Emory Prevention Research Center

The Two Georgias Initiative

Cross-site Evaluation

Final Report

2017-2022

Prepared by

Emory Prevention Research Center

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Acknowledgments

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EXECUTIVE SUMMARY

Introduction

The Two Georgias Initiative. Healthcare Georgia Foundation (Foundation) designed *The Two Georgias Initiative* as a place-based effort to address the role of social determinants of health (SDOH) as a means to achieve health equity in rural Georgia. The overall goal was to achieve greater health equity by improving social conditions and health care, and building community, organizational and leadership capacity to address health equity among communities in rural Georgia. The five-year grant period (7/2017-6/2022) included a planning year (i.e., coalition formation, conduct community health needs assessment (CHNA), and develop community health improvement plan (CHIP)), three years of implementation and evaluation, and a final year focused on sustainability. An Initiative-level technical assistance structure was comprised of several technical support groups that worked with coalitions throughout the Initiative, including a dedicated community coach, a team of health equity experts, and evaluation support. The 11 funded coalitions reflected the diversity of rural Georgia communities in terms of geography, racial composition, resources, and needs. The Initiative-level evaluation consisted of both a local, site-specific evaluation led by a local evaluator in each county and a cross-site evaluation led by the Emory Prevention Research Center (EPRC). The purpose of the cross-site evaluation was to address the Foundation's broad individual, organizational, and community-level outcomes of interest across the 11 coalitions.

Methods

Cross-Site Evaluation Design and Data Collection. The cross-site evaluation used a mixed-methods approach to answer process and outcome evaluation questions. The EPRC developed a set of process and outcome evaluation questions, as well as related indicators, and a logic model to guide the overall cross-site evaluation. Quantitative components of the evaluation included a coalition member survey (Years 2 & 4) and population-based surveys (Years 2 & 5) on equity outcomes. Qualitative components included semi-structured key informant interviews (Years 2-5) and review of program documents (all years). A Community Change Tracking Tool (Years 3-5) had both qualitative and quantitative elements. We collected data from coalition staff and members as well as county residents for each of the 11 coalitions/communities. Limitations of the evaluation included use of a limited number of data sources, lack of comparison counties, heavy reliance on a few key informants for some indicators, and possible social desirability bias.

Results

PART 1. COALITION FORMATION AND FUNCTIONING

Composition of Coalition Membership. Based on coalition member survey data, the best represented sectors were education, community-based organizations, and health care. Social/human services, business, faith, public health, local government, civic groups, mental/behavioral health, law enforcement and elected officials were also represented on most coalitions. Most coalition members were women, White, in their early 50's, and had college degrees, although there was some variation across coalitions, especially in terms of racial composition. Most respondents were residents of the county they served, represented an organization or group, and could attend coalition meetings on work time.

Structure of the Coalitions. At the end of the planning year, 10 coalitions consisted of a steering committee with highly structured, topic-specific subcommittees. The most common work groups were focused on food security/nutrition, literacy/education, health care access, and access to physical activity opportunities. By the end of the implementation phase, four coalitions had aligned with the local Family Connection, in addition to the one that had been aligned with their local Family Connection from the beginning. Two coalitions did not substantively change in structure.

Member Assessments of Coalition Functioning. Multiple aspects of coalition functioning were assessed through the coalition member survey. Members rated *communication* as frequent and productive with little change between the two time points. All coalitions rated *leadership* positively, with steady ratings between the two time points for most coalitions. Members' *decision-making influence* was moderate and decreased from T1 to T2. *Conflict* was generally low at both time points.

Member Satisfaction, Participation and Collaborative Synergy. Overall, coalition members were very satisfied with the overall work of their coalitions and member participation was relatively high across all coalitions and varied little over the three years between surveys. Coalition members felt their personal and organizational resources were leveraged very well, with some variation across coalitions.

PART 2. SUPPORT SERVICES OFFERED

Three main support teams provided support in three largely distinct areas of the Initiative: community coaching (Georgia Health Decisions), healthy equity training (Partnership for Southern Equity), and evaluation (Emory Prevention Research Center). Coalition staff generally were very appreciative of the support and resources they received from the different support teams in the form of increased knowledge and skills, but also had substantive suggestions for improving support offered in the future. A majority of coalitions expressed the need for more structure, accountability, and feedback, as well as an increased emphasis on specific capacity-building skills such as grant writing.

PART 3. CHANGES IN COMMUNITY READINESS AND CAPACITY TO ADDRESS HEALTH EQUITY

One of the major goals of the *Two Georgias Initiative* was to strengthen community readiness and capacity to address health equity**.** On average, coalition survey data indicated that *community readiness to address health equity* increased slightly from 5.2 at T1 to 5.7 at T2 (out of 9). At T2, six coalitions had increased community readiness to address health equity, with four moving from Pre-planning to Preparation and two moving from Preparation to Initiation. One community was already in the Initiation stage by the end of the planning phase of the Initiative.

Changes in *community capacity to address health equity* were measured by several indicators including opportunities for diverse and/or grassroots residents to have a voice in the Initiative. *Community voices* were solicited through community assessment, providing input through coalition events and evaluation-related activities, serving as a coalition or work group member, and involving nontraditional sectors. Opportunities for *leadership development* included formal leadership positions, assistance with data collection efforts, leading implementation of a specific activity, volunteer opportunities, training opportunities, and appointment or election to leadership positions. The coalition member survey measured *increased planning and collaboration skills*, which showed that of 14 skills assessed, the greatest increases were reported for understanding diverse perspectives, followed by understanding health equity and root causes of inequities. Coalitions described benefits of *personal/professional networks expanded*, including professional development and learning experiences, networking and forming new connections, gaining evaluation support, and being better able to serve their clients. Some interviewees also discussed forming personal bonds and friendships. County-level coalition member survey data at T2 indicated an increase in groups/organizations with whom their organization collaborates to exchange information, coordinate services, and undertake joint projects, programs, or activities.

Change in *organizational capacity to address heath equity* was explored in key informant interviews, specifically institutional commitment to health equity, hiring practices to increase diversity, new structures for community input, and new or more frequent efforts to identify disparities. Coalition member surveys assessed the extent to which participation in the Initiative increased or elevated their organization's commitment to address health equity, showing the greatest gains in collaborating with other organizations to address health equity, including health equity in organizations' mission or vision statements, and using data to identify gaps in health status.

PART 4. IMPLEMENTATION OF THE CHIPs AND CONTEXTUAL FACTORS

Overall, of 176 strategies included in the original CHIPs and tracked by the evaluation, 124 (70.5%) were implemented and 52 were dropped or never gained traction. Priority areas included food access, healthy lifestyle education & nutrition guidelines/support, health care access, leadership development/youth development, access to physical activity opportunities, behavioral health, literacy/education, safety, substance use, housing, and economic development. A diverse set of strategies across coalitions was implemented for each domain, varying in reach from less than 25 to thousands of people. Strategies with a priority population often focused on low-income residents and youth, while other strategies targeted the full county.

Facilitators of coalition success included staff and coalition partner attributes as well as direct byproducts of their efforts (e.g., improved coordination, external funding). Evaluation, health equity, and specific elements of Initiative infrastructure also supported coalition successes. On the flip side, coalitions also experienced numerous barriers to success when forming partnerships, in community assessment and priority-setting, and during implementation. The five years of the Initiative coincided with several global and national events that further impacted coalitions, including the COVID-19 pandemic, a social and racial justice movement in 2020, natural disasters, and inflation/price increases of essential goods. *The Two Georgias Initiative* was instrumental in positioning the coalitions to respond to the pandemic and other challenges that arose during the course of the Initiative.

PART 5. COMMUNITY CHANGES TO PROMOTE HEALTH EQUITY

Coalitions contributed to a large number of policy, systems, and environment changes through implementation of their CHIPs. Policy changes included local government commitment to comprehensive housing plans, implementation of healthy eating guidelines in a range of organizations, and evidence-based clinical system changes (e.g., diabetes prevention program), implementation of a naloxone policy among first responders, and smoke-free policies, among others. Systems changes involving infrastructure and process-based strategies included new inter-organizational collaborations, such as establishment of referral networks, providing new services at an existing facility (e.g., reading connections program in county jail), expansion of a United Way catchment area, and establishing mental health clinics in schools. Examples of environment changes include garden plots, farmers markets, reestablishing emergency rooms, and new recreational facilities, among others. Community changes that were not considered a policy, system, or environment change included stand-alone programs or one-time events.

PART 6. POPULATION-BASED SURVEY FINDINGS

Despite a substantive amount of community change, population-level survey data from randomly selected county residents suggested that the changes generally did not have sufficient reach or intensity to result in population-level change over a relatively short three-year time period (and in the midst of a pandemic). Positive changes were observed for routine doctor visits in the past 12 months and use of various sources of fruits and vegetables (e.g., community/home gardens, produce trucks/mobile markets). Negative changes, although small, were documented for well-being, food security, social capital, physical activity spaces, and fruit and vegetable access. Changes from T1 to T2 did not substantively narrow existing gaps by race (Black versus White) or by annual household income. However, a few outcomes indicated a slight narrowing. Across the board, the advantaged groups tended to report better access and indicators of health than the disadvantaged groups, especially with respect to income where the gaps were wider than those for race. Despite the many community changes achieved by the coalitions over the course of the five-year Initiative, results suggest the COVID-19 pandemic may have had undue influence on population-equity outcomes measured by this survey and that population-level changes requires a long-term investment.

PART 7. SUSTAINABILITY

A major goal of the Initiative from the beginning was to position the coalitions to be able to sustain themselves and their work beyond the Initiative funding period. The cumulative total *funding leveraged* by all coalitions,

excluding Initiative funds, was $12,365,082. Funds came from grant money (80.5%), donations (3.5%), and city/county/other budget allocations (16.0%). Coalition staff identified *key strategic partnerships* from a variety of sectors that supported coalition growth and connections as well as access to resources. The top three sectors identified were education, local government, and faith-based organizations. Coalition survey member data at T2 indicated that respondents were extremely optimistic that their coalition would continue, with 92.2% saying they were either somewhat or very confident that the coalition would continue beyond the Initiative and 96.8% saying the programs implemented would continue beyond the Initiative. The most common approach to coalition sustainability was to align with the local Family Connection organization. The most important factors for sustainability, cited by coalitions, were partnerships, funding, and dedicated staff. Of all the different strategies implemented by the coalitions, over 75% were expected to be sustained. The most sustainable strategies tended to be policy, system, and environmental changes.

Conclusion

Eleven multi-sectoral coalitions effectively engaged a broad range of organizations to identify priority areas, implement strategies, and achieve community change. The relationships created between people and organizations will outlast the Initiative or any single grant. Coalitions achieved many short- and intermediate-term outcomes that could lead to reductions in health inequities over the long-term with continued investment. Sustainability planning was particularly effective, as the coalitions and most strategies will be sustained. Coalitions raised awareness and changed mindsets among coalition members about disparities and solutions. Coalitions recognized (especially once COVID-19 became a pandemic) urgent needs that required their immediate attention but also saw the value in pursuing longer-term change. Several aspects of the Initiative worked well, including funding the coalitions for five years, including a dedicated planning year and focus on sustainability, expectations for specific products (e.g., CHIP, CCTT), prioritizing a local and cross-site evaluation, having a core management team with different skill sets, cross-coalition networking opportunities, and flexibility with funding as local needs and situations evolved. Evaluation results show that capacity for addressing health equity was strengthened in a variety of ways, and that continued investment in rural communities is needed to accelerate progress toward the shared goal of eliminating barriers to health for all.

INTRODUCTION

Rural communities are characterized by resilience, independence, creativity and social connectedness [1]. Harnessing these strengths for collaborative problem-solving has the potential to at least partly mitigate challenges that contribute to health disparities based on rural residence [2-4]. A large body of research documents that life expectancy, all-cause mortality, infant mortality, chronic disease, and health behaviors can vary significantly by level of rurality [5-18]. These disparities are largely caused by socioeconomic disadvantage due to lower levels of education, fewer well-paying jobs, and higher levels of poverty often present in rural communities [14, 19-22], and exacerbated by limited availability of resources such as health and social services, public transportation, broadband, and access to supermarkets and recreational facilities [2, 20, 23]. Yet, with concerted effort and collaboration across different sectors within rural communities, innovative and creative solutions to these major drivers of disparities are possible [1].

Health inequities are rooted in economic or social disadvantage based on unfair policies and practices [24-25]. Initiatives to address health equity in rural communities tend to focus on disparities relative to urban communities; however, significant inequities exist within rural communities as well [5-7, 11, 26-30]. Community-driven initiatives to address health equity are often led by multi-sectoral community coalitions [22, 31]. Guidance on collaborating for equity and justice highlights the need to deliberately build power among those experiencing disparities and to ensure their meaningful engagement in all aspects of the work, along with addressing social determinants of health [32-34].

The Two Georgias Initiative

Healthcare Georgia Foundation (Foundation) recognized the growing health inequities between metropolitan and rural parts of the state. The Foundation designed *The Two Georgias Initiative* as a place-based effort to address the role of social determinants of health (SDOH) as a means to achieve health equity in rural Georgia. After an environmental scan, literature review and listening sessions across rural Georgia, the Foundation released a call for applications for *The Two Georgias Initiative*. This five-year grant program aimed to address health inequities in 11 rural Georgia counties selected through a competitive process. The overall goal was to achieve greater health equity by improving social conditions and health care, and building community, organizational and leadership capacity to address health equity among communities in rural Georgia.

Grants began in July of 2017 with a one-year planning phase, followed by a three-year implementation phase through June of 2021, and a fifth year of bridge funding with an emphasis on sustainability, ending in June of 2022. During the planning phase, grantees established and/or expanded existing local coalitions, conducted a community assessment, and developed a Community Health Improvement Plan (CHIP). The following three years were spent implementing the CHIP, with the final year focused on ensuring the sustainability of the coalitions and their work.

HEALTH EQUITY is the removal or elimination of health and healthcare disparities and systemic barriers which impact an individual's and communities' abilities to embrace a healthy lifestyle. (Healthcare Georgia Foundation)

Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." (CDC)

HEALTH INEQUITIES are reflected in differences in length of life, quality of life, rates of disease, disability, and death, severity of disease, and access to treatment. (CDC)

SOCIAL DETERMINANTS OF HEALTH are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. (World Health Organization)

Grant recipients ranged from regional health districts to local non-profit organizations; funds generally covered a part-time coordinator, implementation efforts, and a local evaluator focused on site-specific strategies. Grants were $70,000 during the planning phase/year, $100,000 per year during the implementation phase, and $80,000 for the final phase/year focused on sustainability (Table 1).

