About Our Project

Our project was mainly focused on increasing healthy produce in the diets of our community. The adult obesity rate in Scott County is 31% making it higher than the national and state average. In order to decrease further health problems such as type 2 diabetes, high blood pressure, and other chronic diseases, this project needed to focus on diet. The goal of this project was to make the healthy choice the easy choice in order for our community to live long, happy lives to their full potential. We helped achieve this goal through in store promotion techniques, nutrition education, increasing access to community resources, and bringing together community members of all facets.

Objectives

1. Increase the number of grocery stores with new on-site and in-store placement and promotion strategies for healthy foods in the target community from 0 to 7.
   We ended up incorporating onsite promotion in 4 of the local Hy-Vee stores and have talked about continuing to partner with produce taste-testing.

2. Increase the number of grocery stores and non-profit organizations using new tools or resources to create awareness of how to access healthy food options in the community from 0 to 2.
   We were able to place our resource guide in 4 of the local grocery stores, 2 of our WIC clinics and Edgerton Women’s Health Center.

3. Increase the number of grocery stores participating in the Share Our Strength Cooking Matters at the Store program in the target community from 0 to 4.
   We were able to utilize 4 dieticians from the local grocery stores and trained them to lead store tours. We successfully led 150 families in understanding how to shop and eat healthier.

4. Increase the number of community events signing clients up for the WIC program from 0 to 60.
   As a result of staff changes, WIC was too short staffed to allow staff members to go to community events during the week. However, we were able to pass out WIC information and give people instructions on how to sign up as well as the income guidelines.

5. Increase the number of health insurance companies who reimburse for nutrition services provided by WIC staff in the target community from 0 to 1.
   This intervention unfortunately did not work out since the health insurance company we worked with, no longer worked with Medicaid and had to back out of the project. This is definitely a doable activity with an interested health insurance company as well as enough time to do a pilot program.

6. Increase the number of health care providers and non-profit organizations with providers and/or staff that receive cultural competency training in the target community from 0 to 45 staff members.
   This was completed by the director of the Davenport Civil Rights Commission. She did a training on the history of the African-American community and their hesitancies with healthcare. This opened the eyes of staff members as to why this community does not actively seek medical care until the situation gets very bad.

7. Increase the number of public messages on CPHMC efforts and achievements related to improving access to environments with healthy food and beverage options from 0 to 10 by the end of the project period.
   This intervention was completed by creating a TV commercial, radio broadcast, Pinterest page, Facebook page, and a resource guide pertaining to improving access to healthy food and beverages.
8. Increase the number of public messages on CPHMC efforts and achievements related to improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from 0 to 5 by the end of the project period.
   This intervention was completed by creating a TV commercial, radio broadcast, Pinterest page, Facebook page, and a resource guide pertaining to improving opportunities for chronic disease prevention.

9. Increase the number of partner messages on CPHMC efforts and achievements related to improving access to environments with healthy food and beverage options from 0 to 4 by the end of the project period.
   This intervention was completed by creating a newsletter for community partners with monthly updates and current information about the progress and achievements of the CPHMC project.

10. Increase the number of partner messages on CPHMC efforts and achievements related to improving opportunities for chronic disease prevention, risk reduction or management through community and clinical linkages from 0 to 4 by the end of the project period.
    This intervention was completed by creating a newsletter for community partners with monthly updates and current information about the progress and achievements of the CPHMC project.

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