC encourages organizations delivering the DPP curriculum to apply for the Diabetes Prevention Recognition Program (DPRP) to assure quality and to report data and outcomes to the national registry. Deschutes County Health Services has applied for recognition status with CDC (to be determined in February 2018). More information about CDC recognition can be found here: http://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf

In order to meet the requirements for recognition, our program will need to meet criteria in the following categories:

- Participant eligibility: over age 18; not pregnant at time of enrollment; have a BMI ≥25 kg/m2 (≥23 kg/m2, if Asian American). All must be considered eligible based on either a recent blood test, gestational diabetes history or a positive screening for diabetes based on the Risk Test. Minimum of 35% of participants must be eligible based on either a blood test or history of GDM.
- Program duration and intensity
- Session Attendance (during months 1-6 and 7-12)
- Weight Loss achieved at 12 months
- Documentation of physical activity minutes
- Documentation of body weight
- Lifestyle Curriculum

**Funding Match**

*Are you seeking any funding matches or additional contributions to support your project? If so, provide the organization/entity name that will be providing the match. If you are not seeking a match, please write*

Donations are solicited from various vendors to provide additional incentives for participants and price discounts on building rentals and advertising. This occurs on an ongoing basis and cannot be delineated in this application. An example, however, is reduced publication fees in the Sisters Nugget newspaper in order to advertise the Sisters based cohort start up.

**Funding Match Amount (if not applicable, leave blank)**

**Sustainability**

*Please provide the sustainability plan for this project.*

It was exciting to bring the DPP to Central Oregon in advance of developments that will help to make it more sustainable in years to come. Medicare began covering DPP in 2018. DPP will be covered for OHP members in
2019. The Clinical Diabetes RHIP Workgroup developed an algorithm for providers to use with patients with prediabetes (including referral to DPP); this demonstrates to our community that local subject matter experts prioritize prevention with high-risk patients. We are working to build the infrastructure –acquiring CDC Recognition, enrolling recognized organizations in Medicare DPP (MDPP), and developing billing systems for these services—needed to use these resources, and continue to monitor funding opportunities that may support our efforts. Meanwhile, we believe RHIP funding support is essential for maintaining continuity of DPP among partners and providers that recognize the value of this program, and to our many community members that are seeking help with lifestyle change.

**Evaluation**

*Please provide the evaluation plan for this project.*

Adherence to the CDC Recognition Standards provides assurance of fidelity as well as a means for evaluating quality of program delivery and outcomes.

Participant attendance: participant data is considered only for those that attend a minimum number of sessions, placing an emphasis on appropriate recruitment and retention.

Physical activity minutes: every cohort must have physical activity minutes documented at least 60% of the sessions. This means LC’s strongly encourage participants to engage in and document physical activity from early in the program.

Weight Loss: Because the original research found weight loss to be the strongest indicator of risk reduction, we aim to demonstrate overall improvements in participant weight loss at 12 months across the region. The completed cohorts for all PDCO sites have lost an average of 4.8% of their starting body weight to date. To achieve recognition status, the average weight loss across all participants must be a minimum of 5%. Considering this average is the culmination of 2.5 years of work across multiple sites, learning and improving along the way, we anticipate all of our sites will achieve Full Recognition status in the coming year; this would be a strong indicator of program quality and success in achieving the proven health outcomes of DPP.

**Process/Quality Improvements**

Early cohorts had low retention rates. We have adopted multiple strategies to tackle this:

- pre-screening for every registrant
- session zero (no-obligation intro class),
- LC emphasis on relationship building: call all no-shows; follow up on every question that comes up in class; reach out to the group between sessions; be available for questions or troubleshooting. These actions are key to building trust, which increase engagement and commitment, boosting attendance and retention.