Table 1. Overview of The Two Georgias Initiative *phases*

Phase	Description	Years
Phase 1 (Year 1)	Planning: Establish coalition, conduct community health needs assessment, develop community health improvement plan	July 2017-June 2018
Phase 2 (Years 2-4)	Implementation: Implement and evaluate community health improvement plan	July 2018-June 2021
Phase 3 (Year 5)	Sustainability: Transition to sustainable funding of strategies, identify approach to sustaining the coalition	July 2021-June 2022

An Initiative-level technical assistance structure consisted of a management team comprised of several technical support groups that worked with coalitions throughout the Initiative. Each coalition was assigned to work with a dedicated community coach from Georgia Health Decisions (GHD) who served as strategic thought partners and resource brokers and supported coalitions with partnership and CHIP development and implementation. In the fourth year of the Initiative, the coaching team delivered a sustainability-focused curriculum titled "Seeds for Sustainability" which included sessions focused on shared responsibility and ownership for achieving equity, building up the coalition for lasting impact, and generating monetary and human resources. A team of health equity experts from Partnership for Southern Equity delivered a series of trainings on health equity to the coalitions and provided related resources, including a Health Equity Assessment Guide. The Emory evaluation team supported the local evaluators in developing and implementing local evaluation plans and facilitated peer learning capacity-building opportunities. In the planning phase, a team from Porter Novelli supported coalitions with the prioritization process and development of their CHIPs. Health Analytics at Georgia Tech developed a data web portal for coalitions to use to access community-level health care data for a variety of measures.

"One's health should not be determined by place of residence or zip code."
-Healthcare Georgia Foundation

About the Grantee Counties

Eligible applicants were from Georgia-based non-profit health organizations, hospitals, and government agencies with a 501(c) (3) entity representing a rural community health coalition. Rural communities were defined as those with populations of less than 35,000 residents [35]. Eleven grantees were awarded funds in 2017. Grant application review criteria included: having a defined community health coalition membership, vision, and goals, rationale/justification for the selected target population and rural community, technically sound approach to development of the CHIP, alignment of the coalition and plan with Initiative goals, analysis of partner capacity and readiness, and budget justification.

Table 2 shows selected demographics for the counties where the 11 rural health coalitions were funded to work [36-37]. County populations ranged from 3,024 in Clay County to 31,567 in Lumpkin County. In terms of race, three counties had majority Black populations (Hancock, Clay, Early), whereas the Black population in both Haralson and Lumpkin Counties was less than 5%, compared to Georgia overall at 31.3%. The Hispanic population in Appling County is similar to that of Georgia overall (about 9-10%), while it is much smaller in most of the other coalition counties. The percent of persons living in poverty overall was much higher than the Georgia state average, 25.3% compared to 16.9%, with the highest poverty rates in Clay and Hancock Counties.

The percent of residents with a Bachelor's degree or higher is below 15% in most counties, except for Early and Lumpkin, and all are lower than Georgia's 29.9%. Many of the Initiative counties are quite large in terms of square miles (and, as Figure 1 illustrates, relative to other Georgia counties), yet population density is low, with a range from 15 persons per square mile in Clay County up to 118 persons per square mile in Lumpkin.

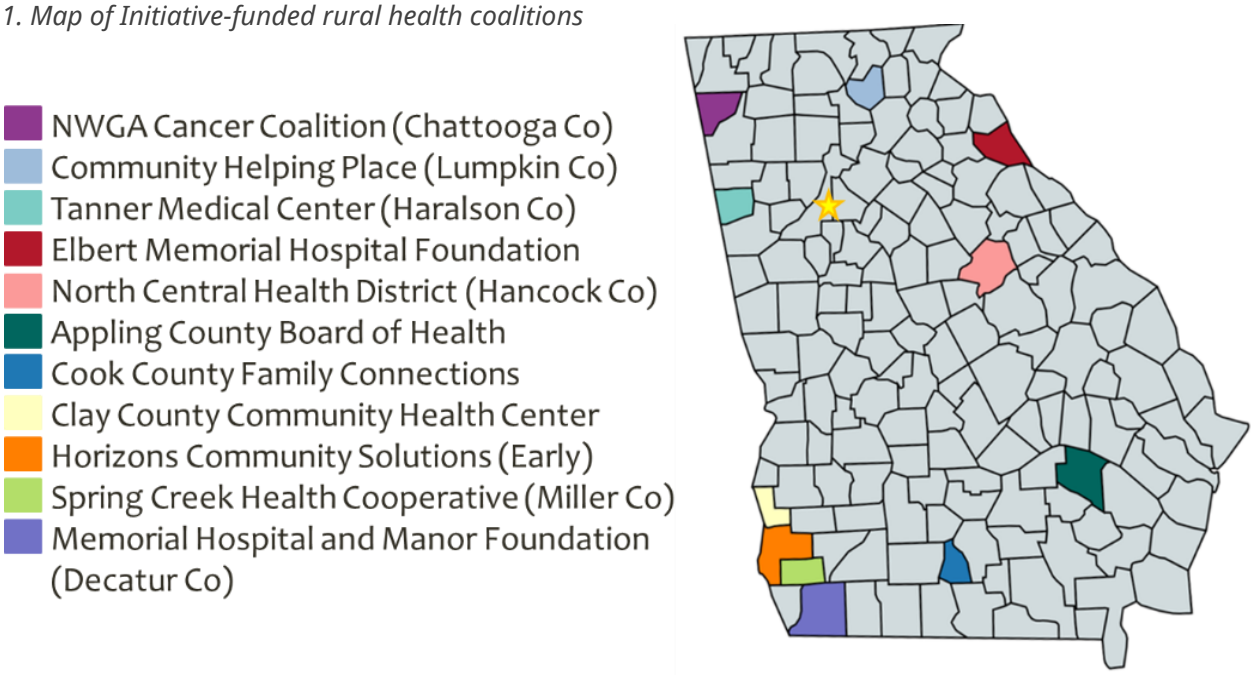
Table 2. The Two Georgias Initiative coalition county demographics

Coalition	Total population *	% Black*	% Hispanic*	% below poverty level*	% with Bachelor's degree or higher*	Land mass^	Population density per square mile^
Lumpkin	31,567	2.3	4.7	20.1	26.7	283	118
Haralson	28,722	4.3	1.5	18.0	14.1	282	106
Decatur	27,023	42.1	5.8	24.1	14.9	597	49
Chattooga	24,880	10.3	4.7	22.5	10.1	313	80
Elbert	19,288	30.5	5.5	22.4	11.1	351	56
Appling	18,471	17.9	9.7	24.7	11.5	508	36
Cook	17,190	27.3	5.8	24.2	14.8	228	75
Early	10,405	51.0	2.2	27.5	17.0	513	21
Hancock	8,667	73.0	1.8	30.0	8.7	471	19
Miller	5,884	30.4	0.4	23.3	11.4	282	21
Clay	3,024	64.3	4.7	41.4	8.9	195	15
COUNTY AVERAGE	17,738	32.1	4.3	25.3	13.6	366	54
GEORGIA	10,201,635	31.3	9.3	16.9	29.9	57,716	185

*2017 American Communities Survey 5-year estimates, ^2020 U.S. Census

Figure 1 shows a map of the 11 counties where the coalitions were based, with about half located in the northern part of the state and half in the southern part of the state. The star indicates where Emory University is located in Atlanta.

Figure 1. Map of Initiative-funded rural health coalitions



Evaluation Overview

The Initiative-level evaluation of *The Two Georgias Initiative* consisted of both a local, site-specific evaluation and a cross-site evaluation. The local evaluation entailed a local evaluation contractor for each of the 11 coalitions to design and conduct an evaluation of that coalition's work over the five-year grant period. Coalitions were required to allocate at least 10% of their annual budgets toward evaluation activities. The local evaluation requirements served the dual purposes of ensuring that data for local process and outcome measures of interest would be collected and to help build local evaluation capacity in each funded community. The Emory Prevention Research Center (EPRC) team worked with local evaluators as needed to develop their evaluation plan and logic model, including identifying appropriate process and outcome measures and data collection methods. The cross-site evaluation was led by the EPRC Team. The purpose of the cross-site evaluation was to address the Foundation's broad individual, organizational, and community-level outcomes of interest across the 11 coalitions. The Foundation provided several specific questions of interest that informed the development of cross-site evaluation questions and measures. Complete details about the cross-site evaluation can be found in the Methods section.

METHODS

Cross-Site Evaluation Design

The cross-site evaluation used a mixed methods approach to answer process and outcome evaluation questions. Quantitative components of the evaluation included a coalition member survey and population-based surveys on equity outcomes. Qualitative components included semi-structured key informant interviews and review of program documents. A Community Change Tracking Tool had both qualitative and quantitative elements.

We collected data from coalition staff and members as well as county residents for each of the 11 coalitions/communities whenever possible. With that said, two counties were not funded in the fifth and final year of the Initiative, and they did not participate in the final data collection activities. Thus, most data collected in Year 5 is limited to the nine coalitions that were funded through Year 5. The Emory University Institutional Review Board determined that this evaluation was a "non-research program evaluation" that did not require Institutional Review Board approval.

Evaluation Questions

The EPRC developed process and outcome evaluation questions based on a review of the literature, past evaluations of similar initiatives, and *The Two Georgias Initiative* Phase 1 grantee and evaluation request for proposals. With stakeholder input, the evaluation team finalized the evaluation questions for *The Two Georgias Initiative* in June, 2018. Prioritized questions were those that were of high interest to program stakeholders, aligned with Foundation priorities for *The Two Georgias Initiative*, and could feasibly and accurately be answered given the resources available for the evaluation.

Process Evaluation Questions

1. How well and in what ways do coalitions ensure an equity orientation in various stages of the Initiative?
2. What are the major barriers and facilitators to success at various stages of the Initiative, including coalition formation, community assessment and priority-setting, implementation, and sustainability?
3. How well are the coalitions functioning at various stages of the Initiative?
4. What strategies are implemented to address health equity, which are implemented with fidelity, and how do strategies vary over time?
5. What is the reach of intervention strategies with respect to the prioritized populations?
6. What support services are offered and in what ways does support offered to the coalitions influence effectiveness of the Initiative?
7. What steps are taken to ensure sustainability (e.g., political support, funding, strategic partnerships)?

Outcome Evaluation Questions

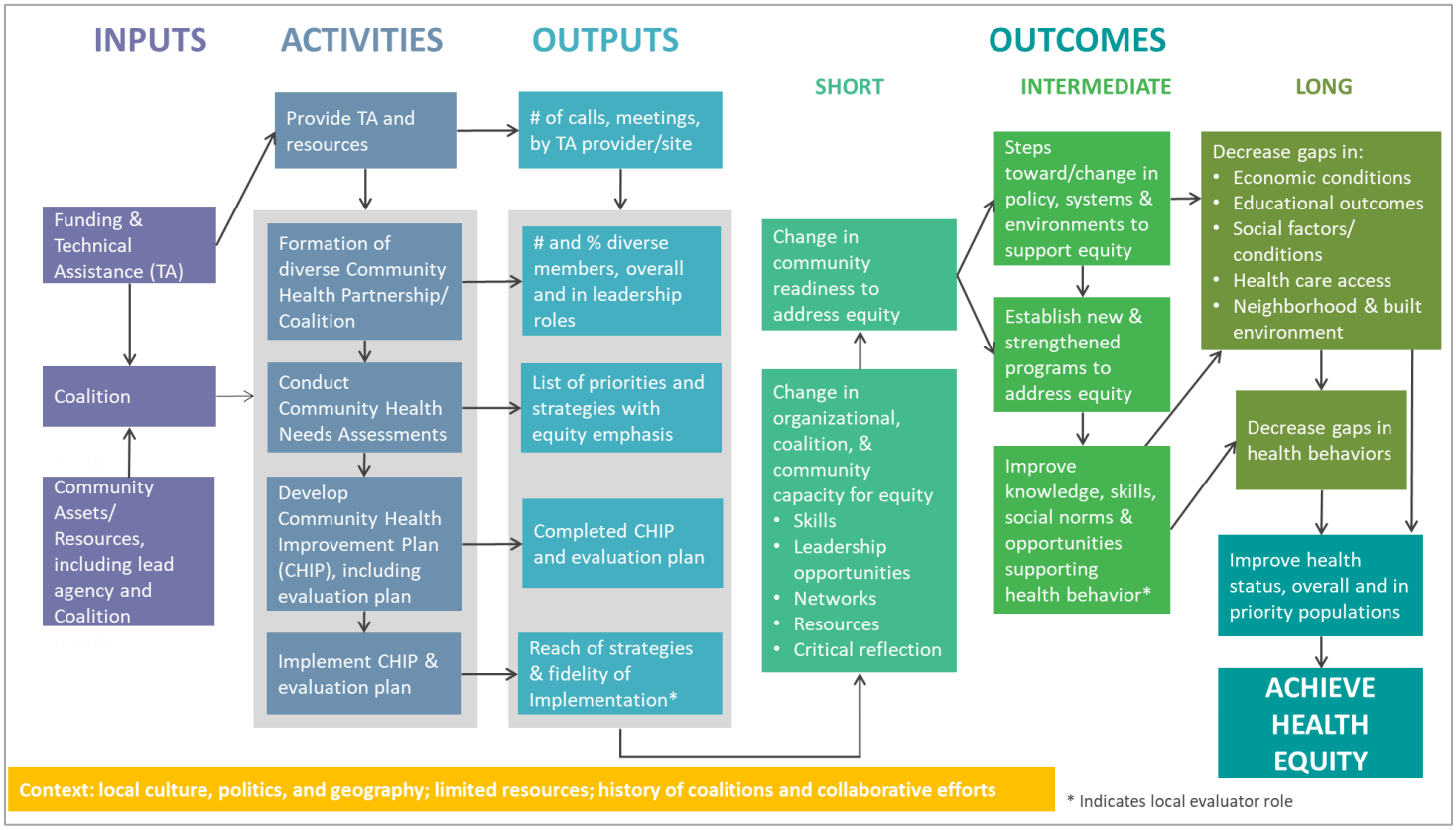
1. To what extent and in what ways does community readiness and capacity to address health equity change as a result of the Initiative?
2. Does organizational capacity to address health equity change as a result of the Initiative, and if so, in what ways?
3. Has greater health equity been achieved as a result of the Initiative and for which outcomes?
4. What aspects of the Initiative and related community changes are likely to be sustained beyond the funding period?

Cross-Site Evaluation Logic Model

The evaluation was guided by a logic model (Figure 2) which suggests that forming coalitions, conducting an assessment, and developing a CHIP will lead to changes in community readiness and strengthened organizational and community capacity to achieve health equity. The logic model shows two paths toward

health equity. One pathway is through changed policies, systems and environments that help to close gaps in structural determinants of health. These gaps, based on income, race, and geography, contribute to differential access and exposure to resources, opportunities, and stressors that directly and indirectly impact health [38-39]. The second pathway operates through specific programs and services that increase knowledge, skills, norms, and opportunities that support health and health behaviors. These programs and services can offer short-term relief and support immediate needs (e.g., health care services, healthy food) that result from persistent inequities in access to resources needed for health.

Figure 2. Logic model for The Two Georgias Initiative *evaluation*



Indicators and data collection methods by evaluation question

Table 3 lists each of the process evaluation questions, related indicators, and data sources. Local, site-specific evaluations focused on implementation of action plans, outputs, including reach and fidelity of implementation, and short-term outcomes as depicted in site-specific logic models.

