Partnering4Health
Ways the American Heart Association (AHA)
Supported its 30 Communities

The American Heart Association's (AHA) ANCHOR (Accelerating National Community Health Outcomes Through Reinforcing Partnerships) program worked in thirty (30) regional communities to clear the air of secondhand smoke, improve access to healthy food and beverages, and increase physical activity opportunities

AHA Table 1: Community Recruitment and Areas of Focus

	Cohort 1	Cohort 2	Total
# of Affiliates invited to apply	7	7	N/A
# of Communities Selected	15	15	30
# Addressing Healthy Food Procurement	8	10	18
# Working on Food Financing	4	1	5
# Strengthening Farmers Markets	5	3	8
# Negotiating Shared Use Agreements for Physical Activity	2	1	3
# Strengthening School Physical Education	3	3	6
# Improving Community Opportunities for Physical Activity	0	2	2
# Increasing Smoke Free Venues	3	3	6

The ANCHOR national program management team (referred to as the "core team") managed the overall program. A principal Investigator who was an AHA Vice-President plus AHA subject matter expert advisors provided strategic guidance and support. The Senior Program Manager planned and guided the overall program working closely with the Principal Investigator to stay abreast of federal funder needs and requirements. Due to the importance put on training, technical assistance, and communications, AHA created a Specialist position to spearhead this and serve as a coach and resource person on these areas. Although AHA has operations, finances, and contracts personnel and procedures, the complexity of the ANCHOR project required adding two dedicated staff to support these functions and meet the requirements of federal grant processes. The heavy reporting requirements and the robust evaluation plan necessitated another Specialist to support these functions.

In each local ANCHOR community, a dedicated AHA staff person known as a Regional Campaign Manager (RCM) was embedded within the AHA's Affiliate health strategic team. AHA chose three Regional Campaign Managers as Team Leads. They had responsibility for implementing a local campaign in addition to having an elevated leadership role. The Team Leads provided peer-level coaching and

consultation support to four RCMs by providing additional capacity support to field-level questions and address peer-coaching needs. Team Leads referred Issues or challenges to the core team and the Senior Program Manager. For ANCHOR staff (national and RCMs) who were new to the organization, the AHA used its formal national on-boarding process plus the AHA Affiliate's specific procedures and priority trainings as part of their orientation. In addition, the ANCHOR core team provided training and technical assistance that included both the unique ins and outs of the initiative and the specific knowledge and skills required to implement a comprehensive campaign plan for the local project's priorities. Key approaches included ongoing, tailored training and technical assistance; affinity (peer-to-peer) learning opportunities; and customized individual coaching.

Early on the ANCHOR core team recognized that a key factor for success would be the institutional integration of this project within AHA Affiliates and their priorities. The ANCHOR core team convened face-to-face trainings for RCMs from each cohort to accelerate the planning and implementation of community action plans (CAPs) and address the accelerated timelines. The face-to-face time also provided an opportunity to ensure alignment of national and Affiliate priorities and goals. To support the project, AHA drew on internal subject matter experts and hired the external evaluation staff from Texas A&M University. These experts helped ensure that each local ANCHOR community employed best practices, used the latest tools and resources, considered coordination aspects, and leveraged available AHA expertise. AHA-provided trainings included opportunities to leverage available resources such as those developed through AHA's Voices for Healthy Kids project, evaluation tips, key learnings, and message research findings as well as new project-specific procedures or procedure improvements. Affinity calls provided peer-to-peer learning opportunities between communities and provided opportunities to share local successes, challenges, feedback, and advice.

For Cohort 1, the ANCHOR Senior Program Manager and the local AHA teams jointly developed the first community action plans (CAPs), which resulted in CAPs that met a deadline rather than ones that engaged the community. Subsequently, RCMs submitted revised CAPs at regular intervals when they built or expanded coalitions or engaged new partners. Based on the experience of Cohort 1, the ANCHOR core team revised the CAP template and created a detailed work plan template for Cohort 2. The ANCHOR core team had several approaches to program monitoring and reporting including bi-weekly status update calls to monitor progress and discuss the biweekly reports each community uploaded to AHA's internal intranet site SharePoint. This reporting enabled RCMs and core team members to share key findings, products developed, successes and challenges as well as identify operations, contracting, and training and technical assistance needs. The bi-weekly calls included the ANCHOR core team and Team Leads. The Senior Program Manager also held bi-weekly status update

calls with each Team Lead. The joint and individual calls provided touch-points in keeping the pulse on wins and barriers.