Provider/community awareness: multiple efforts being made towards this

- Hired a creative firm to develop logo/brand/marketing materials that present PDCO as regional, community based resource for adults seeking to prevent/manage chronic diseases like diabetes.
- Use multiple channels to market PDCO using regional brand and messaging. Recent publicity that has led to enrollment includes a KTVZ spot, radio interviews (KOAK, 104.1 and Inside Central Oregon), and the Next Door community app.
- Ongoing outreach and networking with community partners and providers to get the word out.
Additional metrics: we have also been collecting the following data:

- Participant numbers/demographics: 177 adults have participated in PDCO; of these, over 70% are 60 or older. 91% of participants to date are white, with 3% identifying as American Indian, Alaska Native, Asian, or Asian-American. 8% of participants report Hispanic, Latino or Spanish origin (primarily in Madras and Bend). The majority of participants (87%) are female.
- Referral Source: 52% of enrolled participants were referred by a health care provider. A multitude of other sources accounted for the other 48%: print advertising; fliers/brochures; Next Door community app; and word of mouth. Multiple sites have had participants bring spouses/family members or friends.

Anecdotal data is collected through testimonials, videos and blood test reports to Lifestyle Coaches.

**Preliminary approval**

All applicants must go through a preliminary approval process before applications can be approved. Please select how you will receive preliminary approval from the list below. The majority of applicants will present to a RHIP workgroup.

Present to a RHIP workgroup

**RHIP Workgroup**

If the proposal will, or has already been presented to a RHIP workgroup, please select the workgroup from the list below.

Cardiovascular Disease/Diabetes Prevention

**RHIP Goals**

If your proposal has been or will be submitted through a RHIP workgroup, it must contain at least one goal (clinical or prevention) that corresponds with a workgroup. Please select the applicable workgroup goal(s) that your proposal addresses.

Decrease the number of those at risk for type II diabetes

**Pillar 10 vital condition - maximum impact**

Please select the Pillar 10 condition(s) that you expect your project to have the most impact.

Nutritious Food
Physical Activity

**Pillar 10 vital condition lesser impact (continued)**
Please select any additional Pillar 10 vital condition areas that you expect your project may have a lesser impact on, if any.

Preventative Services & Policies

**Board of Directors Approval***

*If you have been notified that your proposal must be presented to the COHC Board of Directors, your proposal must address one of the Board’s priority areas. Please select which priority area your proposal addresses.*

N/A

**Objectives**

**Objective #1***

Ensure quality delivery and achievement of health outcomes at all PDCO sites.

**Target for objective #1***

*Target for objective #1. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).*

By June 30, 2020, all sites will achieve CDC Diabetes Prevention Recognition Program status.

**Baseline data for objective #1***

*Please provide information that indicates where you are starting as it relates to your target (see example above).*

Currently, there are three organizations submitting data to CDC with the goal of achieving recognition. Their current status is as follows:

- DCHS: Pending
- LPCHC: Preliminary
- CCHD: Pending

**Objective #2***

Establish eligibility for billing Medicare.
Target for objective #2*

Target for objective #2. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

By June 30, 2020, at least two delivery sites will be MDPP program suppliers.

Baseline data for objective #2*

Currently, two organizations are or will be pursuing eligibility to bill Medicare:

LPCHC: has applied, will likely receive MDPP Preliminary Supplier status after next data submission

DCHS: will be applying for MDPP status after February 2019 data submission

Objective #3

Increase capacity to offer DPP in Madras

Target for objective #3

Target for objective #3. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).

By August 30, 2019, identify at least 2 individuals to lead cohorts in Madras.

Baseline data for objective #3

The most recent Madras program was started in October 2017. It was initially coached by two trained staff- a one from MM, and one from SCHS. Both LC’s unexpectedly moved away shortly after it started, and multiple people stepped in to lead the class until the next LC was trained and available to complete the year. This situation highlighted the need to identify a qualified person or people who can lead cohorts in Madras. Whether they are staff or other members of the community, ideally these LC’s do not require traveling far to lead the program. In any case, we aim to have a strong program running in Jefferson County in 2020.

