Healthy Here

Communities Leading Healthy Change

2014 – 2015
Evaluation Report

UNM SCHOOL of MEDICINE | PREVENTION RESEARCH CENTER
Prevention & Population Sciences

Acknowledgments

2015 Healthy Here Evaluation

Introduction

Healthy Here is a collaborative initiative led by Presbyterian Healthcare Services and the Bernalillo County Health Council in partnership with numerous community organizations. The initiative is funded through a Centers for Disease Control and Prevention (CDC) Racial and Ethnic Approaches to Community Health (REACH) cooperative agreement. *Healthy Here* aims to reduce racial and ethnic health disparities in two under-resourced communities within Bernalillo County, NM – the International District and the South Valley.

Healthy Here uses policy, system, and environmental change strategies and activities to address three factors related to health promotion and prevention of chronic diseases: access to healthy food and beverage options, opportunities for physical activity, and promoting community and clinical linkages. While these three factors are being addressed in multiple ways in Bernalillo County and across the state, the REACH *Healthy Here* evaluation is limited as described: 1) evaluation of the initiative's ability to increase access to healthy food and beverage options will focus on use of a mobile market to bring locally grown produce into target communities; 2) evaluation of increased opportunities for physical activity will focus on the development of walking paths or routes and improvements to the physical environment that enhance walkability; and, 3) evaluation of community and clinical linkages will center on referrals for self-management of chronic disease, specifically measuring use of a referral system by clinics and providers in the target communities.

This report is an initial evaluation of these efforts made during Year 1 of the *Healthy Here* initiative. It is divided into three sections: Mobile Market, Walkability Audit, and Referral System.

Mobile Market

Background

Individuals living in under-resourced communities face many barriers to accessing healthy foods. The external factors that influence food access are deeply rooted in a system that is unlikely to invest in expensive reconstruction and zoning policies that have the potential to positively change the food environment. Communities must often come up with creative approaches to improving access to healthy foods. Mobile markets are one such approach. They are being used as an alternative to expensive grocery stores to promote locally grown foods and reduce health disparities. In addition, mobile markets offer more flexibility than traditional grocery stores and have the ability to serve multiple communities.

The Hispanic and American Indian populations in the International District and South Valley communities of Bernalillo County experience both health disparities and limited access to healthy foods. To address these inequities, the *Healthy Here* initiative piloted a mobile market with a goal of increasing access to affordable, high-quality, healthy foods within these communities.

Numerous *Healthy Here* Mobile Market partners worked together to begin pilot-testing on July 14, 2015. Partners included: Agri-Cultura Network, Adelante, Bernalillo County, Storehouse NM, Presbyterian Community Health, Street Food Institute, UNM Community Health Worker Initiative, La Cosecha, International District Healthy Communities Coalition, UNM SE Heights Clinic, First Nations Community Healthsource, First Choice Community Healthcare, and Presbyterian Medical Group. The pilot season is scheduled to end on October 20, 2015. Two clinics in the South Valley (First Choice Community Healthcare and the Presbyterian Medical Group Clinic) and two in the International District (First Nations Community Healthsource, and the University of New Mexico Southeast Heights Clinic) were chosen by Mobile Market partners as the initial sites for piloting the initiative. The pilot Mobile Market sold local and organically grown produce at a subsidized cost, in addition to providing food tastings, nutrition education, and healthy recipes on site during mobile market events. A brief summary of the 2015 Mobile Market pilot schedule is highlighted below.

***Healthy Here* Mobile Market 2015 Pilot**

Dates: July 14 – October 20, 2015

Participating Clinic Sites and Operation Times:

South Valley

Presbyterian Medical Group Clinic (12-2pm)

First Choice Community Healthcare (3-5pm)

International District

First Nations Community Healthsource (12-2pm)

UNM SE Heights Clinic (3-5pm)

The Mobile Market was held every other Tuesday alternating between the two communities.

The purpose of the Mobile Market pilot evaluation was to assess whether the market expanded access points for fresh local produce to the Hispanic and American Indian populations living within the South Valley and International District of Bernalillo County. The evaluation was specifically designed to measure actual use of the Mobile Market and whether it influenced fruit and vegetable consumption. The evaluation questions were:

1. To what extent are people in general and specifically, Hispanic and American Indian individuals, using the Mobile Market?
2. To what extent do purchases from the Mobile Market increase over time?
3. To what extent are individuals consuming fruits and vegetables in a manner more closely aligned with Dietary Guidelines for Americans' recommendations following the implementation of the Mobile Market intervention?

Methods

In order to answer the above evaluation questions, the evaluation team conducted a literature review, collaborated with partners on the development of data collection instruments, and analyzed data collected and entered by partner organizations implementing the Mobile Market.

Instrument Development

A review of evaluation practices for mobile market programs revealed a lack of comprehensive and consistent measurement tools. The limited number of similar intervention

evaluations did not align with our specific questions and most were not readily available. Due to the relatively new concept of mobile market interventions and the specific evaluation questions, the *Healthy Here* evaluation team worked with *Healthy Here* partners to develop a registration form to be completed by participants at the time of their first encounter with the *Healthy Here* Mobile Market.

The registration form was purposely designed to quickly gather information without discouraging participation. The 11-item registration form included demographic information, fruit and vegetable consumption questions, and social marketing questions (see Appendix A). The questions were created using the Centers for Disease Control and Prevention's (CDC) 2014 Behavioral Risk Factor Surveillance System (BRFSS) questionnaire, a food behavior checklist (Murphy, Kaiser, Townsend, & Allen, 2001), two Farmer's Market Customer surveys (i.e., Green Carts and Community Food Security Coalition), and input from the Mobile Market partners. The questions were revised to be culturally appropriate and suitable for individuals with low literacy. The registration form was also available in Spanish.

Using input from the Mobile Market partners, the evaluation team drafted a follow up survey to be administered to participants by Mobile Market partners during the last two weeks of the pilot season (October 2015). The survey includes fruit and vegetable consumption questions and process evaluation questions designed to gather data for program improvement (e.g., barriers and facilitators). After the draft survey is finalized, a paper version will be made available to participants. In addition, a survey link will be sent out via email and text message from Mobile Market partners to participants that agreed to be contacted electronically by the program. The follow up survey will also be available in Spanish.

Data Collection

The registration form was administered on-site to first time customers of the Mobile Market prior to shopping for produce. Market implementers assisted participants with the forms as needed. The information collected at the Mobile Market was entered into a data management system (Salesforce) by Adelante staff during the week following each event. Purchase data were also tracked throughout the season by the Mobile Market staff using Salesforce. In addition to individual purchases, the total amount of produce purchased for the Mobile Market was documented.

Results

Results include demographic information, fruit and vegetable consumption habits, and sales data for all Mobile Market participants during the 2015 pilot season. Please note that these are preliminary results and do not reflect the entire Mobile Market season which ends October 20, 2015. Data presented here are from the first nine weeks of the market and include information through September 8, 2015.

Mobile Market attendance was recorded to determine the overall reach of the intervention. A total of 487 people attended the Mobile Market during the first 9 weeks of the pilot season. Overall, there were 634 total visits to the Mobile Market, including repeat customers. Participation peaked during the second week in the International District with 134 participants (Figure 1). The International District (even weeks) consistently had higher participation than the South Valley (odd weeks). Participation declined throughout the pilot period.

Figure 1. Mobile Market pilot attendance by week, July 14 - September 8, 2015
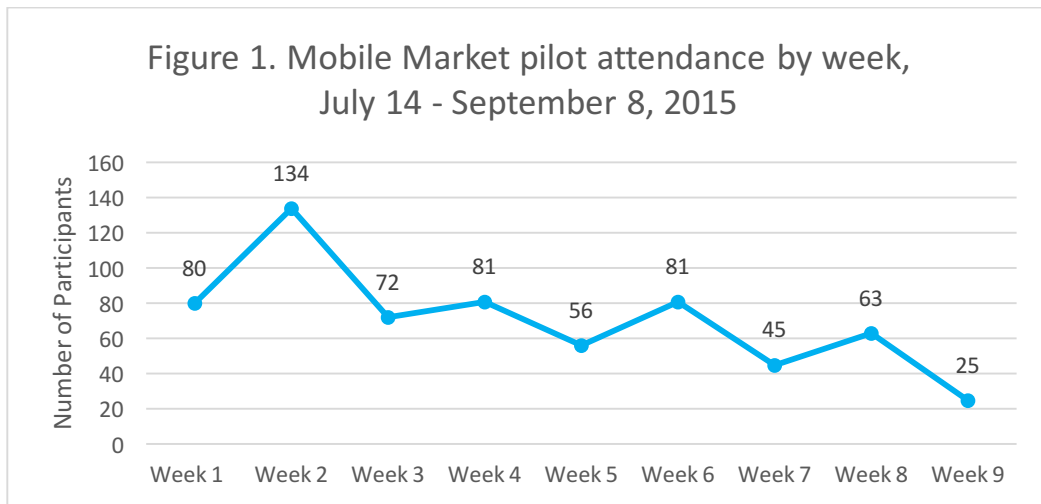
More than one-third (35.5%) of Mobile Market participants attended at the First Nations location (Figure 2). The First Choice and UNM SE Heights clinics each served about one quarter of the participants (23.7% and 24.9%, respectively). The Mobile Market located at the Presbyterian clinic saw approximately one sixth of participants.