Table 3. Process evaluation questions, indicators, and related data sources

Evaluation Question and Indicators	Program Documents*	Site-specific Evaluations	Community Change Tracking Tool	Key Informant Interviews	Coalition Survey	Population Survey
1. How well and in what ways do coalitions ensure an equity orientation in various stages of the Initiative?						
Composition of the membership in terms of diverse demographics, grassroots residents and sectors during planning and implementation	X			X	X	X
Structure of the coalitions (e.g., leadership teams, work groups)	X			X		
Proportion of leadership positions filled by residents and/or members of the prioritized populations				X	X	
Types of opportunities provided to give diverse demographics, grassroots residents and non-traditional sectors a voice in planning, priority-setting, implementation and evaluation	X			X		
Range of ways health equity was conceptualized	X			X		
Common data collection methods and comparisons made to identify health disparities	X			X		
2. What are the major barriers and facilitators to success at various stages of the Initiative, including coalition formation, community assessment and priority-setting, implementation, and sustainability?						
Description of major barriers to success at each stage	X			X		
Description of major facilitators of success at each stage	X			X		
3. How well are the coalitions functioning at various stages of the Initiative?						
Member assessments of communication, decision-making, staffing, leadership and conflict management					X	
Member satisfaction with the coalition					X	
Member participation in the coalition and related activities					X	
4. What strategies are implemented to address health equity, which are implemented with fidelity, and how do strategies vary over time?						
List of priorities and strategies implemented at each time point	X		X			
Types of strategies implemented with fidelity to the CHIP and types of strategies that are difficult to implement as planned	X	X	X			
Reasons for changes in strategies over time	X		X	X		
5. What is the reach of intervention strategies with respect to the prioritized populations?						
Average reach of intervention strategy by type		X	X			
Average reach of intervention strategies to prioritized population by type		X	X			
6. What support services are offered and in what ways does support offered to the coalitions influence effectiveness of the Initiative?						
Description of support viewed as most useful to the coalitions and why				X		
Suggestions for how support could be improved				X		
7. What steps are taken to ensure sustainability (e.g., political support, funding, strategic partnerships)?						
Political support obtained and how				X		
Funding and other resources leveraged	X					
Strategic partnerships established for sustainability				X		

* Program Documents= Documents include applications, Community Health Improvement Plans, & progress reports

Table 4 lists outcome evaluation questions, indicators, and data sources. As shown, major data sources for the outcome evaluation include key informant interviews for the readiness, capacity and sustainability-oriented

questions, interviews and coalition survey for assessing organizational capacity, and site-specific evaluations, population-based surveys and secondary data sources for the equity-oriented outcomes. The indicators were informed by the Foundation's original evaluation questions, literature on health equity and related indicators [40-47], literature on community and organizational readiness and capacity [48-52], and our past work on similar initiatives [53-57].

Table 4. Outcome evaluation questions, indicators and related data sources

Evaluation Question and Indicators	Program Documents*	Site-specific Evaluations	Community Change Tracking Tool	Key Informant Interviews	Coalition Survey	Population Survey
1. To what extent and in what ways does community readiness and capacity to address health equity change as a result of the Initiative?						
Changes in stage of readiness to address priority equity issues (i.e., current efforts, community awareness and support, leader and organizational support, resources available, community efficacy)				X	X	
Increased planning & collaboration skills				X	X	
Leadership opportunities created				X		
Personal and/or inter-organizational networks expanded and/or linked				X	X	
Resources leveraged for priority issues	X			X		
Evidence of community power redistributed towards equity				X		
Evidence of critical reflection on issues of health equity (e.g., root causes, role of social, political and economic history of the community, dominant values of the community)				X		
2. Does organizational capacity to address health equity change as a result of the Initiative?						
Changes in institutional commitment to address health inequities among partner organizations				X	X	
Changes in hiring practices among partner organizations				X	X	
Creation or enhancement of new structures to obtain community input among partner organizations				X	X	
Adoption of more frequent or new ways to examine disparities among partner organizations				X	X	
3. Has greater health equity been achieved as a result of the Initiative and for which outcomes?						
Changes in economic conditions		X				X
Changes in educational outcomes		X				X
Changes in social conditions		X				X
Changes in health behaviors		X				X
Changes in health care		X	X			X
Changes in neighborhood and built environments		X	X	X		X
Changes in other policy, systems, and environmental changes related to health equity			X			
Changes in health outcomes		X				X
4. What aspects of the Initiative and related community changes are likely to be sustained beyond the funding period?						
Number of coalitions sustained beyond funding period				X	X	
Number and types of programs sustained beyond funding period				X		
Number and types of policies and systems changes sustained beyond funding period				X		

* Program Documents=Documents include applications, Community Health Improvement Plans, & progress reports

Data Collection

The cross-site evaluation included four sources of primary data collection: a Community Change Tracking Tool, coalition member surveys, key informant interviews, and population-based surveys. In addition, we used program data sources including initial grantee applications, progress reports, Community Health Needs Assessments (CHNAs), CHIPs and sustainability plans, as well as site-specific evaluations (including plans, logic models, and findings). The following data collection methods, when looked at separately, answered various cross-site evaluation questions; and when taken together offer a complete picture of the implementation process and impact of *The Two Georgias Initiative* on the funded communities.

Coalition Survey

A web-based coalition survey was self-administered to active coalition members at two points in time throughout *The Two Georgias Initiative* funding period. The first survey (T1) was launched early in Year 2 (2018), at the beginning of the implementation phase and a post-implementation survey (T2) was administered at the end of Year 4 (2021), at the end of the implementation phase. Both surveys measured coalition functioning (i.e., communication, decision-making, task focus, cohesion, conflict management); perceptions of staffing and leadership quality; participation levels; member engagement and satisfaction; related dimensions of organizational, coalition, and community capacity; and community readiness to address health equity. Both surveys also provided information on various dimensions of diversity, including gender, age, race/ethnicity, education, resident status (i.e., grassroots resident, resident professional, non-resident) and sectoral and organizational representation. The T2 also survey included questions about community changes achieved, organizational capacity to address health equity, collaborative synergy, and COVID-19 impacts. Prior to each survey administration, local coordinators or evaluators provided the EPRC with a roster, including e-mail or postal addresses and phone numbers, of active coalition members. For both surveys, we defined "active" as having attended at least one meeting in the past six months. Mail surveys were used to reach members without reliable internet access or who preferred that form of communication. Despite coalition coordinator encouragement and multiple attempts to reach coalition members for the survey at each time point, there may have been a non-response bias such that certain perspectives were present on the coalition but not captured in the survey. For example, coalition members representing certain sectors might not have been able to complete the survey compared to those representing other sectors. Sample size and response rate details are shown in Table 5. Overall, we achieved a 59.1% response rate at T1 and a 56.6% response rate at T2.

Table 5. Coalition member survey response rates

County	1st Time Point (T1)			2nd Time Point (T2)		
	# contacted	# completed	Response rate	# contacted	# completed	Response rate
A	43	26	60.5%	25	15	60.0%
B	44	18	40.9%	50	22	44.0%
C	29	19	65.5%	49	27	55.1%
D	27	18	66.7%	38	31	81.6%
E	39	17	43.6%	14	12	85.7%
F	26	22	84.6%	23	21	91.3%
G	37	27	73.0%	35	27	77.1%
H	40	15	37.5%	43	28	65.1%
I	62	41	66.1%	93	44	47.3%
J	19	8	42.1%	35	15	42.9%
K	33	24	72.7%	51	16	31.4%
TOTAL	**399**	**236**	**59.1%**	**456**	**258**	**56.6%**

Key Informant Interviews

Semi-structured key informant interviews were conducted annually with local coalition coordinators, coalition leadership/partners, and local evaluators. These interviews were conducted in-person via annual site visits until the onset of the COVID-19 pandemic in Year 3. All interviews conducted after March 2020 were conducted by phone or via online video conference. Interview guides were updated each year and covered a broad range of topics including strategies to address equity, barriers and facilitators to the planning and implementation process, dimensions of organizational and community readiness, capacity to address health equity and prioritized equity outcomes, and sustainability. Coalition coordinators and local evaluators were interviewed each year, 2-5. In Year 2, we also interviewed two coalition members in leadership positions, and in Year 3, we interviewed one active coalition member who was identified as deeply knowledgeable about at least one major strategy (Table 6). Average interview length was 60-70 minutes per person, each year, and interviewees were offered a $30 gift card as thanks for their time.

Table 6. Key informant interviews conducted each year

County	Year 2	Year 3	Year 4	Year 5	TOTAL
A	4	3	2	2	**11**
B	4	3	2	2	**11**
C	4	2	2	2	**10**
D	5	3	2	2	**12**
E	4	3	2	2	**11**
F	4	4	2	2	**12**
G	4	3	2	2	**11**
H	4	3	2	2	**11**
I	6	2	2	--	**10**
J	4	3	2	2	**11**
K	4	4	3	--	**11**
TOTAL	**47**	**33**	**23**	**18**	**121**

Population-Based Surveys on Equity Indicators

The coalitions' CHIP priorities and strategies revealed a wide variety of plans and approaches across sites. As an initial step, in summer 2018 we worked with local evaluators to refine logic models and identify priority outcomes that could be expected to improve given potential reach and intensity of intervention strategies. Unfortunately, much existing secondary data are not useful for assessing change resulting from this Initiative due to small sample sizes at the local level (e.g., state or regional rates typically reported) or a significant time lag before data are available (e.g., Medicaid data). For common equity indicators, we explored the availability and utility of existing data for measuring change at the local level, but such sources were deemed insufficiently useful.

To address a lack of available data that are sufficiently sensitive to detect change, we conducted population-based surveys before and after CHIP implementation. We sent the first surveys (T1) during the beginning of the implementation phase to randomly selected households throughout each county from December 2018 through June 2019. We purchased lists of eligible households from a vendor called Marketing Systems Group to serve as the sampling frame for this survey. From the list of addresses, we randomly selected households to receive a mail survey. The number of surveys mailed to households in each county varied by county population size. One adult per household was eligible to participate. Each mailing included an introductory letter describing the study and information on the incentive (a $15 gift card), the survey, and a stamped return envelope. These materials were co-branded with Emory, Initiative and individual coalition logos. If necessary, each household received a postcard reminder and a second survey. We conducted a post-implementation survey (T2) following the end of the Initiative, with mailings sent in waves from July 2022 through February 2023 to those who responded to the survey at T1. For the T2 surveys conducted after the end of the Initiative, we received permission to co-brand our survey with all nine coalitions funded through Year 5 as well as one of the two coalitions that were not funded in Year 5. Survey methods used at T2 largely mirrored those used at T1. A few differences include the inclusion of the social capital module and a question about food security to all surveys and offering a $20 incentive at T2 instead of $15.

Table 7. Population survey modules by coalition

County	Food Security/ Access	Healthy Eating	Physical Activity	Health Care Access	Social Capital	Health Status & HRQOL	Well-being	Demographics
A	X	X	X	X	--	X	X	X
B	X	X	--	X	--	X	X	X
C	X	X	--	X	--	X	X	X
D	X	X	X	X	X	X	X	X
E	X	X	X	X	X	X	X	X
F	--	X	--	X	X	X	X	X
G	X	X	X	X	X	X	X	X
H	X	X	X	--	--	X	X	X
I	X	X	--	X	X	X	X	X
J	X	--	--	X	--	X	X	X
K	--	--	X	X	X	X	X	X

We developed the survey questions based on our prior literature reviews identifying commonly used measures for a set of 10 equity outcome measures when possible to allow for comparisons with regional, state or national data. Surveys included up to eight modules (Table 7). We consulted local evaluators and coalition coordinators from each coalition about how to tailor the surveys for their community based on relevant priorities from their CHIP and where they expected to see the most change by the end of the implementation phase. While certain modules were required for all surveys, the first five modules shown in the table were able to be fully or partially included at the discretion of coalition staff.

*Table 8. Population-based survey response rates^*

County	1st Time Point (T1)			2nd Time Point (T2)		
	# mailed	# completed	Response rate	# mailed	# completed	Response rate
A	1084	276	25.5%	252	137	54.4%
B	1089	299	27.5%	266	146	54.9%
C	948	253	26.7%	226	130	57.5%
D	648	205	31.6%	179	111	62.0%
E	1176	251	21.3%	223	109	48.9%
F	775	184	23.7%	169	96	56.8%
G	975	232	23.8%	207	132	63.8%
H	763	242	31.7%	218	127	58.3%
I	1160	303	26.1%	273	141	51.6%
J	1179	333	28.2%	310	180	58.1%
K	824	210	25.5%	188	112	59.6%
TOTAL	**10,621**	**2,788**	**26.2%**	**2,511**	**1,421**	**56.6%**

^excludes mailings that were returned to Emory/were not delivered

At T1, a total of 10,621 surveys were sent, and 2,788 were completed (26.2% response rate); county-specific response rates ranged from 21.3% to 31.7% (Table 8). Because the T2 surveys were mailed to respondents who had previously completed the T1 survey, the T2 response rate was higher. At T2, the overall response rate was 56.6%, with county-specific response rates ranging from 48.9% to 63.8%. Of 2,511 surveys mailed to respondents who completed the baseline survey, we received a total of 1,421 completed surveys (56.6% response rate). The survey data presented in the Results (Part 6: Population-based survey findings) include only those respondents who completed the survey at both time points (n=1,421).

Community Change Tracking Tool

The community change tracking tool documented strategy implementation and related community changes (steps toward and actual changes in policy, systems, and environmental changes) by each coalition and allowed

us to monitor any changes to strategies over time. At the start of Year 3, using a web-based screen-sharing platform, our team worked with the coordinator from each coalition to introduce them to the Excel-based tool and completed an initial draft together. Each strategy listed in a coalition's CHIP with the potential to lead to a community change (e.g., policy, systems or environmental change) was included in the tracking tool. Twice a year, coordinators answered a series of questions about each strategy, including its current status, the unit of change and priority population, critical events in its implementation, current reach, potential reach over time, and how it addressed health equity. At the end of Year 3, following the onset of the COVID-19 pandemic, the tool was also used to document strategies interrupted, expanded, or stopped due to COVID. These data were summarized across sites to inform the Initiative-level evaluation.

Data Analysis

Key informant interviews were audio recorded and recordings transcribed verbatim. Data (transcripts) were coded and key themes and points summarized. We created a codebook to capture major themes for each topic covered. Two coders coded each transcript independently, and discrepancies were resolved through consensus. NVivo was used for data management and analysis. Content analysis was performed on coded text to identify themes, and matrix-style tables were constructed to help identify patterns by coalition and community characteristics.

Abstraction forms were used to streamline the collection of relevant information from various program documents including the initial applications, progress reports, and CHIPs as they related to evaluation questions. Abstraction forms and the Community Change Tracking Tool data involved both qualitative (themes) and basic quantitative (simple counts) data analysis procedures, depending on the information entered.