Objective #4

Target for objective #4

Target for objective #4. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).
Baseline data for objective #4

Objective #5

Target for objective #5
*Target for objective #5. Please include a numerical target whenever possible, and the date that you expect to hit the target (see example above).*

Baseline data for objective #5

Objective #6

Target for objective #6
*Original target for objective #6*

Baseline data for objective #6

Objective #7

Target #7

Baseline data for objective #7

Objective #8

Target #8

Baseline data for objective #8

Objective #9

Target #9

Baseline data for objective #9
**Financial Information**

**Project Budget***

*Please download the Health Council's budget document, found here. After downloading and completing the budget document, please upload it below.*

COHC-Project-Budget-Final.xlsx

**Amount requested***

*Total amount of funds requested from the Health Council for this project.*

$202,961.00

**Funding request - year one**

**Funding request - year two**

**Funding request - year three**

**Follow-up questions and/or supplemental information**

*This section is to be used ONLY if you received follow-up questions following your presentation to a workgroup or to the Board of Directors. Please use this space to provide the answers to all questions you may have received post-presentation.*

- Please make every effort to type or copy the answers into the text box below.
- In the event that you have documentation such as flow-charts or graphics that you would like to provide that will not copy into a text box, you may use the file upload to attach.
- If you have multiple attachments, they will need to be scanned together and uploaded as one file.

**Workgroup Approval**

**Did you complete all portions of the application?**

**Was your project solicited by a RHIP workgroup as part of an A3 process?**

**Did you include a proposed budget?**
**RHIP Workgroup Approval**

*Have you already presented and been given preliminary approval by a RHIP workgroup?*

Yes, I presented and have been given preliminary approval

---

**Process Following Submission**
Application Files

Applicant File Uploads

- RHIP DPP LOS CCHD.pdf
- COHC-Project-Budget-Final.xlsx
January 14, 2019

Central Oregon Health Council
PO Box 6689
Bend, OR 97708
Attn: CVD/Diabetes Prevention RHIP Workgroup

Dear Workgroup,

The Council on Aging of Central Oregon proudly supports the Deschutes County Health Services proposal to continue supporting coordinated delivery of the Diabetes Prevention Program (DPP) in our region. We have been pleased to see this highly successful, evidence-based program serving a wide range of communities in Central Oregon since 2016.

One out of four Americans who are 65 or older have Type 2 diabetes. Serious complications such as hearing loss, vision problems, cognitive impairment, and mobility difficulties are especially apparent in seniors whose diabetes isn’t properly managed. In at-risk adults, DPP can reduce the risk of developing Type 2 diabetes by 58%. In adults age 60 and older, that risk reduction is even greater-71%. As aging alone increases risk for diabetes, and adults over 60 see even greater health benefits in DPP; we recognize that this program meets a critical need among the older adults that we serve.

We have dedicated a health educator on staff that is a trained lifestyle coach. She is currently leading her second cohort at the Senior Center in Redmond. We have seen tremendous success among her participants, and we are pleased to have the chance for continued resources to support her ongoing engagement with this program.

Sincerely,

Susan Rotella
Executive Director
Council on Aging of Central Oregon
srotella@councilonaging.org
January 14, 2019

Central Oregon Health Council
PO Box 6689
Bend, OR 97708
Attn: CVD/Diabetes Prevention Workgroup

Dear Workgroup,

I am pleased to offer this letter of support for the proposal for continued coordination of the regional Central Oregon Prevent Diabetes program from Deschutes County Health Services (DCHS). As part of a long-standing partnership with DCHS, Living Well self-management programs have been coordinated, marketed and delivered in our community for many years. This partnership has extended to include support for Diabetic Prevention Program (DPP) since 2016. I believe that DCHS is the appropriate agency that will effectively continue to lead in the role of coordinating DPP for Central Oregon.

I have seen the growing impact of diabetes in our patient population and recognize that this increase mirrors state and national trends. Even more striking is the large proportion of adults who are estimated to be at risk for developing diabetes: 86 million, or 1 in 3 US adults. The evidence is clear that for individuals who make significant lifestyle changes to increase physical activity and lose weight, the risk of a diabetes diagnosis can be significantly lowered. This is an urgent issue facing our health system and we are dedicated to taking action with cost-effective, evidence-based approaches. Alongside Living Well, DPP is part of the suite of offerings – proven to help adults prevent and manage complex chronic conditions – that we are committed to offering in our community.