Figure 2. Percentage of Mobile Market participants by location

N=465
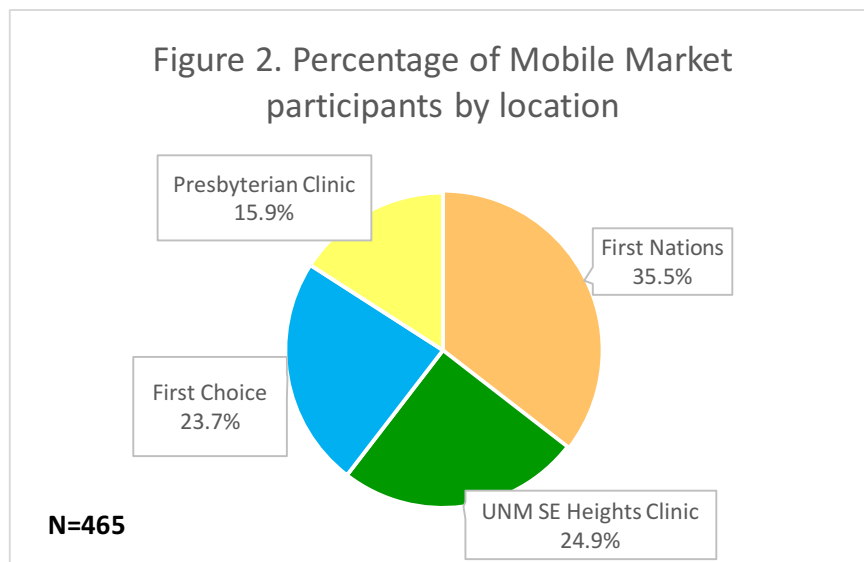
*Figure 2 presents data from the first 8 weeks with 4 markets at each site.

Demographic Characteristics

Among participants that completed the registration form, 77.6% were female. Participants ranged in age from 14 years old to 100 years old. Participants between the ages of 45 to 54 years old made up 28.5% of registered participants, while approximately half of the participants were either 25 to 34 years old (26.9%) or 35 to 44 years old (25.6%).

The majority (64.8%) of pilot Mobile Market participants self-reported their race and ethnicity as American Indian or Hispanic (Table 1). Overall, nearly half (47.6%) of participants were Hispanic and 17.2% were American Indian. Participant race and ethnicity differed by Mobile Market location. First Nations, a health clinic originally charged with serving the American Indian population in Albuquerque, had the largest percentage of American Indian participants. The other International District location, UNM SE Heights clinic, also had a substantial percentage of participants identifying as American Indian. Hispanics were significantly represented at all pilot Mobile Market locations.

Table 1. Race and ethnicity of pilot Mobile Market participants, overall and by clinic site, 2015.

	First Nations	UNM SE Heights	First Choice	Presbyterian	Overall
American Indian	36.2%	16.0%	0.0%	4.1%	17.2%
Asian or Pacific Islander	3.9%	2.0%	0.9%	1.4%	2.3%
Black or African American	5.3%	5.0%	2.8%	0.0%	3.7%
Hispanic	27.6%	45.0%	68.9%	61.6%	47.6%
Non-Hispanic White	23.7%	25.0%	22.6%	28.8%	24.6%
Other	3.3%	7.0%	4.7%	4.1%	4.6%

*123 participants did not provide race or ethnicity information

The *Healthy Here* initiative focused on reaching populations in the International District (zip code 87108) and South Valley (zip codes 87102 and 87105). Sixty-four percent of pilot Mobile Market participants reported living in those three zip codes (Figure 3).

Figure 3. Mobile Market participants by zip code, July 14 - September 9, 2015
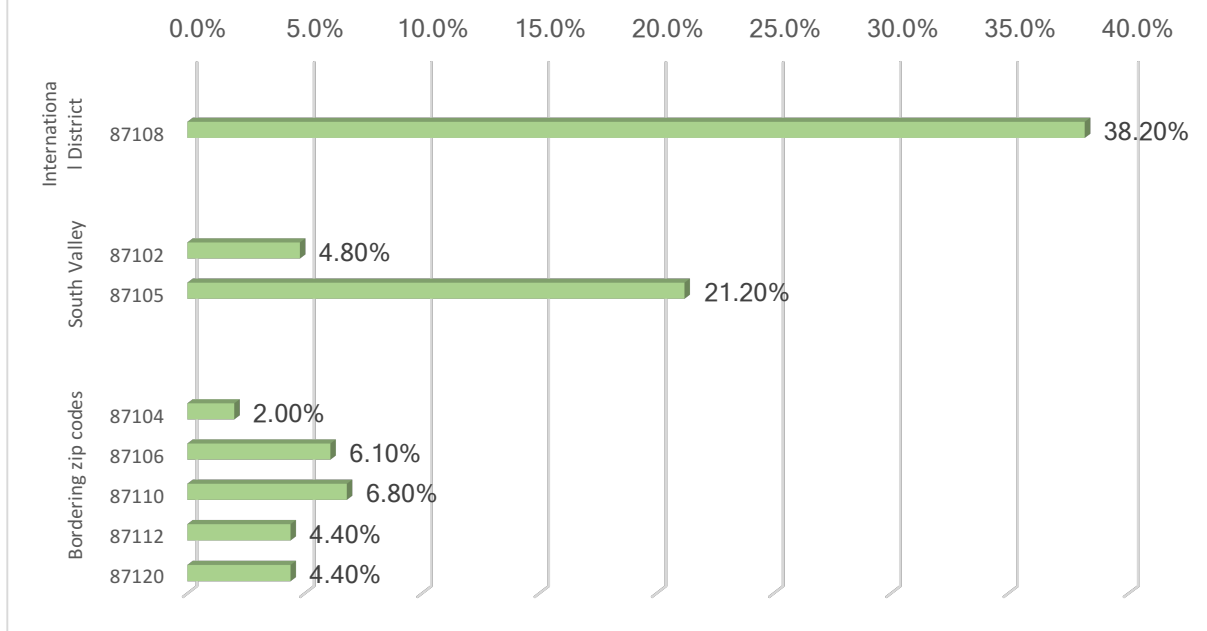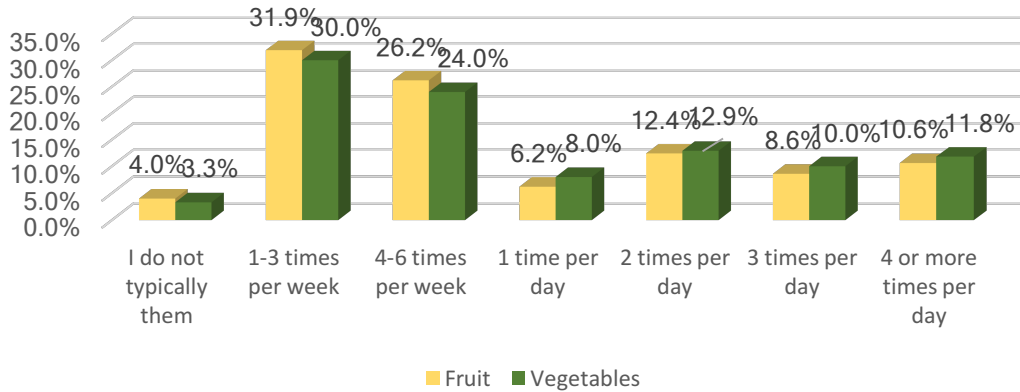
The International District zip code, 87108, had the highest rate of participation. Residents from the two South Valley zip codes made up 26% of all Mobile Market participation. Participation among individuals from bordering zip codes was also reported, with approximately 25% of participants living in 87104, 87106, 87110, 87112, or 87120. Other reported zip codes made up 12.9% and are not represented in Figure 3.

