Project Objectives, Activities, and Measurements

Example

Example Project: Community-based organization implements produce prescription program (Produce Rx) with health care provider to identify patients for food insecurity and elevated BMI or chronic disease diagnosis, host a six-month group nutrition class at the clinic (or virtually) and provide vouchers to purchase fresh produce at the farmers' market. Project utilizes community health workers for participant navigation, classes, resource referrals and tracking health outcomes.

Project Objective #3: Decrease 50% of patients' BMI to 29.9 or less by December 2024.

Activity	Key Staff/Partner Organization Responsible	Start/End Dates *MM/DD/YY-MM/DD/YY*	Measurable Outcome(s) *Description of expected results for process outcomes, project impact and/or health measures. For health measures, consider BMI, A1C and BP.*	Baseline Data for this Outcome *Include indicator(s) and time period(s)*
1. Activity: Refer patients who are food insecure and have high BMI (30.0+) to Produce Rx Program.	**Health Care Provider:** Clinic staff/providers; clinical dietitian **CBO:** Community health workers for patient consent, enrollment and program information.	12/01/22 – 05/30/24	All patients who are food insecure and have BMI over 30.0+ will be referred to health care provider's nutrition education class taught by clinical dietitian.	Currently zero (0) patients are referred to health care provider's nutrition class.
2. Activity: Host weekly nutrition class at clinic with virtual attendance option that provides nutrition education and culturally-appropriate seasonal recipe demonstrations.	**Health Care Provider:** Clinic Registered Dietitian to lead classes, Clinic staff EHR tracking. **CBO:** Community health workers for class facilitation and utilization tracking.	01/01/23 – 12/31/24	40 patients will attend weekly nutrition classes for six-months. The program will have a total of 4 cohorts. Individual participant BMI will be tracked weekly at each class. At the end of each six-month session, at least 80 out of 160 total participants will have a BMI < 29.9.	Currently zero (0) nutrition education classes are hosted,
3. Activity: Provide participants vouchers to redeem for fresh produce at farmers' market.	**Health Care Provider:** Provide vouchers at weekly nutrition education classes. **CBO:** Coordinate with farmers' market to develop voucher tracking system. Community health workers track voucher utilization	01/01/23 – 12/31/24	All 160 Produce Rx participants will receive weekly vouchers. 80% will redeem 80% or more of the total voucher value.	Currently zero (0) vouchers are distributed to program participants.
4. Activity: Refer all eligible participants to CalFresh and assist with enrollment.	**CBO:** Community health workers provide information and enrollment assistance.	01/01/23 – 12/31/24	All 160 Produce Rx participants will receive CalFresh referral and/or enrollment.	Currently zero (0) Produce Rx participants receive CalFresh referral and/or enrollment.

Evaluation Methods:
How will your outcomes be measured? Include the source of your baseline and outcome data and the partner organization responsible.
Screening for food insecurity and high BMI (30.0+) will be conducted by health care provider during every patient visit and logged in EHR. Screening reports for patients with food insecurity and high BMI will be generated by clinic staff from the EHR and enrolled patients referred to CBO community health workers to engage in produce prescription program. CBO will provide clinic staff monthly reports of patient's produce prescription program utilization to enter in EHR. Clinic staff will monitor and report pre and post-program BMI for patients who complete program. Additionally, participant pre and post-surveys will be conducted to track patient change in perception regarding knowledge of nutrition concepts, use of fresh produce and application of healthy habits.

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