For the coalition and population-based surveys, we conducted descriptive analyses, including means, percentages, and cross-tabulations. For the population-based surveys, because we followed up at T2 among respondents from T1, we were interested in whether there was a significant difference between those who responded to T2 and those who did not. To do this, we analyzed T1 demographics including age (average in years), gender (male-female), race (White-Black), education (college degree vs no college degree), and income (3 categories) for follow-up responders and non-responders. The only significant difference observed was for age: participants who completed the T2 survey were on average 3 years older at baseline than those who did not complete the T2 survey (61 vs. 58). Pre-post comparisons were conducted using linear and generalized linear mixed models that nest observations (level-1) in participants (level-2) and adjusted for nesting in counties through fixed effects (i.e., indicator variables). The change over time effect was coded as time=0 for baseline and time=1 for follow-up. We ran one model to compare the entire sample and group-specific models for White and Black identifying respondents as well as those in the low-, medium-, and high-income groups as determined by their baseline income level. We also ran models to see whether gaps were narrowed or widened by race and income to assess potential impact on health equity. Specifically, interactions between the change and our two moderators of interest (i.e., race and income categories) were assessed separately for each outcome through expanded models with the terms time, the main effect of race or income, and the interaction term of time*race/income. The final term is the one assessed for significance of interaction. These two models allowed us to assess whether the change in an outcome variable differed by race and/or by income. All analyses were conducted in SAS 9.4.

RESULTS

Coalition names are masked through much of the results section, although they are named in sections that discuss implementation of specific activities.

PART 1. COALITION FORMATION AND FUNCTIONING

Community coalitions were central to *The Two Georgias Initiative.* Coalitions were formed or expanded early in the Initiative to engage in the community assessment, followed by development and implementation of the CHIPs. Coalitions are typically multi-sectoral and ideally include members who represent organizations that serve the community as well as representatives from the prioritized communities. Given the equity focus of the Initiative, engagement of groups historically disenfranchised was especially important. Special attention was paid to those with "lived experience" as well as Black, Latino, and lower income county residents. Coalitions often start with a core group of organizations or individuals interested in a particular topic. In the *Two Georgias Initiative*, this was typically the group that applied for the grant. In some cases, an existing coalition was expanded and in other counties the coalitions were newly formed from the core group that applied for the funding.

Research and coalition theory suggest that more formalized coalitions and those that function well in terms of communication, shared decision-making, task focus, cohesion, leadership and staffing are more likely to have engaged coalition members who contribute their time, resources and talents to the coalition, thus creating collaborative synergy [58]. Collaborative synergy, in turn, leads to deeper understandings of community strengths and challenges, more comprehensive and culturally appropriate solutions, and greater community ownership which can enhance sustainability. As part of the evaluation of the Initiative, we assessed coalition membership, functioning, staffing/leadership, structure, and collaborative synergy.

Composition of Coalition Membership

Table 9 shows sectoral representation on the coalitions. Sectors that are commonly on community coalitions were well-represented, with education, community-based organizations, and health care the best represented sectors at both time points. Social/human services, business, faith, public health, local government, civic groups, mental/behavioral health, law enforcement and elected officials were also represented on a majority of coalitions at both time points. The diversity of community sectors speaks to the breadth of community engagement by the coalitions. Among the least represented sectors were media, recreation, and housing. At both time points, (after the planning phase and after the implementation phase, respectively), the percentage of coalition members who identified as interested residents not representing a certain sector was relatively low. An important caveat with respect to these findings is the possibility that representatives of some sectors did not complete the survey, thus the data in the table may under-represent certain sectors.

Table 9. Sector representation on coalitions

Sector	T1 (n=236)		T2 (n=258)	
	% of total members	# coalitions with sector represented	% of total members	# coalitions with sector represented
Education	27.5	11	27.1	11
Community-based organization	26.3	11	24.8	11
Health care	26.3	11	19.8	11
Social/human services	18.6	11	14.3	10
Business	18.6	11	12.8	11
Faith	18.6	10	12.8	11
Public health	16.5	10	10.5	9
Local government	12.3	11	9.3	9
Civic group	10.2	9	5.8	8
Mental/Behavioral health	9.3	8	8.5	11
Law enforcement	8.9	7	5.8	6
Elected officials	8.1	8	5.4	9
Housing	7.2	8	3.9	5
Recreation	6.4	8	2.7	5
Neighborhood group	4.7	7	3.5	7
Media	3.4	5	1.2	3
Other	2.5	5	0.7	2
Interested resident (no sector)	1.7	4	0.4	1

Note: Respondents could check all that applied

Table 10 presents selected demographic data on the coalition members. Based on data from the coalition member surveys administered at the end of the planning phase (T1) and end of the implementation phase (T2), the majority of coalition members were women, White, and in their early 50's. The majority also had college degrees. With respect to race/ethnicity, the membership composition varied widely by coalition due to regional differences in the racial composition of Georgia communities. There was very little Latino representation at either time point. At both time points, about two in three respondents were residents of the county they served. Most respondents represented an organization or group and most could attend coalition meetings on work time.

Table 10. Selected coalition member survey demographics

Demographics	T1 (n=236)	T2 (n=258)
Men, %	31.3	27.4
Race/Ethnicity, %		
White	75.6	73.5
Black/African American	21.4	23.5
Latino	0.4	1.0
Age (mean, SD)	51.1 (12.16)	52.1 (12.33)
College degree, %	76.2	78.7
County resident, %	64.1	69.0
Organizational affiliation, %		
Represent organization or group, %	77.6	80.5
Attend on work time, %	82.4	80.1

Structure of the Coalitions

At the end of the planning year (summer 2018), 10 of 11 coalitions consisted of a steering committee (also called a board, or an advisory committee) with highly structured, topic-specific subcommittees, also called work groups or strategy teams. One of these coalitions was aligned with the local Family Connection. The only coalition to use a different structure was led by a steering committee only.

The most common work groups were focused on food security/nutrition, literacy/education, health care access, and physical activity access. Several coalitions also had other kinds of work groups dedicated to various aspects of coalition work such as community outreach/engagement, communications/media, sustainability, data & reporting/evaluation, and financial/fundraising.

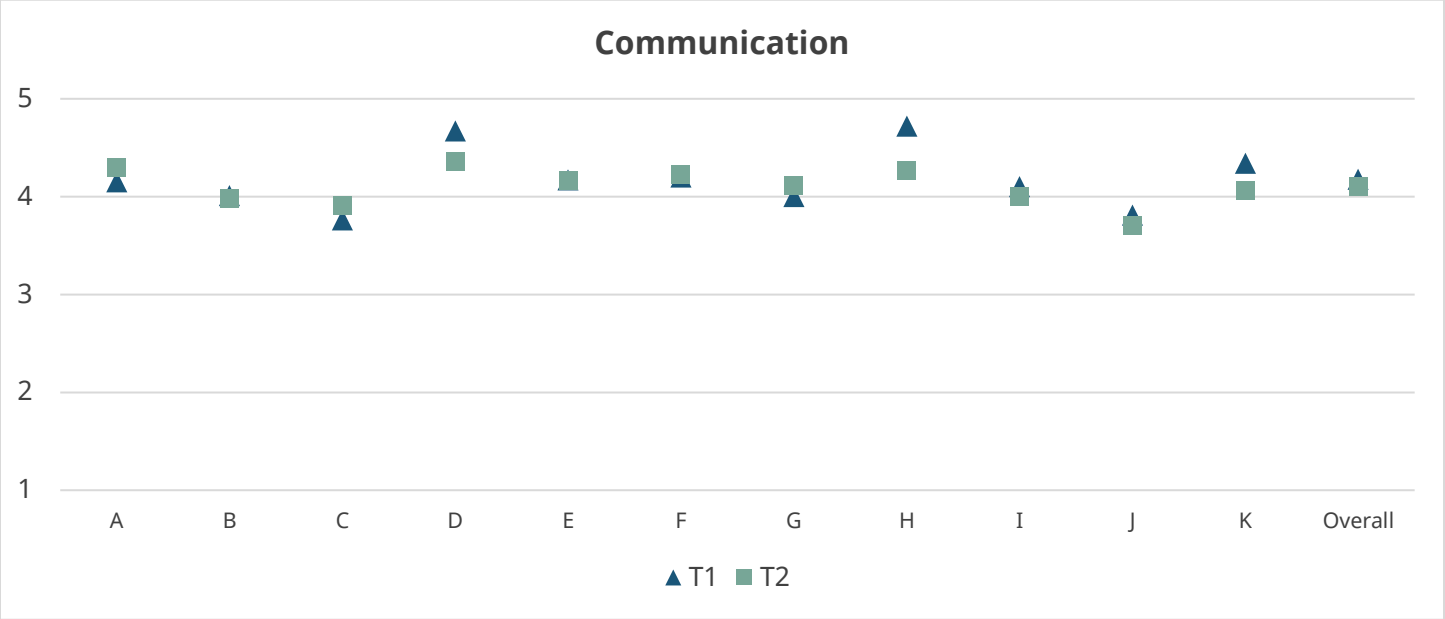
Structures evolved over time, in part due to COVID-19 and the limited opportunities for members to meet. By the end of the implementation phase (summer 2021), and following a year-long sustainability planning process led by the GHD team, four coalitions had aligned with the local Family Connection organization, in addition to the one that had been aligned with their local Family Connection from the beginning. Two coalitions did not substantively change in structure. The implications of coalition structure for sustainability are discussed in the Results (Part 7: Sustainability).

Member Assessments of Coalition Functioning

Multiple aspects of coalition functioning were assessed through the coalition member survey, including frequency and productivity of communication, influence in decision-making, and levels of conflict. Staff/leadership competence was also assessed.

Coalition members rated communication between staff and coalition members as well as among coalition members. Response options were 1=infrequent to 5=frequent, and 1=unproductive to 5=productive. Figure 3 shows that members rated communication as frequent and productive with little change between the two time points.

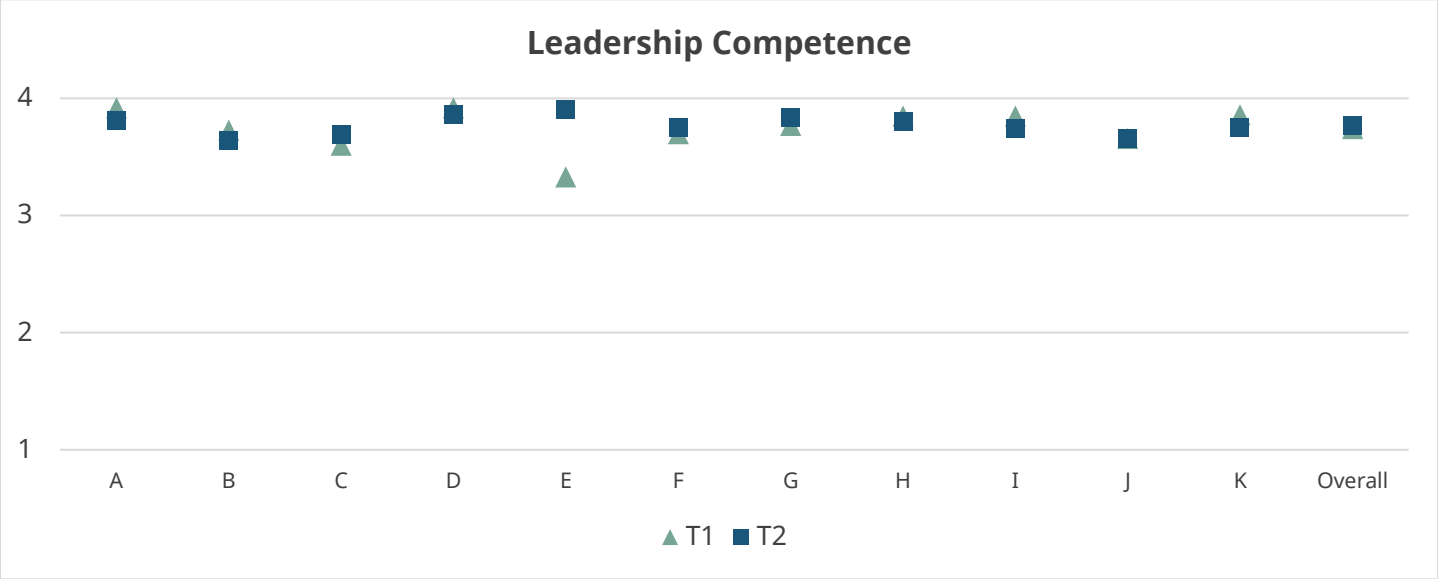
Figure 3. Communication, coalition member survey



NOTE: 1=unproductive/infrequent; 5=productive/frequent

To assess staffing and leadership, coalition members were asked to respond to a series of statements about the coalition leadership and staff, with response options of 1=strongly disagree to 4=strongly agree. As the funded project managers generally served as coalition leaders, leadership and staffing items were combined into one score. Sample statements include: intentionally seeks out your views, is respected in the county, is competent and responds well to criticism. As seen in Figure 4, all coalitions rated leadership positively, with steady rating between the two time points for most of the coalitions. Across coalitions and at both time points, the most highly scored item was that leadership makes them feel welcome at meetings. Other highly scored items included leadership having respect of the coalition members, was viewed as competent and respected, and had a clear vision for the coalition.

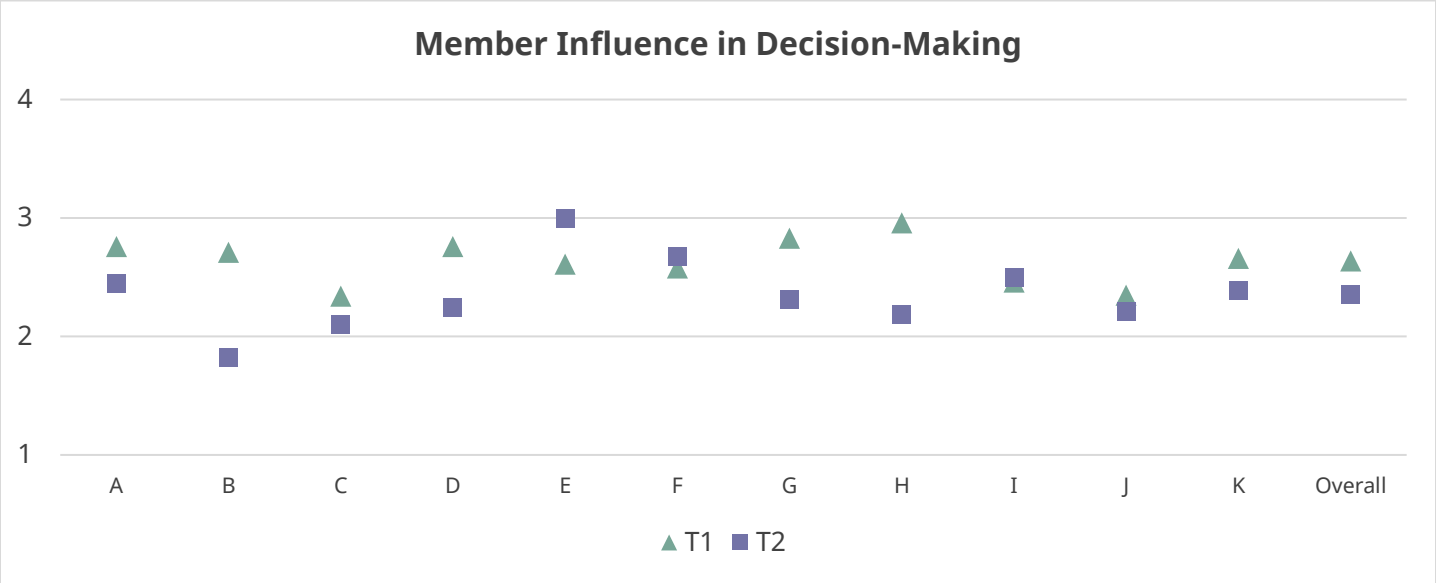
Figure 4. Coalition leadership competence, coalition member survey



NOTE: 1=strongly disagree; 4=strongly agree

Figure 5 below shows member views on how much influence they had in making decisions for the coalition (ranging from 1=no influence to 4=a lot of influence). They responded to six items: setting meeting agendas, goals, and objectives, deciding on coalition activating, budgeting, and staffing as well as how to implement projects, and how the coalition functions overall. Of note, decision-making influence had greater variation across the two time points than the other measures of coalition functioning. Members influence decreased from 2018 to 2021. Influence in setting goals and objectives for the Initiative was the highest scored item across coalitions at both T1 and T2. Influence in budget and staffing for the Initiative was the lowest scored item across coalitions at both time points.