Participants also reported income level at the time of registration. Nearly one third of all Mobile Market participants reported their annual household income for the last year was less than $11,999. Approximately, 9% of participants reported an annual household income of $12,000 to $15,999 and 8.9% reported incomes between $16,000 and $20,999. The mean household size of Mobile Market participants was 3.0 persons. More than half (58%) of participants reported that they received at least one form of public assistance (e.g., food stamps, SNAP, EBT, free or reduced school lunch, WIC, food pantries) during the last year.

Reported fruit and vegetable consumption during a typical week are presented in Figure 4. The majority of participants reported eating both fruits and vegetables 1-3 times per week, or 4-6 times per week. Overall, 4% of Mobile Market participants indicated they do not typically eat fruit while 3.3% reported not typically eating vegetables. Typical fruit and vegetable consumption reported from the South Valley locations differed from International District locations. Approximately 14% and 8% of Mobile Market participants from the International District reported that they did not typically eat fruits and vegetables, respectively. This is compared to approximately 1% and 4% of the South Valley participants that reported not typically eating fruits or vegetables.

Figure 4. Frequency of fruit and vegetable consumption at the time of Mobile Market registration, July 14 - September 8, 2015

Legend: Fruit, Vegetables

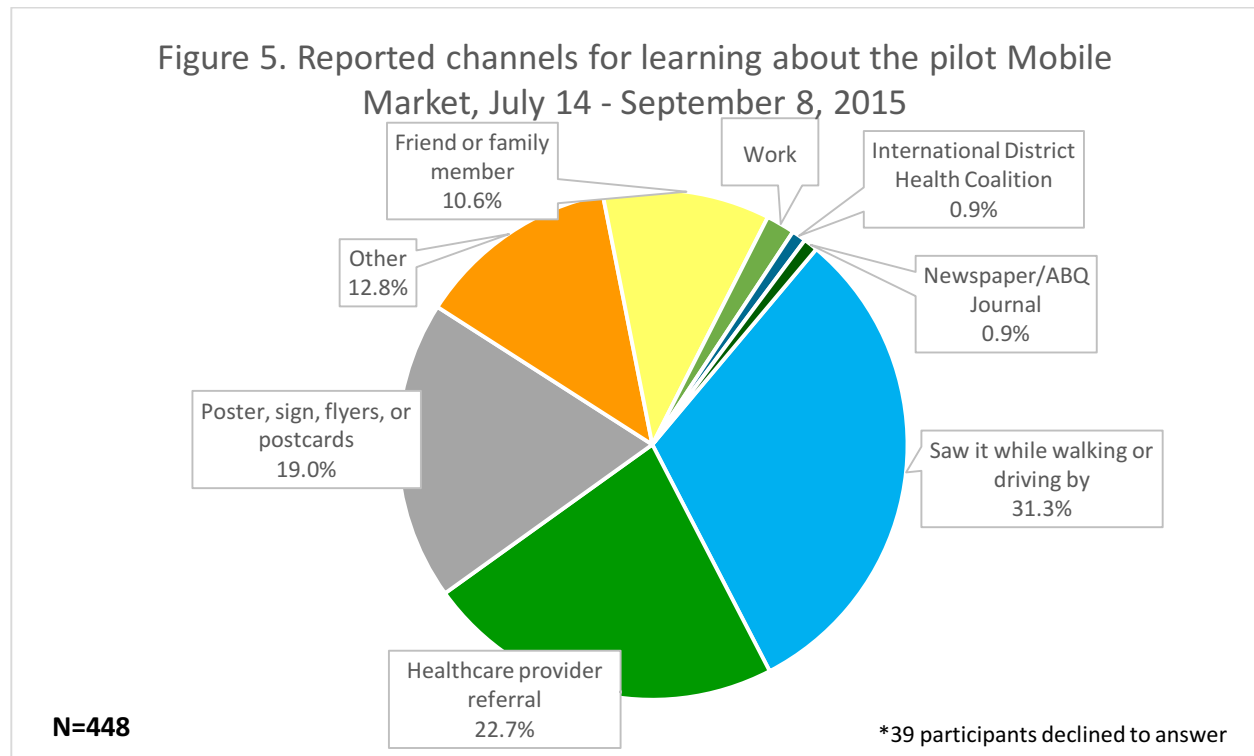| Category	Fruit	Vegetables
I do not typically them	4.0%	3.3%
1-3 times per week	31.9%	30.0%
4-6 times per week	26.2%	24.0%
1 time per day	6.2%	8.0%
2 times per day	12.4%	12.9%
3 times per day	8.6%	10.0%
4 or more times per day	10.6%	11.8%

*36 participants did not answer fruit consumption question while 37 did not answer vegetable consumption question

A comprehensive community outreach campaign was launched prior to the start of the Mobile Market and continued through the season. Postercards (see examples below), signs, flyers, and johnny boards (indoor advertisements) were utilized for the social marketing campaign.

A marketing question was included on the registration form in order to identify how participants learned about the Mobile Market. Of the 487 registered Mobile Market participants, 448 people responded to the question (see Figure 5).

Figure 5. Reported channels for learning about the pilot Mobile Market, July 14 - September 8, 2015

- Friend or family member 10.6%
- Work
- International District Health Coalition 0.9%
- Other 12.8%
- Newspaper/ABQ Journal 0.9%
- Poster, sign, flyers, or postcards 19.0%
- Saw it while walking or driving by 31.3%
- Healthcare provider referral 22.7%

N=448

*39 participants declined to answer

The most commonly reported channel by which respondents learned about the Mobile Market was seeing it while walking or driving by, followed by hearing about it through a healthcare provider referral, and seeing posters, signs, flyers or postcards. The most common ways participants learned about the Mobile Market differed by location. Respondents attending the Mobile Market at First Nations were more likely to report that they saw it while walking or driving by (42.3%) compared with the UNM SE Heights clinic location (22.4%). The UNM SE Heights location had a higher proportion of participants referred by a healthcare provider (33.6%). First Choice and Presbyterian clinic locations had distributions that were very similar to the overall distribution in Figure 5.

There were also differences in how participants heard about the Mobile Market by gender. Nearly half (43.6%) of males indicated that they saw it while walking or driving by compared to 27.9% of women. Women reported learning about the Mobile Market more often from healthcare provider referrals (24.1%) and posters, signs, flyers, or postcards (20.6%) compared to males, 17.8% and 13.9%, respectively.

Follow up questionnaire

The follow up questionnaire has not yet been finalized or administered. There are no results to report at this time.

Mobile Market Purchase and Sales Data

This section presents the pilot Mobile Market purchase and sales data. A variety of fruits and vegetables were purchased locally to be sold at the Mobile Market venues (Table 2).

Table 2. Amount of fruits and vegetables purchased to supply the Mobile Market, July 14, 2015 – September 8, 2015.

Produce Purchased	Quantity	Total Amount
Basil (Green & Purple)	98 (oz)	$98.00
Beets	47 (lbs)	$188.00
Blackberries	10 (lbs)	$80.00
Carrots (Orange and Rainbow)	168 (lbs)	$672.00
Chard	21 (lbs)	$84.00
Chives	16 (oz)	$16.00
Collards	11 (lbs)	$44.00
Colored Peppers (Different varieties)	36.95 (lbs)	$147.80
Cucumbers	103.18 (lbs)	$309.54
Garlic	33.54 (lbs)	$234.78
Green Beans	41 (lbs)	$205.00
Green Chile	199 (lbs)	$727.00
Jalapeno	27.5 (lbs)	$110.00
Kale	62 (lbs)	$248.00
Leeks	13.5 (lbs)	$67.50
Mint	14 (oz)	$14.00
Onions	141 (lbs)	$564.00
Oregano	16 (oz)	$16.00
Parsley	4 (oz)	$4.00
Pears	6 (lbs)	$18.00
Radishes	31 (lbs)	$124.00
Salad	11.5 (lbs)	$69.00
Scallions	1 (lbs)	$4.00
Serrano Peppers	13.5 (lbs)	$54.00
Squash-Summer	233.6 (lbs)	$700.80
Tomatillo	4 (lbs)	$24.00
Tomatoes (Heirloom or Hybrid)	160 (lbs)	$700.00
Turnips	20 (lbs)	$80.00
Watermelons	8 (lbs)	$64.00
TOTAL		**$5,667.42**

Food for sale at the Mobile Market was purchased from wholesale vendors and totaled $5,667.42. During the first 9 weeks of the Mobile Market, a total of 334.3 pounds of produce were left unsold. The leftover produce was donated to a local food pantry for distribution.