Our agency has dedicated resources to offer DPP at our clinic and will continue to do so. One staff person, a Registered Nurse, is a trained Lifestyle Coach, and is currently leading her fourth cohort of the year-long program. Each cohort has brought new learnings and increased community awareness and demand for DPP. We are now well-positioned to offer new programs twice annually. We appreciate the opportunity to be a part of a coordinated regional effort that brings additional resources to offset training, marketing, supply and staffing costs.

I am very enthusiastic about continuing this coordinated, regional partnership to this program, which was recently branded as the Prevent Diabetes Central Oregon. We are pleased to be a part of this effort and support DCHS in their proposal for RHIP funding to continue offering this essential program without interruption.

Sincerely,

Charla DeHate
Chief Executive Officer
La Pine Community Health Center
Date: January 16, 2019

To: Central Oregon Health Council
   Attn. CVD/Diabetes Prevention RHIP Workgroup

From: Crook County Health Department

RE: Letter of support for Deschutes County Health Services

I would like to express my enthusiastic support for Deschutes County Health Services’ (DCHS) proposal for RHIP funds to continue coordination of the Central Oregon Prevent Diabetes program (DPP). Crook County Health Department has partnered successfully with DCHS on Living Well self-management programs since 2007, and DPP since 2016. We are confident that DCHS has the capacity, commitment, and expertise to continue serving our region as the coordinating lead agency.

As an organization, our aim is to promote the health of the population of Crook County. The burden of diabetes on our population, with its impact on quality of life and health care costs, is a major concern of our agency. The number of adults at risk for developing diabetes is rapidly increasing nationally and here in Oregon. We are concerned with the rising rates of obesity and physical inactivity that contribute to this chronic disease burden. DPP is an essential, proven resource that helps at-risk adults prevent the onset of this condition with small, sustainable lifestyle changes that make a huge difference over the course of the year.

Through our collaboration to date, our agency has supported implementation of five DPP cohorts. We have a dedicated staff person that is a trained Lifestyle Coach, and is leading her fifth cohort to date – including a new location in Sisters. We are pleased to have the opportunity to partner with you to ensure that DPP is aligned regionally, and resources used efficiently and effectively.

I fully support your efforts of DCHS as they seek external funding to continue coordinated delivery of Prevent Diabetes Central Oregon. We look forward to a strong and successful partnership promoting the health of Central Oregonians with this program.

Sincerely,

Muriel DeLaVerne-Brown, RN, MPH
Health & Human Services Director
Crook County Health Department
## Project Budget

### Total Requested Project Funds from COHC:

<table>
<thead>
<tr>
<th>Personnel Costs: Name</th>
<th>Position (FTE dedicated to this project)</th>
<th>Salary</th>
<th>Benefits</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Educator III: Sarah Worthington</td>
<td>1.0 FTE</td>
<td>75,303</td>
<td>42,741</td>
<td>118,044</td>
</tr>
<tr>
<td>Prevention Supervisor: Jessica Jacks</td>
<td>.08 FTE</td>
<td>8,630</td>
<td>4,762</td>
<td>13,392</td>
</tr>
</tbody>
</table>

Sub-Total: Personnel $83,934.00 $47,503.00 $131,437.00

<table>
<thead>
<tr>
<th>Materials &amp; Supplies</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohort participant books and supplies ($236.85 per cohort)</td>
<td>1,895</td>
</tr>
<tr>
<td>Printing participant handouts ($643 per cohort using 2012 curriculum (4 cohorts) and $380 per cohort using T2 curriculum (5 cohorts))</td>
<td>4,472</td>
</tr>
<tr>
<td>Incentives ($707.85 per cohort)</td>
<td>5,663</td>
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</table>

Sub-Total: Materials & Supplies $12,030.00

<table>
<thead>
<tr>
<th>Travel Expenses</th>
<th>Total Cost</th>
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<tbody>
<tr>
<td>Regional Coordinator travel throughout Central Oregon (0.58 cents per mile)</td>
<td>1,200</td>
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</table>