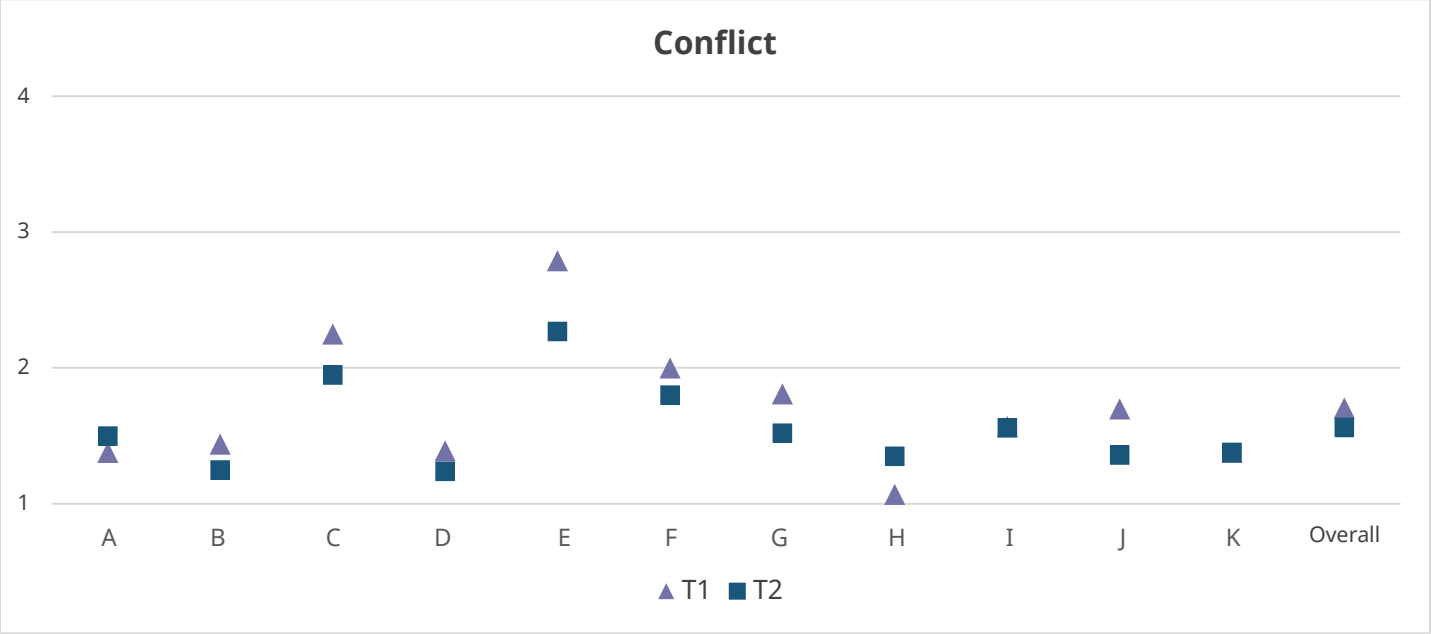
Figure 5. Member influence in decision-making, coalition member survey



NOTE: 1=no influence; 4=a lot of influence

Coalition members answered a question about perceived tension or conflict within the coalition on a scale of 1 to 4 with 1=none at all and 4=a great deal. While tension/conflict was generally low at both time points, the coalitions that had higher tensions levels in the beginning showed the largest decreases at T2 (Figure 6).

Figure 6. Coalition conflict ratings, coalition member survey

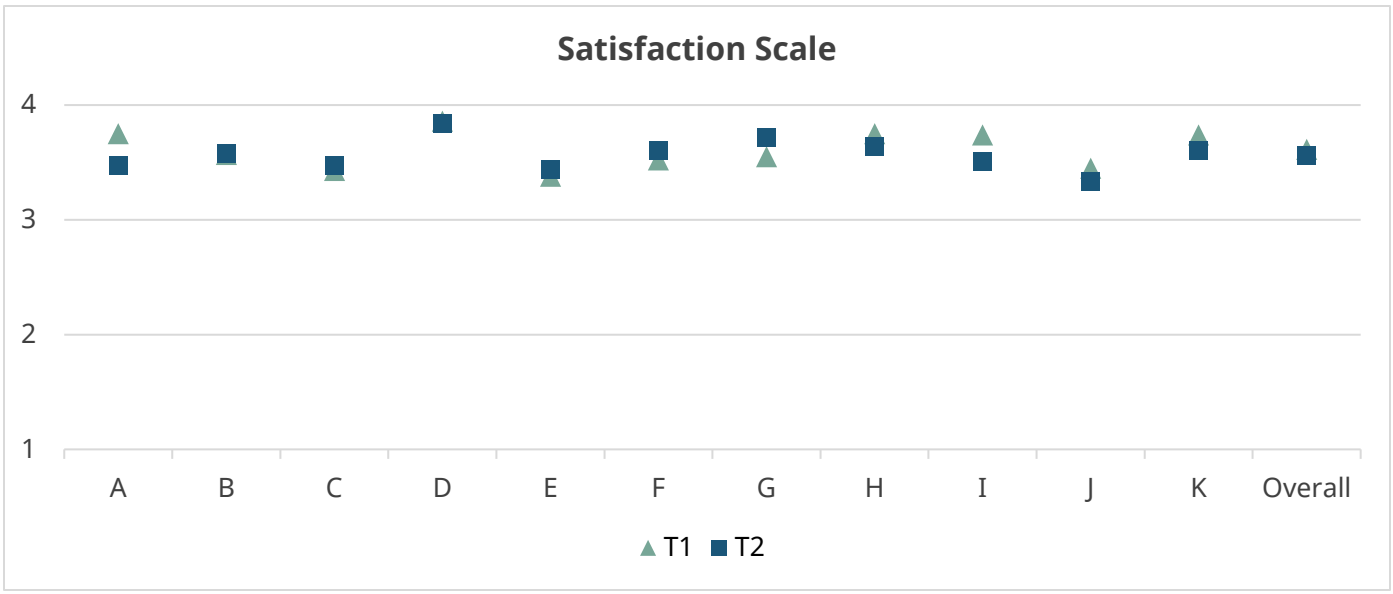


NOTE: 1=none at all; 4=a great deal

Member Satisfaction with the Coalitions

Coalition members were asked to reflect on their satisfaction with different aspects of their coalitions at both time points. Response options ranged from 1=very dissatisfied to 4=very satisfied. Overall, coalition members were very satisfied with the overall work of their coalitions (Figure 7).

Figure 7. Satisfaction with coalition accomplishments, coalition member survey

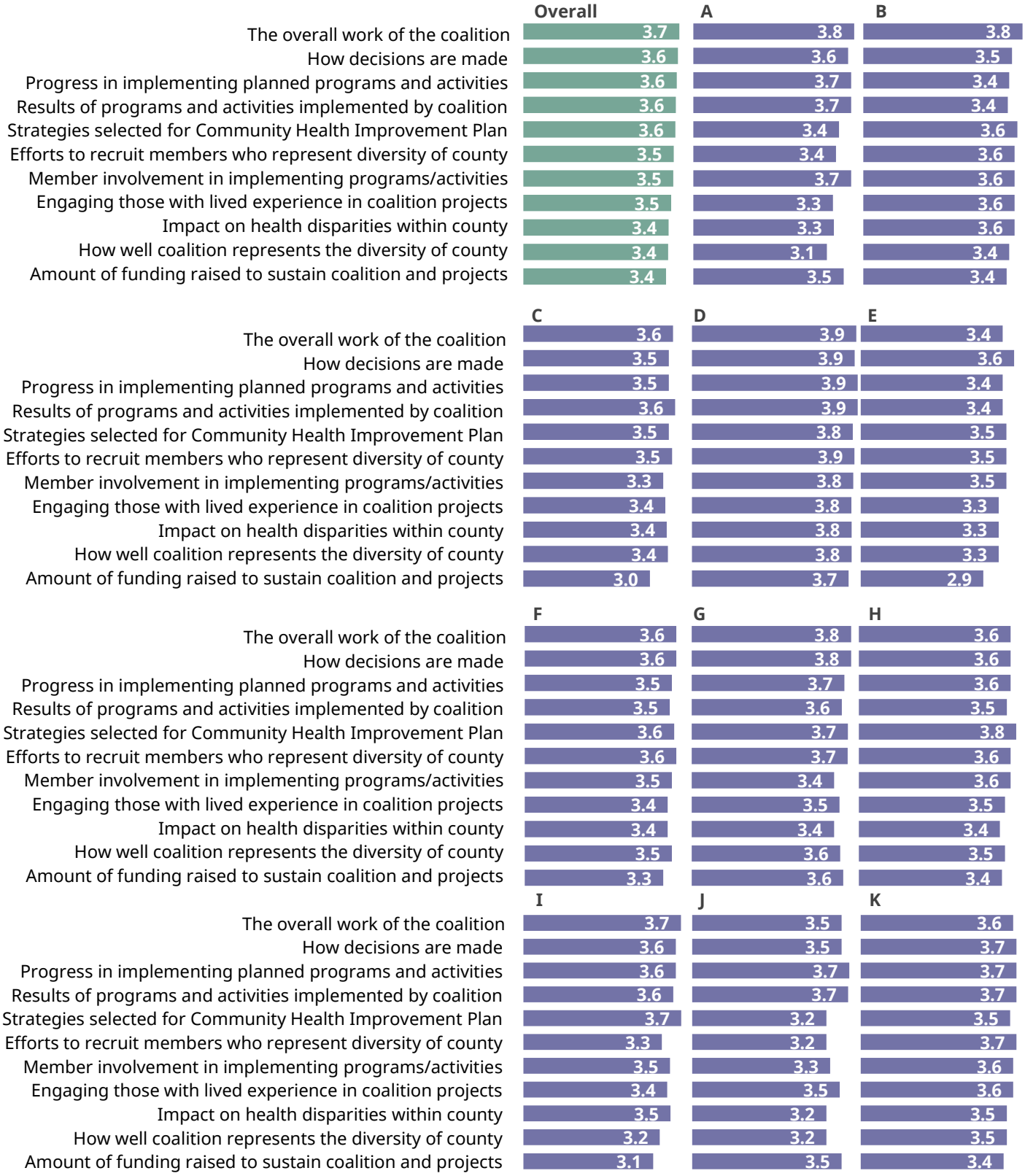


NOTE: 1=very dissatisfied; 4=very satisfied

Figure 8 provides more detail on specific aspects of satisfaction for each coalition. Members rated the overall work of the coalition most highly (3.7 out of 4), with progress on implementing planned programs and activities, results of those programs and activities implemented by their coalitions, and the strategies selected for the CHIPs also rated highly. While still relatively high, members were generally less satisfied with the impact on health disparities within the county, how well their coalitions represented the diversity of their counties,

and the amount of funding raised to sustain the coalitions and high priority projects beyond the Initiative funding period.

Figure 8. Item- and coalition-level satisfaction



NOTE: 1=very dissatisfied; 4=very satisfied

Member Participation in Coalition and Related Activities

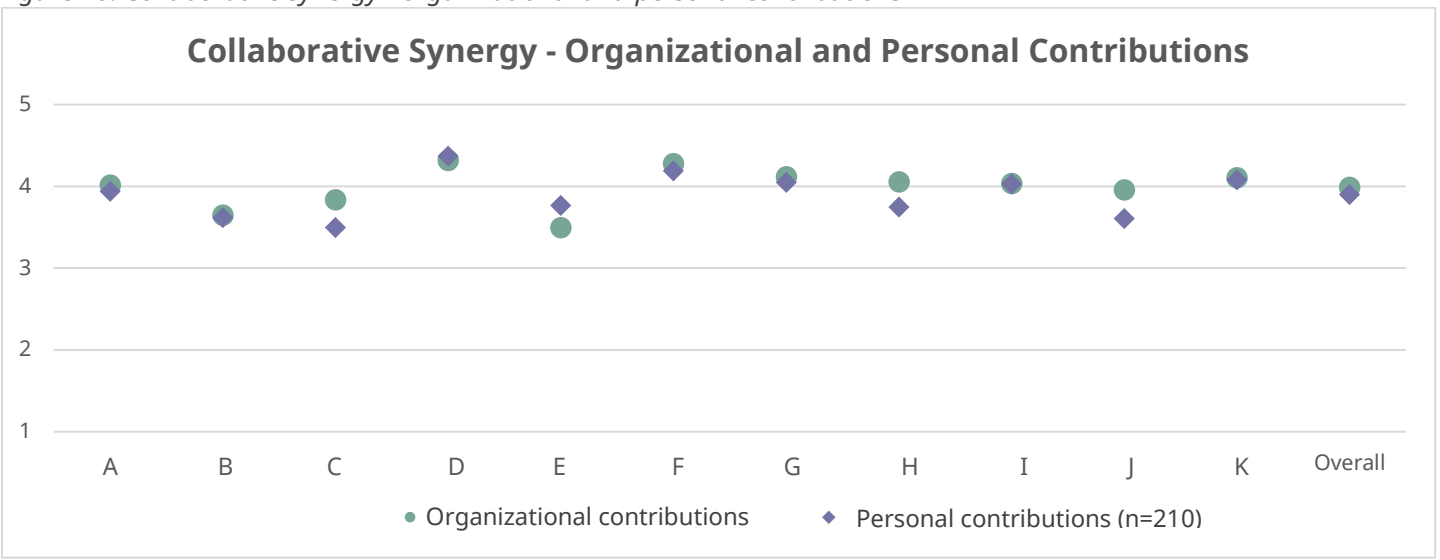
At both the T1 and T2 timepoints, coalition members were asked to consider their level of participation in the coalition in a variety of roles such as: served as an officer or chair, recruited coalition members, presented coalition information, helped assess needs or assets, set priorities, selected strategies, implemented strategies, promoted changes in policy or practice, evaluated progress or planned for sustainability. Figure 9 shows the percentage of these roles that members played. Overall, the data show that coalition member participation was relatively high across all coalitions and varied little over time.