Pilot sales data include the total amount of produce purchased by individuals, as well as coupon amounts and the average sale amount per person, per event over the first nine weeks of the Mobile Market (Table 3). Although Mobile Markets held at First Nations had the most attendees, Mobile Markets held at First Choice had the highest net sales with $531.74 and the highest coupon usage. The Mobile Market offered coupons to increase access to healthy produce and participation in the market.

Table 3. Pilot Mobile Market sales data by location and overall, July 14, 2015 – September 8, 2015.

Location	Gross sales	Coupons	Net sales	Average sales/ person/event
Presbyterian Clinic	$431.36	$58.00	$373.36	$6.25
First Choice	$615.74	$84.00	$531.74	$5.66
First Nations	$519.14	$48.00	$471.14	$5.46
UNM SE Heights	$360.66	$40.00	$320.66	$5.46
Overall	**$1,926.90**	**$230.00**	**$1,696.90**	**$5.71**

Discussion

The initiative launched the pilot season of the Mobile Market in four locations, two in the International District and two in the South Valley. Partner organizations successfully navigated issues of transportation, permitting, purchasing of local produce, distribution and set-up, pricing, acceptance of SNAP/EBT, registration, database development and tracking of sales. Buy-in from clinics, healthcare providers, community health workers and other partners was seen as essential to establishing the Mobile Market.

Communication efforts around the Mobile Market were also successful in getting the message out. A brand and logo were developed and example messages and communication strategies were provided by the *Healthy Here* communication team. Dedicated partners gained earned media from local news outlets for the initiative. A detailed evaluation of media and communication efforts will be provided by the communication team.

Preliminary data indicate that the Mobile Market is reaching the target population of low-income, American Indian and Hispanic residents living in the International District and the South Valley communities in Bernalillo County. Approximately half of participants reported annual household income of less than $21,000, and 58% had received at least one form of public assistance over the past year. Nearly two-thirds of participants self-identified as

American Indian or Hispanic and 64.2% lived in the three target zip codes with an additional 23.7% living in bordering zip codes.

Fewer than 12% of the participants reported eating the recommended amount of fruits and vegetables (5 or more a day) at the time of registration. With the follow up questionnaire we hope to answer whether or not the Mobile Market has increased fruit and vegetable consumption.

Preliminary data showed a strong kick-off for the Mobile Market with a decline in participation over the 9 week period. Potential factors in the decline include limited days and hours of operation, availability of foods, and pricing. Participation for the full season will be analyzed following completion of the Mobile Market on October 20, 2015. Barriers to participation will be explored using the follow-up survey and the initiative will have a debriefing session to discuss process issues, lessons learned, and plans for the 2016 Mobile Market. Issues of sustainability will also be examined at that time.

Murphy, S. P., Kaiser, L. L., Townsend, M. S., & Allen, L. H. (2001). Evaluation of validity of items for a food behavior checklist. *Journal of the American Dietetic Association*. http://doi.org/10.1016/S0002-8223(01)00189-4

Walkability Audit

Background

The International District is a vibrant community in Bernalillo County with a racially and ethnically diverse population. The area is under-resourced and suffers disproportionately high rates of obesity and chronic disease, as well as high rates of pedestrian and bicycle conflicts. Environmental factors have resulted in limited access to safe opportunities for being physically active, a known protective factor against many chronic diseases, including diabetes, obesity, and hypertension.

Responding to these concerns, members of the International District, along with public and private community planning agencies, have engaged in planning processes to voice their concerns and propose solutions that would encourage community members to engage in physical activity in an attractive and safe environment. Through these planning processes, several conditions have previously been identified as barriers to active transportation and engaging in physical activity to improve their health. These include:

- Long distances between crossings and the inconsistent size of city blocks
- High traffic speeds, wide lanes (not safe for bikes), and underutilized streets
- Large curb cuts and uneven surfaces on walking paths and sidewalks
- Poor lighting, landscaping, and shade
- Actual and perceived crime in the area resulting in a lack of desire to engage in active transportation due to fear for one's safety
- Commercial spaces are car dependent, and not oriented for pedestrian and bike access

Given the concerns expressed by the residents of the International District, the *Healthy Here* evaluation team has posed the following evaluation question regarding walkability and active transportation within these communities:

1) Do residents of the International District have access to safe places to walk?

2) To what extent has access to and enhancement of safe places to walk increased?

Methods

Drawing from the evidence that factors within the built environment influence ones desire to walk for recreation or transportation, the *Healthy Here* evaluation team conducted a walkability audit of roadway segments within the International District in Albuquerque. Specifically, sections of Central Avenue and Zuni Rd were targeted by *Healthy Here* as a focus for improvements in safety and walkability. In order to conduct the audit, the evaluation team reviewed several tools to determine their applicability to urban communities with a high percentage of low income, minority populations. Factors such as reliability, validity, inclusion of factors of interest to the initiative, and the ability to measure changes of interest in the built environment over time were also considered. This review generated six potential instruments ranging from short checklists to complex environmental scans. The CDC's *Healthy Workplace Initiative's Workplace Walkability Audit Tool (Walkability Audit;* Appendix B*)* was selected. The *Walkability Audit* measures features of the built environment that influence the walkability of a neighborhood, while also ranking features in terms of low, medium, and high levels of importance, and establishing a walkability score for each segment audited. This walkability score can be used to compare the same segment at different points in time. The development and reliability assessment of this tool is described in Dannenburg et. al., 2005.

To address concerns over access to safe and convenient access to public transportation raised in the International District Sector Plan, an additional question regarding transit safety, (adapted from the Pedestrian Environmental Data Scan (PEDS)) was added to the *Walkability Audit*. Following the original instrument's logic that all questions concerning safety be given a high level of importance, the supplemental transit question is ranked similarly. The addition of this question will add an additional possible 15 points to the scale, making the highest possible walkability score for any segment 115 points compared with 100 points for the original *Walkability Audit*.

A pilot test of the *Walkability Audit* tool was conducted on August 4th, 2015, along Zuni Road between San Pedro and Wyoming for the purposes of assessing the instrument. A total of 12 segments were audited using the original tool. During the pilot, it became apparent that the definitions for scoring were not specific enough. The *Healthy Here* evaluation team reviewed the protocols from several validated tools (PEDS, MAPS) and contacted the author of the *Walkability Audit* tool to discuss inconsistent score assignment. A new instrument protocol was developed to clarify scoring definitions and improve inter-rater reliability (Appendix C). The revised documents were used to assess three areas in the International District.

On September 18, 2015, and September 21, 2015, using the newly developed protocol and definitions, two members of the *Healthy Here* evaluation team independently conducted audits of 1) the intersection of Zuni Road and Central Avenue; 2) the intersection at Central Avenue and San Mateo; and 3) Zuni Road between San Pedro and Wyoming. Each side of the street was

assessed. A total of 10 audits were conducted for the intersection and related segments at Central Avenue and San Mateo, and an additional 8 audits were conducted for the intersection at Central Avenue and Zuni Road. The Zuni Road audit consisted of 8 additional segments. In addition to scoring each segment, evaluators made qualitative comments on the ranking. At the end of each section, evaluators met to share their results and comments regarding the sections and to come to consensus on a score for each factor addressed. There were 27 instances where scores initially disagreed (10.4%). The two most common areas for disagreement in scores were crosswalks and aesthetics. All issued were resolved following discussion and review of the protocols and definitions. These results were then entered into a spreadsheet for analysis.

Results

The walkability audit scores for the 26 audited segments are presented in Table 4. Maps identifying the locations of the segments can be viewed in Figure 6 (Central Ave and San Mateo Blvd [SM]), Figure 9 (Central Ave and Zuni Road [CZ]) and Figure 11 (Zuni Road [Zu]).

Table 4. Walkability Audit Segment Scores

	Central Ave & San Mateo Blvd Intersection (SM)	Central Ave & Zuni Rd Intersection (CZ)	Zuni Rd (Zu)
1	59.1	52.2	59.1
2	58.3	44.4	68.7
3	41.7	58.3	48.7
4	68.7	56.5	68.7
5	61.7	65.2	60.9
6	69.6	60.9	51.3
7	58.3	58.3	66.1
8	67.8	66.1	62.6
9	65.2	-	-
10	55.7	-	-
Overall Average	**60.6**	**57.7**	**60.8**

Overall, the Central Ave and Zuni Rd intersection had the lowest average score (57.7). None of the individual segments received a score of 70 or higher. The lowest scores were given to segments SM 3, CZ 2, and Zu 3.