Sub-Total: Travel Expenses $1,200.00

<table>
<thead>
<tr>
<th>Consultants &amp; Contracted Services</th>
<th>Total Cost</th>
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<tbody>
<tr>
<td>La Pine Community Health Center (3 La Pine Cohorts)</td>
<td>4,652</td>
</tr>
<tr>
<td>Council on Aging of Central Oregon (1 Redmond Cohort)</td>
<td>8,000</td>
</tr>
<tr>
<td>Crook County Health Department (2 Prineville cohorts; 1 Sisters cohort)</td>
<td>37,517</td>
</tr>
<tr>
<td>DCHS (2 Bend cohort; 1 Madras cohort cost covered as fiscal agent)</td>
<td>-</td>
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Sub-Total: Consultants & Contracted Services $50,169.00

<table>
<thead>
<tr>
<th>Meeting Expenses</th>
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<tr>
<td>Quarterly Lifestyle Coach meetings (snacks)</td>
<td>50</td>
</tr>
<tr>
<td>Annual Partner meeting (food, printing and supplies such as flip chart paper/pens)</td>
<td>275</td>
</tr>
<tr>
<td>Space rental fees</td>
<td>500</td>
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</table>

Sub-Total: Meeting Expenses $825.00

<table>
<thead>
<tr>
<th>Professional Training and Development</th>
<th>Total Cost</th>
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</thead>
<tbody>
<tr>
<td>Lifestyle Coach Training ($600 per online training per staff x 3 staff)</td>
<td>1,800</td>
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<tr>
<td>Regional Coordinator Training (webinar registration fees)</td>
<td>500</td>
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</table>

Sub-Total: Professional Training and Development $2,300.00

<table>
<thead>
<tr>
<th>Other Budget Items</th>
<th>Total Cost</th>
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<tbody>
<tr>
<td>Advertising ($500 per cohort + regional advertising opportunities)</td>
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Sub-Total: Other Budget Items $5,000.00

Total Project Budget $202,961.00
<table>
<thead>
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<th>Amount Requested</th>
<th>Amount Requested</th>
<th>Amount Requested</th>
<th>Amount Requested</th>
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<tbody>
<tr>
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<td>1895</td>
<td>4,652</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>13,392</td>
<td>1,895</td>
<td>8,000</td>
<td>275</td>
<td></td>
</tr>
<tr>
<td>$ 131,437.00</td>
<td>$ 12,030.00</td>
<td>$ 37,517</td>
<td>$ 825.00</td>
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</tr>
</tbody>
</table>

Project Budget $ 202,961.00
### Current State

**Problem:** 33% of Central Oregon adults are overweight contributing to high and growing rates of diet modifiable diseases, such as type 2 diabetes, cardiovascular disease, and some cancers.

**Aim:** By 2019 0% of adults in Central Oregon will have a diet modifiable disease, specifically CVD and/or type 2 diabetes.

**Boundaries:** Focus will be on adults 18+ in Central Oregon.

### Team Members

- **Sponsor:** COHC
- **Process Owner/Team Lead:** MaCayla Arsenault

### Value Stream ID

**Description:**

- **Sponsor:** COHC
- **Facilitator:** MaCayla Arsenault
- **Event Number:** Value Stream ID
- **Revision:**

### Gap Analysis

See attached Fishbone Diagram

### Solution Approach

- If we provide access to healthy and nutritious foods to individuals and families experiencing food insecurity, then we expect those families will incorporate healthier food into their diet.
- If individuals and families incorporate healthier food into their diet, then we expect their risk for developing diabetes type II and cardiovascular disease will decrease. For individuals who currently have cardiovascular disease or diabetes type II as a result of an unhealthy diet, we expect their condition will improve.
- If we increase the access to programs that provide nutrition education, budgeting, and increase fruit and vegetable preparation skills, then we expect individuals and families to purchase and prepare healthier meals for themselves and their family.
- If individuals and families consume healthier meals, then we expect their risk for developing diabetes type II and cardiovascular disease will decrease. For individuals who currently have cardiovascular disease and diabetes type II as a result of an unhealthy diet, we expect their condition will improve.

1. Fund program(s) that increase access to healthy foods to those experiencing food insecurity
2. Fund program(s) that provide nutrition education, budgeting, and increase fruit and vegetables preparation skills.

