Changes We Want to See

Jupiter , FL

Our vision is that the Greater Jupiter community working together will support each person to live the healthiest life possible. The change we want to see is that **people in Greater Jupiter will be healthier and more community oriented**. We think it will take four things to make that happen: increased awareness of resources and risk factors, access to healthy foods, access to physical activities, and access to medical care. This document lists our goals, what we will do (activities), and what we want to achieve.

| **Goals** | **What we will do and what we want to achieve in the next three years**  | **What will we achieve long-term (5 to 7 years)?**  |
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| 2016 through 2019 |
| Awareness | Activities: -Complete and disseminate a comprehensive directory and mapping of Jupiter’s resources – Get Fit Map -Champions: speakers in the community to share the message of Healthier Jupiter-Community assessment  | *Achievements:* *-Residents increase knowledge of Jupiter’s healthy resources* *-Residents increase knowledge of risk factors for diabetes*  | *A 15% increase in the percentage of residents who are aware of Jupiter’s resources (baseline to be established)* |
| Healthy foods | Activities: -Implement Healthier Jupiter restaurant programs, including Eating Smart Partner program-Create a network of community gardens and a local farmers market | *Achievements:* *-Support and change policies to increase healthier eating (e.g., restaurants meeting healthy food criteria)* *-Increase access to affordable healthy produce*  | *42% of people make healthy food choices (compared to 36% at baseline)* |
| Physical fitness | Activities: -Promote and support workplace wellness programs -Promote, support, and/or implement movement programs (e.g., Walk and Talk, bicycling)-Mini-grant program (multiple goal areas) that supports achievements  |  *Achievements:* *-Increase access to neighborhood exercise programs* *-Support and change policies to support physical fitness (e.g., workplace wellness programs)*  | *85% of people are physically active (compared to 77% at baseline)* |
| Access to medical care | Activities: -Distribute and analyze diabetes risk assessments-Sustain access and reduce barriers to access  -Getting Started Toolkit  |  *Achievements:* *-Increased strength of existing systems (# people accessing, results)* | *80% of those identified as at-risk during screenings will access resources or supports.*  |

# Evaluation Plan for March 2017 through February 2018

This document includes four sections: progress on the end result identified in your strategic framework, achievements from the template, key activities from your strategic action plan, and measures of collective impact. The plan will not include all potential achievements and activities but only those that will generate information that can be used. Achievements and how they will be measured will be realistic, appropriate, and flexible.

**What change do we want to see?**

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| --- | --- | --- |
| **What is our end result?**  | **How will we collect the data?**  | **What is the baseline?**  |
| People in Greater Jupiter will be healthier and more community oriented | We will look at risk rates for Type II diabetes through the risk assessments.  | 32% of those screened in 2016 were at risk of Type II diabetes. |

**What will we achieve (outcomes)?**

| **What will we achieve and how will we know?**  | **How will we collect the data?**  | **What is the baseline?**  |
| --- | --- | --- |
| Increase the number of residents accessing neighborhood exercise programs by 5% a year.  | Through the community assessment, plus tracking the number of sustained programs; programs can be mapped to assess coverage.  | 120 People Participated in Healthier Jupiter Walk and Talks in 2016. |
| Increase the number of sites offering affordable healthy produce by 5% a year.  | Through the community assessment, plus tracking the number of sites; sites can be mapped to assess coverage.  | To be determined based on the site listing. 63.6% of community assessment respondents did not eat fruits and vegetables daily.  |
| 42% of residents know at least one risk factors for diabetes | Through the community assessment  | 40% of community assessment respondents did not know at least one risk factor for Type 2 Diabetes  |

**What will we do (ACTIVITIES)?**

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| --- | --- | --- |
| **What key activities do we need to accomplish this year?**  | **How will we collect the data?**  | **What is the baseline?**  |
| Distribute and analyze diabetes risk assessments | Through the diabetes coalition and partners.  | 450 |
| Promote, support, and/or implement movement programs (e.g., Walk and Talk, bicycling) | Track the number of participants through sign in sheets.  | 5 walk and talks with 122 attendees |
| Mini-grant program (multiple goal areas) that supports achievements | From grantees; they will need to report on achievements from the changes document  | n/a |
| Conduct the community assessment | Email distribution through partner organizations, distribution at events, and intercept surveys  | 350 distributed in 2016.  |
| Support and change policies for healthy living | Establish a baseline  | n/a |
| Increased organizational responsiveness to targeted community needs | Number of partners committing resources  |  |
| Increased base of support in the community | Number of partners and/or champions  |  |