Most of the audited segments had continuous sidewalks on both sides of the street. The one exception was segment CZ 2. Lack of a continuous sidewalk lowered the segment score significantly in the *Pedestrian Facilities*, *Path size*, and *Wheelchair Access* categories. None of the sections audited (n=26) had buffers separating the sidewalk from the road, thereby creating

a potential for pedestrian conflicts and prompting a score of 1 out of 5 for that category. Other concerns of note include the presence of faded crosswalks, long distances between crossings, high traffic volume and speeds, and debris on the sidewalks that could potentially cause a tripping hazard. These concerns are consistent with those previously identified by community members. Addressing these barriers would greatly improve the overall walkability of these three sections.

Intersection at Central Ave and San Mateo Blvd

The Central Ave and San Mateo Blvd intersection audit included 10 separate segments. The segments along San Mateo Blvd were from Zuni Rd to Central Ave (SM 1 and 2) and Central Ave to Copper Ave (SM 5 and 6). Central Ave segments were from Washington St to San Mateo Blvd (SM 3 and 4), San Mateo Blvd to Alvarado Dr. (SM 7 and 10), and Alvarado Dr. to San Pedro (SM 8 and 9). Figure 6 illustrates the audited segments for the Central Ave and San Mateo Blvd intersection.

Figure 6. Map of walkability audit segments at the intersection of Central Ave and San Mateo Blvd (SM)
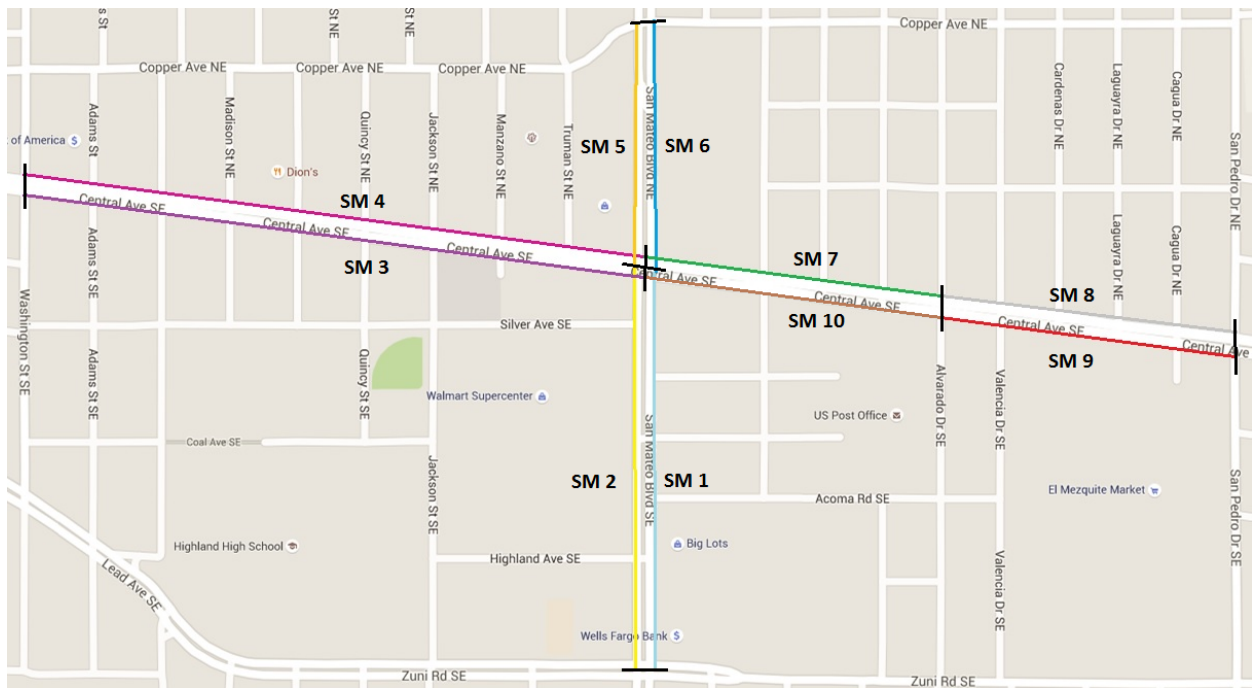
The Central Ave and San Mateo Blvd intersection has been under review due to the high number of pedestrian fatalities. The audit revealed a 35 mph speed limit on Central Avenue, and 40 mph on San Mateo Blvd. Traffic speeds coupled with the high volume of traffic make this section particularly dangerous for pedestrians. The lowest scoring segment in this area was SM 3. The low score was due to a path size decrease to less than 2 feet wide in-between

Madison and Monroe (2 minor arterials). The path size is too narrow and nearly impassable for wheelchairs due to a lack of curb cuts. Figures 7 and 8 are photographs of SM 3 along the block between Madison and Monroe. Figure 7 shows the path size issue, while Figure 8 shows the absence of a curb cut at the Southwest corner of the Central and Monroe intersection.

Figure 7.   **Figure 8.**

This section received an overall rating of 60.6. SM 4 and 6 received the highest scores in this section. SM 4 received the top scores for *Crosswalks, Path size*, and *Transit* while SM 6 received high scores for *Path size*, *Transit*, and *Maintenance*. The two categories that consistently received the lowest scores (1 or 2) in this section were *Pedestrian Conflicts* and *Buffer.* High volume driveways were a consistent issue. Traffic noise and poor air quality lowered the *Aesthetics* scores. A low frequency of shaded areas and places for pedestrians to rest were also noted.

Intersection at Central Ave and Zuni Rd

The Central Ave and Zuni Rd intersection audit included 8 separate segments. The Zuni Rd segments were from Wyoming Blvd to Central Ave (CZ 1 and 2). The segments along Central Ave were Wyoming Blvd to Zuni Rd (CZ 3 and 4) and Zuni Rd to Moon St (CZ 7 and 8). CZ 5 and 6 were between Central Ave to Chico Rd. Figure 9 illustrates the audited segments for the Central Ave and San Mateo Blvd intersection.

This section received an overall rating of 57.7. CZ 5 and 8 received the highest scores. CZ 5 is in a residential neighborhood, which had lower speed limits, more shade, and more attempts at beautification. CZ 5 and 6 were documented as the most pleasant segments to walk. CZ 8 received the highest scores (4 or 5) for *Pedestrian Facilities, Maintenance*, *Path Size*, and *Transit*. The lowest score (44.3) was given to CZ 2 because of excessive amounts of litter and a discontinuity in the sidewalk. The sidewalk turns into a 200ft dirt path with permanent barriers to passage at the sharp curve near the intersection forcing pedestrians into incoming

traffic. Figure 10 illustrates the absence of a crosswalk on the East side of the Central Ave and Zuni Rd intersection.

Figure 9. Map of walkability audit segments at the intersection of Central Ave and Zuni Rd (CZ)

Figure 10. Photograph illustrating the lack of a marked crosswalk on the East side of the intersection at Central Ave and Zuni Rd.
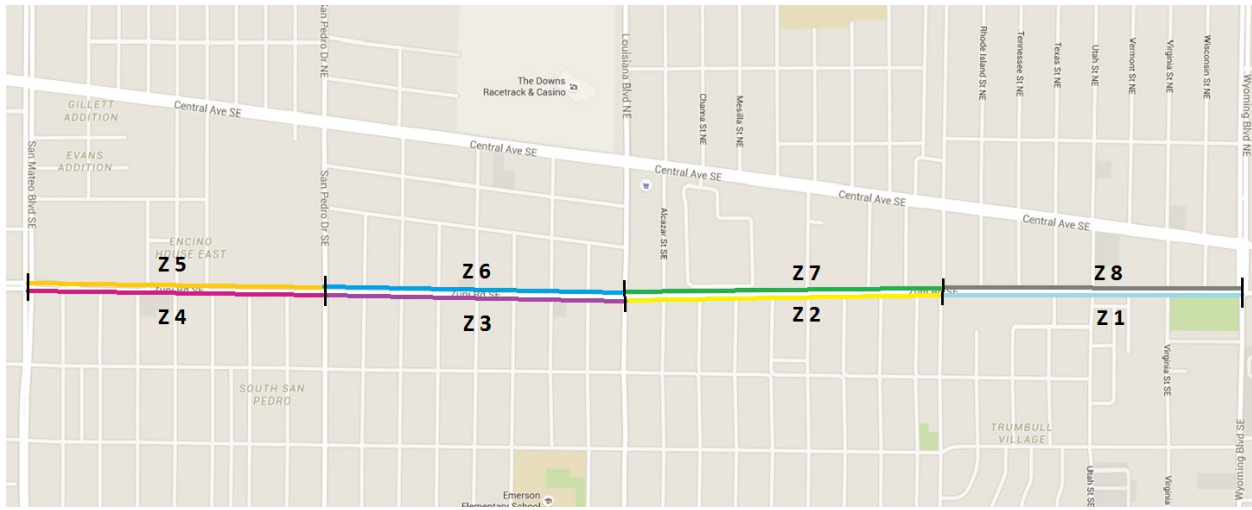

This section received a lower score overall because of poor wheelchair access, maintenance issues, poor aesthetics, small amount of shade, and the other specific deficits mentioned above.