Figure 9. Participation in coalition member roles

Collaborative Synergy

Collaborative synergy is created through engagement of diverse coalition members who pool their talents and resources toward a shared goal. Coalition members were asked about how well their coalition taps into, uses, or takes advantage of the strengths, expertise, and resources of their organizational assets and their own strengths and resources. Response options were 1=not well at all to 5=extremely well. Figure 10 shows that coalition members felt their strengths were leveraged very well, with some variation across coalitions.

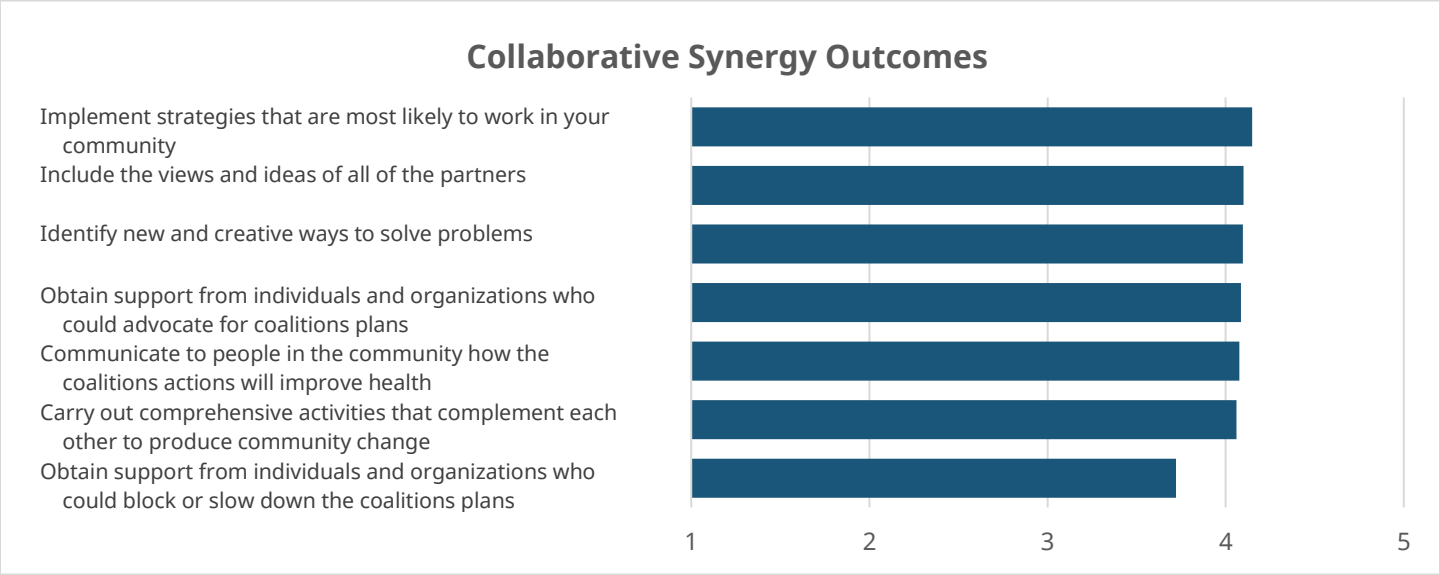
Figure 10. Collaborative synergy - organizational and personal contributions



NOTE: 1=not well at all to 5=extremely well

Figure 11 shows specific items used to assess collaborative synergy outcomes. Almost all of the items were scored highly, suggesting the coalitions were able to benefit from the pooling of resources across their members to implement strategies likely to work, to include views and ideas from all partners, identify new and creative ways to solve problems, and implement a comprehensive set of strategies for community improvement. Only one item was scored lower than the others, and it was related to obtaining support from individuals or organizations that may oppose coalition efforts. It is possible this was less relevant for *The Two Georgias Initiative* given their inclusive priority setting processes.

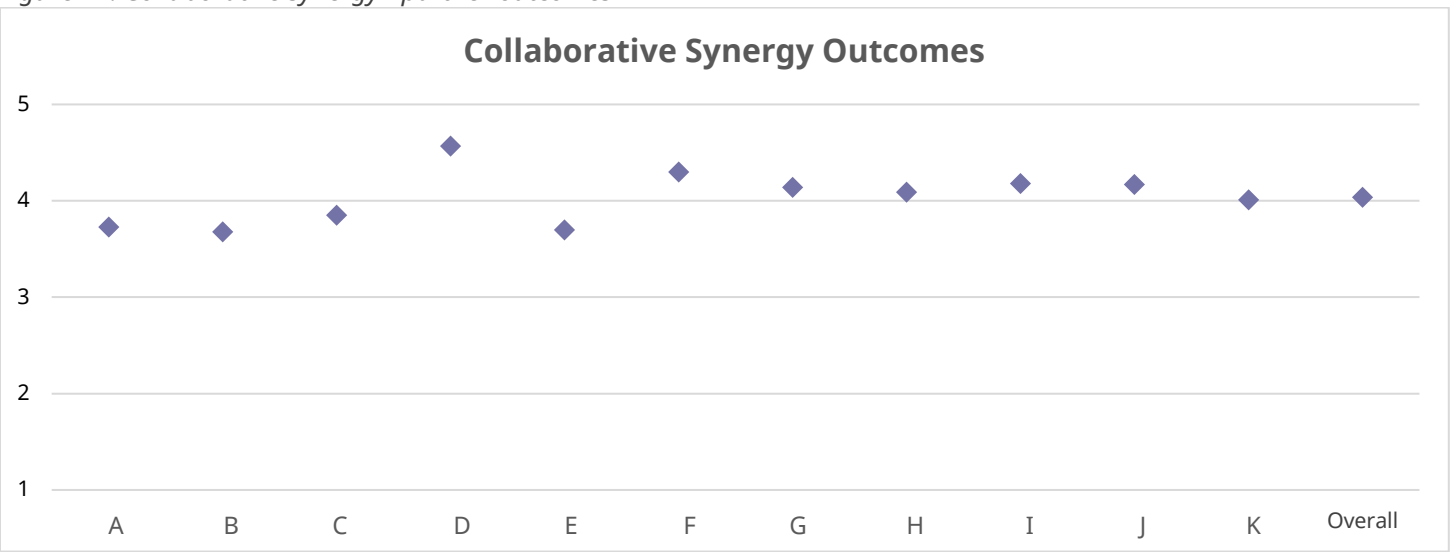
Figure 11. Collaborative synergy outcome indicators



NOTE: 1=not well at all; 5=extremely well

Figure 12 below presents a summary scale score for collaborative synergy outcomes by coalition. Collaborative synergy was generally achieved, although there was some variation across coalitions.

Figure 12. Collaborative synergy - partner outcomes



NOTE: 1=not well at all; 5=extremely well

Summary

Overall, coalitions formed or strengthened through the *Two Georgias Initiative* succeeded in establishing a multi-sectoral membership with organizations influential in rural communities, such as faith-based organizations and businesses, at the table in addition to traditional sectors of education, health and social

services. High levels of engagement of those with “lived experience” in terms of poverty or disenfranchisement due to structural racism was harder to achieve, although engagement through coalition membership is not the only form of meaningful involvement (see Results Part 3 of this report). While some variation across coalitions was evident, overall, they functioned well with frequent and productive communication, strong leadership, and minimal conflict. Members contributed personal and organizational resources toward commonly defined goals, and collaborative synergy was achieved.

PART 2. SUPPORT SERVICES OFFERED

The Foundation established a network of support teams to provide the coalitions with technical assistance and support for various aspects of the Initiative and to ensure their success. Our evaluation plan included one process-focused question about support services offered and how they influenced coalition effectiveness. We asked interviewees each year about their thoughts on the support services they received. This section summarizes the services offered by three primary support teams who worked with coalitions throughout the five years of the Initiative as well as advice about how support could be improved in the future (i.e., if this Initiative were to be offered again).

Description of Support Viewed as Most Useful to the Coalitions and Why

Georgia Health Decisions – Community coaching and sustainability training

Georgia Health Decisions (GHD) community coaches served as strategic thought partners for the coalitions. The purpose of their role was to help ensure the coalitions were successful. Together, coaches and coalition staff worked together to plan and implement strategic approaches, find community resources, facilitate peer-learning, build diverse coalitions, and prepare the coalitions for long-term sustainability in terms of the partnership and impact. In the fourth year of the Initiative, the coaches guided the coalitions through a sustainability curriculum that culminated with the completion of a coalition sustainability plan.

Coalition staff expressed that they felt well-supported by their GHD community coaches who they viewed as reliable, responsive, and engaged in the work. Communication with the coaches was clear and easy, and coalitions viewed their coaches as being visionaries who helped them brainstorm ideas and benefited from their detailed and organized nature. The community coaches provided an array of helpful resources (e.g., knowledge, skills, templates, videos). Through supportive coaching, they formed strong relationships with coalitions and established mutual respect and trust. Coalition staff viewed their coach as their advocate. Working with the coalitions, community coaches helped keep coalitions on track and focused on their purpose, helped build capacity among individual and organizational partners, facilitated diverse partners working together, helped them make hard decisions, and provided connections to the community as well as other Initiative coalitions. Coalition staff valued the Seeds for Sustainability training and curriculum organized by GHD, particularly the variety of helpful resources that ranged from the curriculum to guest speakers. Coalition staff identified several ways they applied what they learned from their coaches to their work: sustainability of strategies and funding, building and maintaining relationships, and applying leadership techniques.

Partnership for Southern Equity – Health equity expertise and training

Equity experts from Partnership for Southern Equity (PSE) supported the coalitions with understanding health equity concepts and the role of health equity in access to health care and other health outcomes. PSE facilitated a training series on health equity which included open dialogues among members, offered regular health equity office hours, hired two community ambassadors to support equity in the northern and southern parts of the state, and provided each coalition with a health equity backpack containing engaging and useful tools to support health equity understanding and application. Finally, PSE developed and shared a Health Equity Assessment Guide. The guide included actionable steps for coalitions to take, including encouraging them to engage diverse populations throughout the community building process, in planning activities, and in decision-making processes; to focus efforts on inequities identified by the coalition and community; to identify and understand the health implications for people most impacted by inequities; ensure data are collected across populations/communities to understand the distribution of health equity impacts; determine strategies that will achieve maximum health benefits and outcomes among populations most impacted by inequities; and monitor and evaluate decisions and actions taken to minimize health inequities.

With the increasing recognition of health equity in recent years, coalition staff appreciated receiving health equity guidance and support from experts at PSE. Interviewees valued the tailored trainings that PSE offered,

highlighting race in counties experiencing racial inequities and focusing on income in communities where there was less racial diversity. In addition to providing formal trainings, PSE shared useful information and resources about health equity (e.g., the Health Equity Assessment Guide). PSE encouraged collaboration and discussion among partners about health equity, race, and income inequality. Coalitions appreciated that PSE fostered open, non-threatening discussions on potentially contentious topics. These trainings, resources, and discussion helped broaden coalition members' perspectives on health equity, especially in applying it to their coalition work.

Emory Prevention Research Center – Evaluation support

The EPRC supported each coalition's local evaluator in developing and implementing a local evaluation plan and logic model. The EPRC held several evaluation webinars each year intended for local evaluators as well as other coalition members interested in evaluation. These webinars were used to gain coalition input and guidance on the EPRC's cross-site evaluation activities and to provide a platform for local evaluators to share their local evaluation approaches and progress with the other local evaluators.

Like PSE and GHD, the EPRC provided useful tools and resources with coalitions and local evaluators (e.g., Community Change Tracking Tool, templates, knowledge), and worked to develop supportive and professional relationships. Coalitions appreciated that the EPRC team was responsive to their needs, and supported good collaboration and clear communication. Several interviewees said that the EPRC gave clear expectations about evaluations and promoted learning through webinars, one-on-one discussions, and hearing from other local evaluators. A few local evaluators who taught college students appreciated that they received information that they could share with their students. Others cited they appreciated the credibility that Emory's involvement brings to the Initiative.

Suggestions for How Support Could be Improved

Year 5 interview participants identified four main ways to improve support during coalition planning and implementation. These suggestions were not directed at a specific support team, but would likely be organized from the top-down, with the Foundation deciding to enact them and who should be responsible. Most commonly, interviewees had suggestions related to providing more structure and accountability (Table 11). These suggestions ranged widely, but generally referred to specific requirements they felt were needed. Specific recommendations included requiring that coalition leads live in the county the coalition represents, requiring greater levels of community engagement/participation, providing clear expectations for the local evaluators, and clear guidance on what is expected of coalitions.

Table 11. General suggestions for improving support services

Improving support offered – general suggestions	# coalitions
More structure and accountability	7
Greater emphasis on capacity building (skills, logistical considerations)	5
Build infrastructure to support deep and sustained relationships among Initiative partners	3
Market accomplishments/success	2

> *"Being in the beginning a little more clear because even though I think the Healthcare Georgia Foundation gave everyone an opportunity to kind of carve out things the way that they would like to, and that's good, it—that's good, but also it—what were some of the boundaries or kind of knowing, okay, what can't we do? What should we do? What exactly is gonna be allowed? A little bit more direction on the front end about where we're trying to go."*

In addition, multiple interviewees expressed a need for specific, tailored, and timely feedback on their coalition's work and deliverables (e.g., reports submitted).

Another common group of suggestions was related to greater emphasis on capacity building. Logistical advice focused on ensuring that TA providers are on board at the beginning of the Initiative to allow the work to begin immediately and to ensure that all of the TA providers have enough time to devote to the effort. Specific types of capacity-building identified as needed included grant-writing trainings and other technical skills training. Interviewees from numerous coalitions described a desire to build infrastructure to support deep and sustained relationships among Initiative partners. Examples of this include putting more emphasis on developing relationships between coalitions and TA providers from the very beginning and requiring regular and frequent communications with TA providers. Other suggestions were more focused on the long-term investment in communities by the Foundation even beyond the funding period to build infrastructure for this work. Finally, a few interviewees gave recommendations related to the marketing of Initiative accomplishments. One interviewee hoped that efforts to promote the Initiative would increase the adoption of similar initiatives by other organizations. This individual was also vocal about capturing the novelty of the Initiative:

> *"That's what Healthcare Georgia Foundation needs to capture in their stories, that what they've done has never been done and look at what they accomplished by doing it, by that vision, just one person's vision. If they would market that as their success, then other larger foundations like themselves would step out there and do the same thing."*

Interview participants offered a few pieces of advice for future equity support and trainings (Table 12). Numerous coalitions would prefer to see trainings and other contacts tailored to community needs. A few interviewees suggested shorter, more efficient trainings that would fit community partners' schedules and one interviewee suggested more frequent one-on-one contacts in between formal trainings. Interview participants also offered suggestions for tailoring training content to fit the rural community context, specifically related to having "tough" conversations that address the political climate and historic racism. One interviewee had several ideas to ensure that health equity capacity can be self-sustained, through use of a train-the-trainer model, use of packaged equity trainings that communities can use, and support for the creation of local health equity teams. These efforts would help coalitions prioritize health equity beyond the funding period.