### Rapid Experiments

### Confirmed State

**Age adjusted BRFSS data for CVD and Diabetes in Central Oregon 2015.**

**Cardiovascular Disease:**

- Oregon 7%
- Deschutes 4.9%
- Jefferson 4.8%
- Crook 6.3%

**Diabetes:**

- Oregon 8.6%
- Deschutes 13.3%* Unreliable
- Deschutes 4.8%
- Jefferson 16%

**Cardiovascular Disease:**

- Oregon 7%
- Deschutes 4.9%
- Jefferson 4.8%
- Crook 6.3%

**Diabetes:**

- Oregon 8.6%
- Deschutes 13.3%* Unreliable
- Deschutes 4.8%
- Jefferson 16%
CVD/DIABETES PREVENTION: BOX 4 FISHBONE DIAGRAM - Nutrition

**WHAT could help us reach our aim?**

- HOW do we do it?

---

**Sugary Beverage Tax**
- Grants for more double up vouchers for SNAP/WIC
- Grants for healthy eating events
- Recipe Apps
- Incentives to attend/buy food at farmers market
- Community programs that offer vegetables as incentives
- Veggie Rx programs
- Food demos and tastings at local food banks
- Increase mobile food bank services
- Meal Prep Partners

**Food store partnership**
- Education around exactly how much sugar is in various beverages
- Leverage the work being done by Nutrition Policy group
- Education for community about food and beverage lobby

**Access to healthy foods**
- Free samples of fruits and veggies
- Free cooking with kids classes
- Tax incentive for food supplier to increase sales of fruits and vegetables in food deserts
- Food Hero events at local grocers
- Cooking demos at local grocers

**Worksite wellness nutrition programs**
- Discounted worksite CSA
- Cooking demos at lunch time for worksites
- Treadmill desks
- Free gym fee or gym located at business
- Promote lunch exercise ex. Lunch walking groups
- Free screening of blood pressure & cholesterol
- Healthy Recipes for staff
- Free fruit/veggies supplied by business for snacks
- Corporate wellness nutrition challenges
- Employer insurance discount for nutritional habits (CSA, lowered BMI, etc.)

**Food as medicine**
- Veggie Rx
- Connect high-risk diagnosis clinic panels with local farm CSAs
- Mobile food banks to stop at healthcare offices
- Financial support for a menu of options, initial diagnosis with diettian
- Lunch and learns with healthcare providers
- CSA discounts for clinics
- Food insecurity screenings
- Study quantifying cost-savings with healthier eating

**Remove sugary beverages from SNAP benefits**
- Letters of support/editor/legislator/lobby

---

**AIM**
By 2019 0% of adults in Central Oregon will have a diet-modifiable disease, specifically CVD/Type 2 Diabetes

- COHC/RHIP or other entity hires research marketing agency to development brand and website
- Catchphrase/slogan (branding)
- Celebrity Partnership
- Create videos and PSAs

---

84
CVD Diabetes Prevention Box 5 Survey Results

**AIM: By 2019 0% of adults in Central Oregon will have a diet modifiable disease, specifically CVD and/or Type 2 diabetes.**

The results of this survey show a common thread of supporting the distribution of healthy foods to individuals experiencing medical and socioeconomic risk. There was emphasis in the comments of pairing food insecurity screenings directly with the distribution of nutritious food. Twelve out of fifteen responses were received for this survey. The following five “hows” & their corresponding “whats” were identified as the highest priority tactics for achieving the AIM:

<table>
<thead>
<tr>
<th>HOWS</th>
<th>WHATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile food banks to stop at healthcare offices</td>
<td>Food as Medicine</td>
</tr>
<tr>
<td>Veggie Rx Programs</td>
<td>Increase Vegetable Consumption &amp; Food as Medicine</td>
</tr>
<tr>
<td>Mobile food bank with fresh foods</td>
<td>Access to Healthy Foods</td>
</tr>
<tr>
<td>Food drives to donate low sodium, low sugar, whole grain foods</td>
<td>Access to Healthy Foods</td>
</tr>
<tr>
<td>Food insecurity screenings</td>
<td>Food as Medicine</td>
</tr>
</tbody>
</table>

See following pages for detailed results and comments.