Zuni Rd

The Zuni Rd walkability audit focused on 8 separate segments. The segments were from San Mateo Blvd to San Pedro Dr. (Zu 4 and 5), San Pedro Dr. to Louisiana Blvd (Zu 3 and 6), Louisiana Blvd to Pennsylvania Blvd (Zu 2 and 7), and Pennsylvania Blvd to Wyoming Blvd (Zu 1 and 8; see Figure 11).

Figure 11. Map of walkability audit segments along Zuni Rd SE (Zu)

This section received an overall score of 60.8. Higher scores were associated with segments that included a high number of bus stops with shelters and public art located in Zu 7 (See Figure 12).

Figure 12.

Zu 2 was received a 5 for crosswalks because there were four traffic calming devices at the minor arterials. Located in segment Zu 8, the University of New Mexico's Southeast Heights Clinic has successfully landscaped and maintained their block with a notable buffer and

landscaping. Lower segment scores were associated with high volume driveways, high speed traffic, and poorly maintained sidewalks. Figure 13 shows one example of the poorly maintained sidewalks that present tripping hazards for pedestrians and make it difficult for wheelchairs to pass.

Figure 13.

Discussion

Baseline data measuring the walkability of three areas within the International District were collected using the CDC's *Walkability Audit.* None of the segments measured scored above 70 points (out of 115). The concerns documented included poorly maintained sidewalks, high traffic speeds, a lack of buffer between pedestrians and traffic, high volume driveways, and a lack of curb cuts. These are consistent with the concerns expressed by community members in previous planning processes and sector plan development. Positive findings from the audits include the existence of pedestrian signals with sufficient crossing time, and specific segments with landscaping and public art.

The *Healthy Here* initiative will promote community involvement in planning and implementation for environmental changes that provide enhanced access to safe places to be physically active, a Community Guide recommendation for increasing physical activity. While changes to the public right-of-way take considerable time, financing and effort, some improvements could be made with more modest investment (e.g., lighting, signage, litter control). Follow-up *Walkability Audits* will be conducted in 2017 to determine if improvements have been made to walkability in the International District.

Clifton, K. J., Livi Smith, A. D., & Rodriguez, D. (2007). The development and testing of an audit for the pedestrian environment. *Landscape and Urban Planning*, 80(1-2), 95-110.

Dannenberg, A.L., Cramer, T.W., & Gibson, C.J. (2005). Assessing the Walkability of the Workplace: A New Audit Tool. *American Journal of Health Promotion*, 20 (1): 39–44
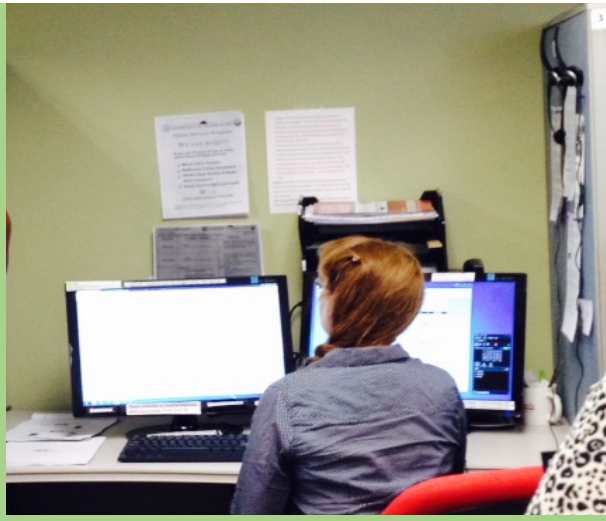
Referral System

Background

As the healthcare system becomes more complex, clinics and providers are looking for tools to help navigate the system and improve patient care. Community-Clinical linkages have been found to maximize healthcare provider time and resources and help ensure patients have access to health management programs. It is an innovative approach to prevention that attempts to lessen pressure on the healthcare system and connect patients to community resources that may improve their quality of life. By building relationships with the community and sharing resources, healthcare professionals and clinics improve their ability to offer a comprehensive array of services that otherwise would not be readily available or accessible to their patients. In addition, it is an evidence-based, cost-effective strategy that builds capacity for health promotion and prevention services.

The *Healthy Here* Initiative aims to increase the number of clinics with providers who are using a referral system to link community members to community resources for chronic disease self-management, healthy food options (e.g., Mobile Market prescriptions), and physical activity (e.g., walking prescriptions). Clinic management, healthcare providers, and members of the care team will be engaged and trained on how to make referrals and employ the system. A referral call center, operated by *Healthy Here* partner Adelante, will act as the link between the healthcare system and community-based resources, providing patients with a customized list of appropriate resources in their area, based on the referral.

The purpose of the referral system evaluation is two-fold: 1) to measure the actual use of the referral program by clinics and healthcare providers; and, 2) to contribute to program improvements. An important goal of the evaluation is to assess whether providers are referring patients with chronic diseases or related risk factors, specifically obesity, diabetes, hypertension, and high cholesterol, to community-based prevention programs. The evaluation is concerned with healthcare provider utilization of the system, rather than patient compliance. In order to determine if healthcare providers are referring patients to the self-management programs and if the patients are utilizing the available programs, the evaluation will monitor the total number of people (as well as the number of Hispanic and American Indian patients)

that are referred to community-based prevention programs by healthcare providers. The number of community organizations providing these programs in the target communities, and the number of people participating in programs in the target communities will also be tracked.

Methods

The evaluation team has worked to identify variables and indicators of interest. The team has also drafted an initial data collection tool in collaboration with Adelante and clinic partners, including information technology (IT) personnel from participating clinics (Appendix D). A web-based system (Salesforce), used by Adelante, will be used to track the referrals. The draft evaluation tool includes demographic information, referral information, and chronic disease diagnosis, as appropriate. Adelante will collect and record referral data in Salesforce and report back to the clinic staff about the referrals. The de-identified data will be available through Salesforce to the *Healthy Here* evaluation team for analysis. IT personnel are exploring the possibility of electronically transferring data to and from electronic medical records to expedite referrals and later feedback on participation. There may also be potential for tracking health data (e.g., cholesterol, blood pressure, and BMI) in the future, but these data are not accessible at this time.

Data Collection

First Choice Community Healthcare, First Nations Community Healthsource, and Presbyterian Medical Group are the three clinics that have expressed initial interest in participating in the referral system. They were asked to share clinic demographic information in order to provide baseline data for the evaluation. First Choice Community Healthcare and First Nations Community Healthsource provided baseline data, including the number of patients and percentage of the clinic population by age, gender, race and ethnicity, and chronic disease status (e.g., diabetes, hypertension, high cholesterol, and obesity) from 2014 (Table 5). Data have not yet been provided by Presbyterian. As the referral system is currently being developed, no referral system data have been collected to date.

Table 5. Patient demographic and disease status data from two health clinics participating in the referral system, 2014.

	Clinic #1	Clinic #2
Average number of patients treated/month	886	3,350
Patients < 18 years (%)	2.11%	5%
Race/ethnicity (%)		
American Indian	0%	50%
Hispanic	91.13%	42%
Other	8.87%	8%
Patients with chronic disease	4,302	1,446
Patients with diabetes	1,370	721
Patients with hypertension	2,108	881
Patients with obesity	2,266	1,378
Patients with high cholesterol	105	889
Number of clinic employees	Not given	105

Evaluation Summary

The *Healthy Here* initiative is making progress toward the three main strategies covered in this evaluation. The Mobile Market intervention was piloted and the evaluation results will be used for program planning for the 2016 season as well as measuring reach and actual use among members of the target population. The walkability audit conducted in the International District will provide a baseline assessment from which to measure improvements in the future, particularly to improved access to opportunities for physical activity. While not yet operating, planning and coordination of the referral system is underway and partners are working to develop systems for promoting and tracking referrals over time. Additionally, while some progress on each of these components has been made separately this year, the initiative plans to integrate these components in the future. For example, healthcare providers may provide patients with referrals to the Mobile Market; participants in the Mobile Market may be provided maps and information on local walking groups; and, the data tracking system may be able to prompt individuals to attend chronic disease self-management classes.