Table 12. Support for future equity trainings

Suggestions for future equity trainings	# coalitions
Tailor training and other contacts to meet community needs	3
Tailor trainings and TA resources to fit rural community context and to help guide tough conversations	2
Ensure that health equity capacity can be self-sustained	1

We specifically asked interview participants to tell us what advice they had to help clarify the distinction between the cross-site evaluator and local evaluator roles. Several interviewees agreed that roles could be better clarified, but few offered specific suggestions. One local evaluator suggested having the cross-site evaluator focus on priority strategies to ensure consistency across sites for common strategies and local evaluators focus on other less common strategies. Most were generally supportive of the local evaluator and cross-site evaluator and recognized the value of having both. Other advice interview participants gave was related to the logic model training offered in the first year – specifically to provide more guidance on these earlier, perhaps via an Evaluation 101 type session, and to offer smaller group trainings

Table 13. Suggestions for future evaluation support

Suggestions for future evaluation support	# coalitions
Help clarify distinction between cross-site & local evaluator roles	4
Provide more guidance on developing logic models	2
Encourage collaboration among evaluators	2

rather than inviting partners from all 11 coalitions at once. A few local evaluators expressed interest in greater engagement and collaboration among the local evaluators (Table 13).

Summary

Coalition staff generally were very appreciative of the support they received from the different support teams in the form of increased knowledge and skills. The three main teams provided support in three largely distinct areas of the Initiative: community coaching, healthy equity training, and evaluation. Coalition staff had substantive ideas for improving support provided in the future. A majority of coalitions expressed the need for more structure, accountability, and feedback, as well as an increased emphasis on specific capacity-building skills such as grant writing. Specific suggestions for equity training included tailored trainings and ensuring health equity efforts would continue beyond the funding period. Evaluation support could be improved through better delineation of roles between the Initiative- and local-level evaluators, providing more guidance on developing logic models, and facilitating collaboration among local evaluators.

PART 3. CHANGES IN COMMUNITY READINESS AND CAPACITY TO ADDRESS HEALTH EQUITY

One of the major goals of the *Two Georgias Initiative* was to strengthen community readiness and capacity to address health equity**. Community readiness** refers to the "*degree to which a community is willing and prepared to take action on an issue*" [59, p. 12]. We adapted the Tri-Ethnic Center for Prevention Research's Community Readiness Model to measure community readiness to address health equity. The model has nine stages of readiness, from no awareness to community ownership (Table 14). The measure assesses community member and leader attitudes, knowledge, efforts and activities, and resources related to the issue at hand, in this evaluation, health equity.

Table 14. Community readiness stages

Stage #	Stage Title
1	No awareness
2	Denial/resistance
3	Vague awareness
4	**Pre-planning**
5	**Preparation**
6	**Initiation**
7	Stabilization
8	Expansion/confirmation
9	Community ownership

Community capacity refers to the ability of a community to mobilize resources to address its priorities. Models of community capacity identify several dimensions common to communities that are able to effectively identify, mobilize and address social and health problems in contrast to communities that are less able to come together to solve problems. We used Goodman and colleagues' [48] conceptualization of community capacity and documented changes in the following dimensions as evidence of improved community capacity to address health equity: deeper critical reflection on the causes of health disparities, increased opportunities for diverse and grassroots residents to have a voice in community problem-solving, increased leadership opportunities for historically disenfranchised groups and community sectors not typically involved in health-related community improvement efforts, strengthened collaborative and planning skills, expanded inter-organizational networks, strengthened sense of community and trust, and redistribution of community power. Resources leveraged, also considered a dimension of community capacity, are presented in the Results (Part 7: Sustainability).

Lastly, we examined **organizational capacity** to address health equity to assess potential deeper changes in capacity within partner organizations represented on the community coalitions and also lead agencies for the local initiatives.

Changes in Community Readiness to Address Health Equity

Community readiness to address health equity was measured with a total of five questions that asked about different dimensions of readiness: resident knowledge about health equity, resident knowledge about local efforts to address health equity, whether county leaders were taking action to address health equity, the community's general level of concern about the issue, and the resources available to address health equity. Coalition members rated these items from one to nine, low to high, in their survey responses.

On average, community readiness to address health equity increased slightly from 5.2 at the end of the planning phase (T1) to 5.7 at the end of the implementation phase (T2) of the Initiative (Figure 13). This increase is modest and signifies the challenges associated with shifting a rural community's readiness to address health equity at the county-level over a three-year period. It may be more meaningful, however, to examine each coalition separately. At the end of the planning phase, four coalitions were in the Pre-planning stage, six were in the Preparation stage, and one was in the Initiation stage. By the end of the Initiative, six coalitions had increased community readiness to address health equity, with four moving from Pre-planning to Preparation and two moving from Preparation to Initiation. One community was already in the Initiation stage by the end of the planning phase of the Initiative.

Figure 13. Change in community readiness to address health equity

NOTE: 4=Pre-planning, 5=Preparation, 6=Initiation

Changes in Community Capacity to Address Health Equity

Evidence of critical reflection on issues of health equity

Critical reflection, as a dimension of community capacity, refers to the ability to reflect on underlying assumptions, as well as how current and historical forces in the political, physical, economic, and social environments influence health. To provide insights into how the coalitions were reflecting on and working towards health equity, we asked coordinators and local evaluators about specific ways they and their coalitions had integrated health equity into their work over the five years of the Initiative. The most common response was simply giving everyone a voice (Table 15). This entailed engaging the community in planning and implementation, decision-making, communications, and other opportunities to give input and to voice concerns. In addition, some also talked about having evening meetings to give members an opportunity to attend and participate, and providing various trainings that helped coalition members find their voice. Some interview participants described how they had seen members challenge local leaders, which may have been an example of using their newfound voice. Several also described how coalitions made concerted efforts to reach underserved, disadvantaged, and other groups. They did this by frequently asking themselves if they were achieving sufficient reach, targeting programs and services to specific groups, and looking at data to understand the extent of their reach. Another common approach to integrating health equity in the work was to bring services to people in different geographic areas to mitigate transportation barriers.

There was some divergence in approaches to equity between increasing community access to health resources versus educating residents. Interviewees from four communities described their focus on addressing access to resources (e.g., health care) and other social determinants. In contrast, interviewees from another four coalitions talked about how they prioritized awareness and education on health, health-equity, and advocacy. A few interviewees talked generally about how their coalition was committed to health equity in all phases of the work, a few spoke about the importance of prevention and the need to increase preventive services/resources for geographically and other underserved groups, and a few described using messages that emphasized equal opportunities to access resources and achieve equitable health outcomes (Table 15).

Table 15. Specific ways the coalitions integrated a health equity perspective in coalition work

Specific ways the coalition integrated a health equity perspective in coalition work	# coalitions
Giving everyone a voice	8
Concerted efforts to reach underserved, disadvantaged, and other groups	6
Bring services to the people, not people to services	5
Address access and SDOH to change behavior/health	4
Raise awareness/educating residents	4
Commitment to addressing equity in all phases of the work	3
Recognize importance of prevention, access to needed preventive services/resources	2
Emphasized equal opportunities to access resources, achieve equitable health outcomes	2

We were specifically interested in how coalitions used data to identify gaps and otherwise inform their approach to health equity in their work as an indicator of critical reflection. Interviewees from a majority of coalitions discussed how they relied on data from initial and ongoing CHNAs, local evaluations, and secondary sources to identify gaps, inform coalition priorities, and understand the extent of their reach to prioritized populations. One person spoke about how they used health outcomes data to educate members about the causes of those outcomes. A few interviewees also described the dearth of existing data in their rural communities, which can make it harder to understand the extent of need in their communities and limited grant opportunities. Two local evaluators expressed that in hindsight, they would have liked to update questions asked in their evaluations to better understand populations being reached through their local initiatives (Table 16).

Table 16. Use of data to identify gaps

Using data to identify gaps	# coalitions
Relied on needs assessment data, other data to identify gaps, inform priorities, understand reach	6
Educated members about health outcomes data and the causes of those outcomes	1
Noted lack of existing data to identify gaps	2
Not done: updated evaluation questions to better understand specific groups	2

Interviewees also reflected on the social, economic, and political history of their counties. The most common comments focused on the importance of relationships in rural communities, on multiple levels (Table 17). Some interview participants discussed the need for newcomers and others without deep roots in the community to get to know residents who have knowledge about available resources. Others talked about how relationships between coalition partners/organizations and community members needed to be based on trust in order to do health equity focused work.

Table 17. Role of social, economic, and political history of community

Reflecting on role of social/economic/political history of community	# coalitions
Importance of deep, strong relationships in rural communities	5
Culturally appropriate methods/programs/services to reach groups	3
History of racial distrust/problems with racism	2
Connections to local leaders, decisionmakers is key	2

Open relationships among coalition members were also highlighted as essential. A few interviewees described the different cultural needs of prioritized populations and the use of culturally appropriate methods, programs, and services to reach those groups. One coordinator described an intentional effort to always prepare Spanish-language materials for Spanish speaking community members as well as getting their messages to the small African American population through a prominent local pastor. A local evaluator described how community input into the coalition work resulted in culturally-appropriate strategies that were likely to succeed in their high-poverty rural community. This person also discussed the need to carefully approach the topic of health equity in discussions with community members:

> *"When you're doing health equity and mindset shift you're really talking about some type of attack on culture in some ways. You've gotta be careful with the way that you approach it because you don't wanna seem judgmental. Or like you're talking down to people. Or that you have some kind of opinion of the way that they've always lived their lives."*

Interview participants from two coalitions mentioned that the history of racial distrust persists in their community and continues to present challenges to advancing progress. Some highlighted the importance of connections to local leaders and decisionmakers in the community. One coordinator discussed the positive impacts of local political and community leaders being engaged in the community, which led to increased morale among community members for the potential for change. A local evaluator expressed frustration with the lack of connection to and visits from the local health district and other decisionmakers. A few other less common comments included a general lack of awareness of the lived experience of others and discussions with local leaders about how health care is an economic issue.

Given the increasing national political polarization that occurred over the course of the Initiative time frame (see Results, Part 4: Implementation & Contextual Factors), we were specifically interested in whether and how political divides in the country made this work harder for the coalitions. Overall, interview participants from one coalition said the political environment made their work harder, interviewees from three coalitions said it didn't impact their work, and interviewees from six coalitions gave mixed responses (Table 18). In terms of how the political divides made the work harder, a common response was the belief that health equity principles and the views of conservative leaders and residents are in conflict. They explained that conservatives espouse views emphasizing individual responsibility for one's health and social position, and a health equity approach that seeks to address upstream determinants of health and socioeconomic status (SES), seemingly absolves individuals of responsibility for their circumstances. Some interviewees discussed how they addressed this mismatch by tailoring their messages to be more palatable for these audiences and to increase the likelihood of support for their efforts. Interviewees from a few coalitions gave COVID-specific examples for how politically-charged disinformation during the pandemic impacted their COVID mitigation efforts, with certain members of the community strongly objecting to wearing masks and vaccination. One interviewee spoke generally about how the political environment created distrust in their community. Several interview participants said the national political environment did not affect their health equity work, with most of those saying they intentionally set aside their political opinions to do the coalition's work. Interviewees from two coalitions suggested that politics wasn't a factor in their communities because the residents are relatively uniform in their

Table 18. Impact of national political divides on coalition work

How political divides in the country make this work harder	# coalitions
Health equity work doesn't match conservative beliefs/values	4
Politically-charged pandemic disinformation made work harder	2
Political climate created distrust among groups	1
Health equity work unaffected by political divides	
Partners set aside political beliefs to do coalition work	5
No political divides--community is uniform in their beliefs, tight-knit	2
Just did not affect the work (no reason given)	1

beliefs, and that the communities are tight-knit. An interviewee from one coalition said that their work wasn't affected by politics but didn't elaborate.

Additionally, we wanted to know how working on a health equity focused initiative for up to five years impacted coordinators' own thinking about health equity and the main causes of inequities (Table 19). Coordinators from three communities discussed how despite their baseline knowledge of health equity, their understanding of the issue grew from personal knowledge on the subject to being able to put that knowledge into practice and apply it to their work as part of the Initiative. Some also said that their deeper understanding allowed them to have conversations with others and to "make the case" for health equity to others. Three other coordinators described how they had gained an increased awareness of the lived experiences of others and how that opened their eyes to the challenges that members of the community face. One coordinator said:

> *"For me, personally, doin' the Healthcare Georgia work, the Two Georgias, it's helped me to connect the dots whereas before all of this work started, if somebody came into the office and said, 'I don't have healthcare. I don't have healthcare access. I don't have this. I don't have that.' I didn't connect the dots on, well, it may be because there may be limitations financially or transportation or there may be a literacy aspect that factors in there, that type thing. It's really broadened my understanding of what all falls into what plays a part in leading to that lack of healthcare or healthcare access in our community."*

Another coordinator mentioned how the community had become more aware of the lived experience of disadvantaged groups and how their thinking evolved:

> *"People are becoming more mindful of how there are groups that really are disadvantaged, and it's not because they're lazy and it's not because they won't get up and go to church, or get a job, or whatever it is …There is a gradual shift, there's a very slow gradual shift in that mindset."*

In a similar vein, two other coordinators described how they had become aware of their own privilege and recognized that some opportunities are not available to everyone.

Table 19. How coalition coordinators' thinking about equity evolved over time

How thinking about main causes of inequities evolved	# coalitions
Understanding of health equity evolved from knowledge to practice/application	3
Increased awareness of the lived experiences of others	3
Recognition of own privilege, some opportunities are not available to everyone	2

We also asked about definitions and views on health equity throughout the Initiative (Table 20). The most common ways that interviewees defined health equity demonstrated an understanding of the underlying causes and barriers that drive inequities and how they are related. Some of the underlying causes identified included structural barriers, policies, and social determinants that all lead to lack of access to sufficient infrastructure and related resources. A frequently discussed element of health equity was the focus on differences between demographic groups, particularly based on low-income/impoverished populations and differences between racial/ethnic groups. For many coalitions, SES and race differences were the basis of their health equity work and in defining priority populations. A few others described the need for equal or fair opportunities in achieving health equity. We also heard from interviewees of two coalitions that rurality itself is a risk factor for inequities, due to lack of resources. A few also mentioned that members of their communities had differing conceptions of health equity. As shown in Table 20, other definitions used in previous years did not come up in Year 5 interviews, suggesting possible change over time in how coalition staff and active members view health equity and the main causes of inequities, although these results should be interpreted with caution given we interviewed different numbers of people at different time points.