The AHA engaged its evaluators from the proposal development concept phase. Texas A&M University developed a comprehensive evaluation plan that included a variety of evaluation surveys and tools tailored for each local project and that it adjusted as new opportunities arose. RCMs submitted monthly summaries of their progress and activities to the evaluators using an Access database created by Texas A&M. The database facilitated local reporting on progress towards policy, systems, and environmental changes by tracking both the number of setting units/sites impacted as well as the potential population reach associated with each successful change. The evaluators created monthly snapshot reports that the core team used during the check in calls with RCMs to consider next steps for meeting goals.

The AHA national core team helped the communities by commissioning a public opinion research firms to conduct phone surveys and test messaging on both issues being addressed and public perception on the policy, systems and environmental changes being pursued in all 30 communities. The surveys questioned community members about smoke-free environments, increased physical activity opportunities, and access to healthy food and beverages. Results highlighted what messages would resonate with the public and identified areas with an increased need for further public education and message dissemination. It also shed light on areas with strong community support allowing RCMs to redirect their efforts on issues in need of more public awareness and education.

A sampling of successes include:

- Working with the Incline Village (NV) community parks and recreation department to display smoke-free signs during the July 4th "Red, White and Tahoe Blue" event. The Incline Village Parks & Recreation pilot tested smoke-free signs at subsequent outdoor events, beaches and playgrounds and decided to make their parks, beaches and trails smoke-free. In the fall 2016, installing permanent signs.
- Piloting with the Beaverton School District *Oregon Kids Move with Heart* in 16 elementary schools. The program began the school day with 10 minutes of physical activity (Brain Boosts), included recess before lunch, and incorporated Brain Boosts activities throughout the school day. As a result of the pilot, the Beaverton School District expanded the pilot to all 33 elementary schools for the 2016-2017 school year.
- Partnering with Heartland Child Nutrition, a North Dakota state sponsor of the federal Child and Adult Care Food Program to provide 500 home childcare providers on-site training, resource materials, and tools for reducing sodium in the food they served.

- Collaborating with the Rhode Island Department of Health on adoption of the American Heart Association's Healthy Food and Beverage Guidelines. That adoption lead to systems changes and healthier food and beverage options becoming available at concession stands within the McCoy stadium and the Dunkin Donut Center through public vending machines and cafeterias as well as at local community meetings and events.
- Helping the Nourish Mobile Market in Chester, PA obtain EBT equipment that allowed them to implement their USDA license and accept SNAP payments. The AHA identified a vendor that provided free EBT equipment to farmers markets and provided technical assistance to the market employees on how to set up the equipment and process transactions. The Nourish Mobile Market and the YMCA partnership resulted in expanding the mobile markets to seven new locations (YMCA branches).
- Building a new regional food policy council in Hampton Roads, VA. The regional food policy council created a strong, unified voice around food issues. The council planned to seek ways of improving food access for all, especially for those living in underserved neighborhoods. It will facilitate collaboration among different organizations and help support change in policies, systems and environment at the local level.
- Accelerating the adoption of shared use agreements with county wellness councils throughout West Virginia through a collaboration with the West Virginia Department of Education's Office of Child Nutrition. The AHA provided guidance and technical support to schools on including shared use agreements as part of their school wellness policies. Schools received communication and other implementation resources to publicize the shared use agreements already in place. Schools used those resources to inform parents and community members about the availability of gyms, sports fields, playgrounds and running tracks before and after regular school hours.

Because the geographic boundaries of many community-based organizations that Cohort 1 communities partnered with extended beyond those communities, AHA built on the Cohort 1 organizational relationships when identifying Cohort 2 communities, thus continuing to align priorities and make greater impact. The continued relationships allowed many Cohort1 partnerships to continue beyond the funded period.