Appendix A: Mobile Market Registration Form

Mobile Market
A *Healthy Here* Initiative

Location: _____   **Date: _____**

Last Name/*Apellido:*	First Name/*Primer Nombre:*
Address/*Direccion:*	City,State,Zip/ *Ciudad,Estado, Zip:*
Cell Phone/*Telefono Cell:*	Other Phone/*Otro Telefono:*
Date of Birth/*Fecha de Nacimiento:*	

Your answers will remain anonymous and will help keep the Mobile Market running!

1. How did you hear about the Mobile Market?
   - Healthcare provider referral
   - Poster, sign, flyers, or postcards
   - Friend or family member
   - Facebook
   - Website
   - Saw it while walking or driving by
   - Other:_____

2. In a typical week, how many times do you eat fruit?
   - I do not typically eat fruit
   - 1–3 times per week
   - 4–6 times per week
   - 1 time per day
   - 2 times per day
   - 3 times per day
   - 4 or more times per day

3. In a typical week, how many times do you eat vegetables (not fried)?
   - I do not typically eat vegetables
   - 1–3 times per week
   - 4–6 times per week
   - 1 time per day
   - 2 times per day
   - 3 times per day
   - 4 or more times per day

4. What is your gender?
   - o Male
   - o Female

5. Are you Hispanic, Latino, or of Spanish origin?
   - o Yes
   - o No

6. Which of the following represent your race?
   - o American Indian or Alaska Native
   - o Black or African American
   - o Asian or Pacific Islander
   - o White
   - o Other:_____
   - o

7. How many people live in your household? (please include yourself) _____

8. How many of those living in your household are under the age of 18? _____

9. In the past 12 months have you received any kind of public assistance for food? Check all that apply.
   - o Storehouse Food Pantry, Albuquerque
   - o Other food pantry
   - o Food stamps/SNAP/EBT
   - o WIC
   - o Food commodities
   - o Free or reduced price school lunch program
   - o Other _____

10. May we contact you regarding reminders and a survey about the Mobile Market?
    - o Yes
    - o No

   If yes, how would you prefer to get reminders about the Mobile Market?
   - o Text message to this number: _____
   - o Phone call to this number: _____
   - o Email: _____
   - o Other:_____

Thank you for providing this information.

Appendix B: Walkability Audit Tool

This tool will help you assess the walkability of your area. Directions and the tool follow.

Directions:

1. Obtain (or create, if necessary) a map of the area that you wish to audit, including likely pedestrian destinations, such as parking lots, nearby restaurants, shops, parks, etc.

2. Decide, either by observation or inference, the most useful or likely pedestrian route between each location of interest on your map, eventually assembling a network of walking segments (link to glossary) that make up your most common walking routes. Label these segments 'A', 'B', 'C' or 1,2,3 to identify one from the other. See Sample Audit Report Map (link) for an example.

3. Take the attached audit tool to the location under study. Take as many copies as you have identified segments on your map—for example, if you have 10 segments on your map, take 10 copies. You will use a copy of the audit tool to assess each segment individually. The tool assesses factors related to safety, aesthetics, and recreational potential, (link to glossary) with safety being the most important.

4. Begin with your first segment, and use the attached audit to rank each feature, using the description provided on the audit. There are no right or wrong answers, just pick the number that most accurately represents your understanding of the segment. Also answer the questions at the bottom of the audit tool, noting potential dangers and improvements.

5. Repeat step 4 for each segment of your map. Some segments may be very different from each other, and some may be very similar.

6. Once you have completed the audit form for all the segments on your map, use the formula in the box halfway through the audit form to create a numerical score for each segment. This score makes safety considerations the most important, followed by things like accessibility and aesthetics (medium importance) and finally shade (least important), and should range from 0-100. Calculate scores for all segments of your map.

7. Now you can input the scores from each segment on your map, and generate a report. If you like, you can follow the format of our sample report. We designated segments with scores of 0-39 points as high-risk and unattractive (red), scores of 40-69 as medium-risk and average or non-descript looking (yellow) and 70 and above as low-risk and pleasant. The questions you answered at the bottom of the audit tool can help you prioritize your needs and wants for improving the walking routes. Email us if you have questions or comments about using the Worksite Walkability Tool.

U.S Department of Health and Human Services Centers for Disease Control and Prevention

Location: _____ Date: _____

A. Pedestrian Facilities (High): presence of a suitable walking surface, such as a sidewalk or path.
> **1** No permanent facilities; pedestrians walk in roadway or on dirt path
> **2**
> **3** Continuous sidewalk on both sides of road, or completely away from roads
> **4**
> **5** Sidewalk on one side of road; minor discontinuities that present no real obstacle to passage

B. Pedestrian Conflicts (High): potential for conflict with motor vehicle traffic due to driveway and loading dock crossings, speed and volume of traffic, large intersections, low pedestrian visibility.
> **1** High conflict potential
> **2**
> **3**
> **4**
> **5** Low conflict potential

C. Crosswalks (High): presence and visibility of crosswalks on roads intersecting the segment. Traffic signals meet pedestrian needs with separate 'walk' lights that provide sufficient crossing time.
> **1** Crosswalks not present despite major intersections
> **2**
> **3**
> **4**
> **5** No intersections, or crosswalks clearly marked

D. Maintenance (Medium): cracking, buckling, overgrown vegetation, standing water, etc. on or near walking path. Does not include temporary deficiencies likely to soon be resolved (e.g. tall grass).
> **1** Major or frequent problems
> **2**
> **3**
> **4**
> **5** No problems

E. Path Size (Medium): measure of useful path width, accounting for barriers to passage along pathway.

> **1** No permanent facilities
> **2** < 3 feet wide, significant barriers
> **3**
> **4**
> **5** > 5 feet wide, barrier free

F. Buffer (Medium): space separating path from adjacent roadway.
  1 No buffer from roadway
  2
  3
  4 > 4 feet from roadway
  5 Not adjacent to roadway

G. Universal Accessibility (Medium): ease of access for the mobility impaired. Look for ramps and handrails accompanying steps, curb cuts, etc.
  1 Completely impassible for wheelchairs, or no permanent facilities
  2 Difficult or dangerous for wheelchairs (e.g. no curb cuts)
  3
  4 Wheelchair accessible route available but inconvenient
  5 Designed to facilitate wheelchair access

H. Aesthetics (Medium): includes proximity of construction zones, fences, buildings, noise pollution, quality of landscaping, and pedestrian-oriented features, such as benches and water fountains.
  1 Uninviting
  2
  3
  4
  5 Pleasant

I. Shade (Low): amount of shade, accounting for different times of day.
  1 No shade
  2
  3
  4
  5 Full shade

J. Transit (High): Access to safe, convenient transit service for neighborhood residents [1]

  1 No bus stops exist
  2 Bus stop with signage only
  3 Bus stop with signage and bus pullout
  4 Bus stop with bench and visible signage
  5 Bus stop with shelter

Sum of High importance (A-C): _____ x **3** = _____
Sum of Medium importance (D-H): _____ x **2** = _____
Sum of Low importance (I): _____ x **1** = _____

Total Score: _____ / 100

---

[1] Adapted from the Pedestrian Environmental Data Scan (PEDS)

Observations

1. What is the most dangerous location along this segment?

2. What is the most unpleasant element of this segment?

3. What improvements would make this segment more appropriate for pedestrian use?

4. Would it be possible to design a more direct route to connect the ends of this segment?

5. Are the conditions of this segment appropriate and attractive for exercise or recreational use?

Appendix C: Walkability Definitions

A. **Pedestrian Facilities (HIGH)**: Sidewalk continuity. *If sidewalk is only present on one side of the road, regardless of condition, this question cannot score above a 3.*
   1. No sidewalk present. Pedestrians walk on dirt path or side of road.
   2. Major obstacles to passage. Major obstacles include anything permanent (e.g., light pole, tree, electrical box). Sidewalk present on only one side of the road and the existence of major discontinuities (multiple discontinuities or more than 10 feet of continuous discontinuity) between sidewalk sections.
   3. Moderate obstacles to passage. Sidewalk present on one side of the road only with no or a minor discontinuity (a single discontinuous segment of 10 feet or less) that does not inhibit safe passage.
   4. Minor obstacles to passage. Sidewalk on both sides of the road with minor discontinuities (a single discontinuous segment of 10 feet or less).
   5. Continuous sidewalk on both sides of the road or completely away from roads without discontinuities.

B. **Pedestrian conflicts (HIGH)**: Potential for conflict with motor vehicle traffic due to driveway and loading dock crossings, speed, and volume of traffic. *Speed refers to posted speed and associated risk to pedestrians.*
   1. Very high conflict potential. Excessive posted speed (45mph+) OR 3 or more high volume driveways (e.g., drive through restaurants, commercial centers, major loading docks, etc.) that place pedestrians in direct conflict with cars.
   2. High conflict potential. High posted speed (40 mph) AND/OR 1-2 high volume driveways (drive through restaurants, commercial centers, major loading docks, etc.) that place pedestrians in direct conflict with cars AND/OR more than 5 unused driveways or curb cuts.
   3. Moderate conflict potential. Posted speed up to 35 mph AND 3-5 unused curb cuts AND/OR 3-5 low volume driveways (e.g., residential driveways, alley).
   4. Moderate conflict potential. Posted speed up to 30mph AND 1-2 unused curb cuts AND/OR 1-2 low volume driveways.
   5. Low conflict potential. Speed posted below 30mph. No unused curb cuts. No high volume driveways.

C. **Crosswalks (HIGH):** Presence and visibility of crosswalks on roads intersecting the segment. Traffic signals meet pedestrian needs with sufficient crossing time.
   1. Marked crosswalks at major intersections (intersections with arterials) are worn or difficult to see OR pedestrian signals are not functioning.
   2. Marked crosswalks present at intersections with arterials, but crossing signal is too short to safely cross AND no marked crosswalks between major arterials.
   3. Marked crosswalks present and in good condition at major arterials with sufficient crossing time allowed, but no marked crosswalks between major arterials.
   4. Marked crosswalks present and in good condition at major arterials with sufficient crossing time allowed, and one marked crosswalk between major arterials.
   5. Marked crosswalks present and in good condition at major arterials with sufficient crossing time allowed, and two or more marked crosswalks between major arterials.

D. **Transit (HIGH):** Presence of bus stops
   1. No bus stops exist in the audit area
   2. Bus stops with signage only
   3. Bus stop with signage and bus pullout
   4. Bus stop with bench and visible signage
   5. Bus stop with shelter

E. **Maintenance (MEDIUM):** Cracking, buckling, overgrown vegetation, standing water, etc, on or near walking path. *Please assess issues in your segment as a whole*
   1. Major or frequent problems. 3 or more heaves or buckles in sidewalks per segment AND/OR major cracks that inhibit passage AND/OR presence of large debris that inhibits safe passage that present major tripping hazards that place pedestrians at risk of conflict with traffic.
   2. 2 major cracks AND/OR heaves or buckles in the sidewalk per segment that present tripping hazards that inhibit safe passage for pedestrians and those using assistive devices.
   3. 1 major crack AND/OR heave AND/OR buckle that presents a tripping hazard.
   4. Minor cracks in the sidewalk AND/OR the presence of minor debris that does not create a tripping hazard.
   5. Sidewalks are free of debris and do not present tripping hazards.

F. **Path Size (MEDIUM).** Barriers are permanent structures that cannot be easily removed. All temporary barriers will be assessed in the maintenance section of the audit.
   1. No permanent facilities (i.e., sidewalks).
   2. Less than 3 feet wide with significant barriers (e.g., light pole, tree) to passage.
   3. Less than 3 feet wide without significant barriers to passage.
   4. At least 3 feet wide but less than 5 feet wide without barriers or at least 5 feet wide with barriers to passage.
   5. At least 5 feet wide without barriers to passage.

G. **Buffer (MEDIUM)**
   1. No buffer from roadway
   2. Less than 2 feet from roadway
   3. At least 2 feet but less than 3 feet from roadway
   4. At least 3 feet from roadway
   5. Not adjacent to the roadway

H. **Mobility Access (MEDIUM)**
   1. Completely impassible for wheelchairs. Those using wheelchairs are forced to travel in the street due to the lack of permanent sidewalks.
   2. Dangerous for wheelchairs. No curb cuts, very steep, or discontinuous sidewalks.
   3. Difficult access. Broken roadways, obstacles, sidewalk heaves, and/or narrow sidewalk.
   4. Moderately accessible. Curb cuts present, sidewalk free of barriers and maintenance issues, but 3 feet wide or less AND crossings free of potholes.
   5. Accessible. Sidewalks are continuous, free of barriers and major maintenance issues such as heaves, cracks, and are greater than 3 feet in width AND curb cuts are present at

all marked and unmarked crossings AND marked and unmarked crossings are free of potholes and major construction.

I. **Aesthetics (MEDIUM)**
   1. Uninviting (Substantial amounts of litter, large number of abandoned homes, graffiti and perceived or real threats to personal safety)
   2. Litter, presence of urban decay, unkempt lawns.
   3. Free of litter and abandoned buildings but no efforts at beautification.
   4. Some landscaping and efforts to keep the area clean and free of physical disturbances.
   5. Inviting (streets are free of litter, no presence of graffiti, presence of landscaping, vegetation, benches, shade, and sufficient space to walk abreast to another person).

J. **Shade (LOW)**
   1. No shade
   2. Minimal shade-less than one quarter of the segment is shaded.
   3. Moderate shade-at least one quarter, but less than one half, of the segment is shaded.
   4. High shade-at least one half, but less than three quarters of the segment is shaded.
   5. Full shade- at least three quarters of the segment is shaded.

Appendix D: Draft Referral System Data

Information the clinic will transfer to the Referral Center

Contact information for Adelante from referral:
    First Name:
    Last Name:
    Patient ID:
    Street Address:
    Address 2:
    City:
    State:
    Zip Code:
    Phone number:
    Alternate phone number:
    Email:
    Preferred patient language: English/Spanish/Other:_____

Referral data:
    Referring organization:
    Referring department:
    Referring provider:
    Program referred to:
    Healthcare coverage:
    Chronic disease/risk factor at time of referral:
        ☐ High blood pressure
        ☐ High cholesterol
        ☐ Pre-diabetes
        ☐ Diabetes
        ☐ Other: _____

Referral Center Call Script

Good (morning/afternoon), my name is _____. I am calling because your healthcare provider (name) referred you for _____. We would like to discuss the different program options available to you. Do you have time to do that now?

If no, *What time would work best for you*?

If yes, discuss available options with the patient. Start with the option that seems most appropriate using the decision tree.

Then ask the following questions:

Participation

1. Do you think you'll be able to participate in [referred program]?
   - Yes (*If yes*)
     - *1A. Will you have any problems getting to the course/program?*
       If yes, what will make it difficult for you?
       In no, confirm the date and time of the course/program that works for them and move to the *Reminders/Information* section.

   - No *(If no)*
     - 1A. Why aren't you able to participate at this time?
       - ☐ Not interested/not motivated
       - ☐ Not healthy enough
       - ☐ No transportation
       - ☐ Family obligations
       - ☐ Inconvenient time
       - ☐ Inconvenient location
       - ☐ Other _____

     - 1B. What would make it easier for you to participate?
       - ☐ Better location _____
       - ☐ Better time _____
       - ☐ Family programs/childcare
       - ☐ Family or friends participating
       - ☐ Other _____
       Take note of why they are unable to participate and send information back to Care Team or CHW.

Reminders/Information

We like to send out reminders and sometimes we need to send information about changes to the schedule.

2. What is the best phone number for us to contact you? _____
   If they do not have a phone number proceed to #4

3. Is that a ___ Cell/mobile   ___ home   ____ work   ____friend's phone?

4. Do you have an email address where we can send you information about the program?
   _____

5. How would you prefer to get reminders about programs?
   - Text message
   - Email
   - Other:_____

Demographics

We have some additional questions that we need to ask for our records:

6. May I have your age (or DOB if in electronic data)? _____

7. What is your gender?
   - Male
   - Female

8. Are you Hispanic, Latino, or of Spanish origin?
   - Yes
   - No

9. Which of the following best represents your race?
   - American Indian or Native American
     - Black or African American
     - Hispanic or Latino
     - Asian or Pacific Islander
     - White or Caucasian
     - Other:_____

10. What is the highest level of formal education you have completed?
    - Less than a High School diploma
    - High school graduate or GED
    - Trade/Technical/Vocational Training
    - Associate's degree
    - College graduate
    - More than a 4 year degree

11. What is the total annual income for your household, before taxes?
    - Less than $11,999
    - $12,000-15,999
    - $16,000-20,999
    - $21,000-24,999
    - $25,000-34,999
    - $35,000-44,999
    - $45,000-54,999
    - $55,000+
    - Unsure/Don't know

That is all the information we need. Do you have any questions for me?

And just a reminder, your class/program is scheduled for (time) at (place).
Thank you for your time.