Table 20. Health equity definitions by coalition staff & members

Health equity conceptualizations	Year 2 # coalitions	Year 3 # coalitions	Year 5 # coalitions
Focus on SES/poverty, racial differences	X	--	X
Equal or fair opportunities for all regardless of background	X	X	X
Understanding underlying causes and barriers driving inequities	X	X	X
Prioritizing specific groups or individuals most in need	X	X	--
Not about fairness: earn/work for the resources available	X	--	--
Minimum level of access that everybody deserves	--	X	--
Improving health of community as a whole	--	X	--
When the community understands and values health	--	X	--
Rurality is a risk factor for inequities	--	--	X
Community members have different definitions of health equity	--	--	X

Lastly, as an indicator of an equity orientation and critical reflection on health inequities, we asked about data collection methods and comparisons made to identify health disparities. We reviewed program documents submitted during the planning phase and asked about this in the Year 2 key informant interviews. Table 21 provides a summary of the types of data collection methods used and the number of coalitions that used each one.

Table 21. Data collection methods coalitions used to identify health disparities

Data collection methods	A	B	C	D	E	F	G	H	I	J	K	TOTAL
Secondary data	X	X	X	X	X	X	X	X	X	X	X	11
Surveys		X	X	X	X	X	X	X	X	X	X	10
Focus groups	X	X	X	X	X	X		X	X	X	X	10
Key informant interviews	X	X	X			X			X	X	X	7
Community forums		X			X	X	X					4
Observational studies						X			X			2

All 11 coalitions used a mix of quantitative and qualitative data collection methods. The one data collection method used by all 11 coalitions was in consulting existing secondary sources of data, including the Community Health Rankings, existing local CHNAs by health care or public health organizations, the US Census, and the online data portal for the CDC's Behavioral Risk Factor Surveillance System (BRFSS), called the Online Analytical Statistical Information System (OASIS). Nearly all coalitions (n=10) also conducted surveys with coalition and community members to gather local perspectives on health issues. The same number of coalitions also conducted focus groups with potential priority population members. Several coalitions went even further in-depth and conducted individual key informant interviews with residents and professionals representing potential key intervention settings. Others held community forums to gather input from potential priority populations. A few coalitions also described using observational studies to gather data on health disparities, such as walkability assessments.

Beyond the types of data collected, we were also interested in understanding the types of comparisons coalitions made to explore health disparities in their communities. Although *The Two Georgias Initiative* was conceived to address rural health, we know that disparities and inequities exist within rural communities as well. Nearly all coalitions explored some type of within-county differences in an effort to identify health disparities (Table 22). Several counties explored differences by age, race and/or ethnicity, gender, and/or geography. In addition, most coalitions also looked outward, and made county-level comparisons with other geographic levels, such as the state of Georgia, the US as a whole, other surrounding counties, and their local health district. A few counties made other comparisons, including examining how they compared to Healthy

People 2020 targets for certain health behaviors or outcomes, comparing their health district to other health districts, comparing rural to urban areas, and looking at data within the state of Georgia.

Table 22. Types of comparisons coalitions made to identify health disparities

Differences explored	A	B	C	D	E	F	G	H	I	J	K	TOTAL
Within county (any)	X		X	X	X	X	X	X	X	X	X	10
Within county (by age)			X	X	X	X	X	X	X		X	8
Within county (by race/ethnicity)	X				X	X	X	X	X		X	7
Within county (by sex)	X					X	X	X	X		X	6
Within county (by geography/area)				X	X	X	X		X			5
County vs other geography	X	X	X	X	X	X	X	X	X	X	X	11
County-state	X	X	X	X	X	X	X	X	X	X	X	11
County-nation	X		X			X	X		X	X		6
County-surrounding counties			X					X	X	X		4
County-health district	X		X									2
Other comparisons					X				X			2
County-HP2020 target									X			1
Across health districts					X							1
Rural-urban									X			1
Within state (by age, race, & sex)					X							1

We also documented the types of assessments that local evaluators made in conducting local evaluations (Table 23). All local evaluations used tracking forms and a variety of program documents. Tracking forms were used to track both process metrics including training/event participants/attendance, social media engagement, services provided, food distributed, as well as outcomes metrics such as policy, system, and environmental changes adopted, weight lost, and collection of other biometric data. Program documents provided information from coalition and program partners. Surveys were administered at various time points, including before and after program implementation/participation, as well as cross-sectionally either as a baseline or follow-up assessment. Interviews were conducted with program participants as well as community and coalition leaders. Secondary data often entailed the collection of data from external programs or organizations not part of the coalition, including school assessments that involved student test scores, medical records or other clinical data, and general statistics. Observations were used in a few local evaluations, including visits to program sites (e.g., community gardens). Finally, local evaluators in a few counties also used focus groups to help answer evaluation questions. Coalition strategies tended to be targeted at reaching specific priority populations. As a result, the local evaluations tended to focus on reach to and impact on those populations, rather than measuring gaps between different groups.

Table 23. Local evaluation data collection methods

Data collection methods	A	B	C	D	E	F	G	H	I	J	K	TOTAL
Tracking Forms	X	X	X	X	X	X	X	X	X	X	X	11
Program Documents	X	X	X	X	X	X	X	X	X	X	X	11
Surveys	X	X	X	X	X	X	X	X	X	X		10
Interviews	X	X	X	X	X	X		X		X		8
Secondary Data			X	X		X	X	X		X		6
Observation	X			X				X				3
Focus Groups	X				X							2

Opportunities for diverse and/or grassroots residents to have a voice in the Initiative

As mentioned above, when asked about how the coalitions addressed health equity, providing opportunities for those historically not at the table to have a voice in community problem-solving was discussed as an important equity-oriented action. We asked about this explicitly over the course of the evaluation as an

indicator of community capacity to address health equity. Specifically, we asked about opportunities for those experiencing disparities, most commonly related to race/ethnicity and SES, to participate in the Initiative beyond the usual role of program or service recipient. We also asked generally about grassroots residents, meaning people who live in the county but do not routinely engage in community improvement work as part of their jobs.

Community assessment

The most robust input from those experiencing disparities was obtained during the community assessment phase of the Initiative. All of the coalitions described at least one concerted effort to reach lower-income people of color, as well as lower-income residents in general. These outreach efforts typically prioritized grassroots residents, as opposed to agency professionals. For example, Clay County surveyed library patrons and residents waiting in commodity lines. Miller County surveyed food bank clients, parolees, and members of selected churches. Elbert County surveyed clients at the health department and library patrons, along with conducting focus groups with parents of children with disabilities. Chattooga County surveyed food pantry clients and conducted focus groups with industry workers. Numerous coalitions surveyed or conducted focus groups with public housing residents.

Provide input through coalition events and evaluation-related activities

A second mechanism was to provide input through coalition events and activities. Most of these were described as informal, often through conversations with those using services or participating in programs. A few coalitions used this approach more strategically. For example, both Cook and Clay conducted photovoice projects. As part of its affordable housing efforts, Early County conducted a door-to-door assessment, a housing observation study, and collected personal stories and created a video related to rural homelessness. A number of coalitions obtained input via evaluation-related activities. Appling County included intercept interviews with recreational complex users as part of its physical activity evaluation efforts. Lumpkin County surveyed clients seeking services from the lead organization, which included those using the food pantry and persons experiencing homelessness. They also surveyed attendees at their resource events.

Serving as a coalition or work group member

A fourth major mechanism for input into the Initiative involved serving as a coalition or work group member. When examining member composition at the coalition-level, relative to the county population, seven of 11 coalitions had a smaller percentage of Black members than might be expected given the demographics of the general population at T1 (four of these had greater than a 10% differential), and one coalition had a higher percentage of Black participants than reflected in the general population. At T2, all but two coalitions had a lower percentage of Black participants than the county demographics, with at least a 10% differential in four of the coalitions. All but one coalition had an under-representation of Latino members relative to the general population. It is possible that Black and Latino members were less likely to complete the member survey so this should be considered in interpreting the results. Overall, however, these findings suggest that ongoing attention needs to be paid to ensure that coalition membership reflects the general population. This is especially challenging with respect to SES. Coalitions are typically structured to facilitate involvement from those who can attend meetings on work time and/or whose job aligns with the mission of the coalition. Using college education as an indicator of SES, all of the coalitions had a very high percentage of college graduates among their membership relative to the population in general at both timepoints (ranging from 61.1% to 89.5% at T1). In the general population, just 8.7% to 26.7% of residents in these counties had a bachelor's degree [36]. Still, at T1, 24.0% of members reported not having a college degree, and 21.4% reported no college degree at T2, thus suggesting that close to a quarter of coalition members reflected education levels of the general county populations.

Nontraditional sectors

Given the importance of addressing SDOH in an initiative focused on health equity, we also asked about nontraditional sectors reached through these various mechanisms. With respect to participating in data collection, coalitions engaged food banks, churches, libraries, clients of social service agencies, shelter

residents, chamber of commerce leaders, faith-based organizations and ministerial associations, housing authorities, industry leaders and workers, first responders, behavioral health professionals, and elected officials. Additionally, in addition to the usual sectors of education, health care, and social/human services, all of the coalitions had business, local government, and community-based organizations present on their coalitions. All but one had faith-based representation, and over half had representation from civic organizations, mental health/behavioral health, law enforcement, neighborhood groups, elected officials, housing, and recreation. This diverse sectoral representation was another mechanism for ensuring that a range of perspectives were included in the coalitions' efforts toward health equity.

Opportunities for leadership development

Another indicator of progress in strengthening community capacity is the extent to which new leadership opportunities are created. Leadership opportunities can provide a structure through which current and potential leaders can contribute their talents, as well as enhance their skills through exposure to new ideas, perspectives and experiences. Table 24 below shows how membership on the coalitions offered a range of growth opportunities to coalition members in general, and coalition members from groups prioritized across many of the coalitions (e.g., lower SES and Black). These opportunities ranged from serving in an official leadership position to engaging in coalition efforts with potential to build confidence and experience in a range of leadership domains (e.g., needs assessment, presentations, strategic planning). A relatively high percentage of coalition members engaged in the full range of participation opportunities, with the highest percentage helping with the needs assessment and the lowest promoting changes in organizational policies or practices. Similar patterns held for coalition members with a lower level of education, and for Black coalition members, presenting information about the coalition to others was most common. In general, engagement was higher in many of the activities for Black coalition members as well as those with less education, relative to the overall coalition membership. This suggests that coalitions were successful in engaging their full membership and that they served as an effective mechanism for offering leadership development opportunities.

Table 24. Leadership development through coalition membership

Leadership development through coalition membership	% overall coalition members (n=239)	% black coalition members (n=48)	% coalition members with no college degree (n=45)
Served as an officer or chair of the coalition or subcommittees	27.8	35.4	40.0
Recruited at least one new person to the coalition	53.4	66.7	46.7
Presented information about your coalition to others	83.7	93.8	86.7
Helped to assess needs and/or assets of the county	86.6	89.6	95.6
Participated in setting priorities	76.8	80.9	84.4
Helped to select strategies for addressing identified priorities	81.9	89.6	86.7
Helped to implement at least one strategy from the CHIP	80.3	91.7	88.9
Promoted policy/organizational changes to reduce health disparities	60.0	76.1	55.6
Helped to evaluate the progress and accomplishments of the coalition	71.1	83.3	72.7
Helped to plan for sustainability of the coalition and/or its efforts	72.0	74.5	82.2

Formal leadership positions

As of June 2021 (end of year 4), among the nine coalitions that provided data, there were a total of 62 formal positions of leadership. The number of leadership positions per coalition range from 4 to 11. Leadership positions include Executive Committee Chair/Vice Chair, Youth Development Chair, and Board Members. Some coalitions had different leadership structures, such as Chattooga County, that did not have specific leadership

positions at this point in the Initiative, but rather a core group of people who completed key tasks at this stage. The percent of leadership positions filled by residents of the county ranged from 54.5% to 100%, with three coalitions completely resident led. Of coalitions that provided data, the percent of leadership positions filled by priority populations ranged from 12.5% to 100%. Examples of priority population include African American, senior citizen, minority, veteran, and faith leader.

Assistance with data collection efforts

In addition to leadership development opportunities through coalition membership, the coalitions provided opportunities by engaging priority population members and/or non-traditional community sectors to assist with data collection efforts, both for the community assessment and evaluation. All but one coalition offered such examples. For example, youth and program participants engaged in door-to-door data collection in Early County, food pantry clients distributed surveys in Chattooga County, and church members distributed surveys in Hancock County.

Leading implementation of a specific activity

Leading implementation of a specific activity is another mechanism for leadership development. All of the coalitions were able to share an example of grassroots residents, priority population representatives, and/or non-traditional sectors leading implementation of a coalition activity. Provision of mini-grants was particularly effective in promoting these opportunities. In Clay County, the City of Fort Gaines led a wall ball court effort and three African American churches implemented Body and Soul, both through mini-grants. In Miller County, several African American churches received health promotion mini-grants; and the Mural City Café and Council on Aging collaborated on healthy meals for seniors. Appling County also distributed mini-grants which allowed a church to build a playground and walking trail. Hancock used mini-grants for grassroots, diverse and non-traditional sectors of the community to create an early literacy station at the library, a tourism assessment and design guidelines for a historic walking tour, and economic development efforts with the chamber of commerce. The Lumpkin coalition facilitated a master gardener's club and girl scout troop working together on a community garden. Early County's C-Hope Ministries, a diverse group of ministers, ran a Neighbor-to-Neighbor program. In Haralson County, the junior leadership team led several activities, including Grow-a-Row, a peer-led anti-bullying program and a suicide awareness campaign, and the Community Christian Council hosted free indoor produce market and served as a produce hub for other organizations. Through a sports leagues engaging local industry, Chattooga County created sports team captain positions filled by blue collar and diverse industry workers.

Volunteer opportunities

Many of the CHIP and spin-off activities further provided volunteer opportunities that could serve as an initial stepping stone to greater civic engagement and/or grooming people for eventual leadership roles. Examples include, youth staffing the KidZone at the Peanut Proud community event, inmates building garden boxes in Miller County, volunteers building gardens as part of the Haralson Community Week of Service, volunteers serving as mentors for the Check & Connect program in Elbert County, food pantry clients volunteering at the pantry, seniors gleaning produce from farm fields in Appling County, and veterans helping with navigation events in Lumpkin County.

Training opportunities

Most of the coalitions also provided training opportunities beyond those offered by the Initiative to coalition members and other organizations in the community. For example, Early County offered Poverty Awareness, youth development, Advocacy 101, and ACES training. Haralson offered training on leadership and presentation skills Bridges out of Poverty, Language of Recovery, and Narcan. Elbert County offered training on character development, the Prevent T2 Program, Check & Connect Mentorship, Establishing Organizational Goals and Grant writing. Cook County offered trainings on trauma-informed care, Economics of Education, Collective Impact, Building Community through Collaboration for business leaders, Powerful Partnerships and Grant Proposals.

Appointment or election to leadership positions

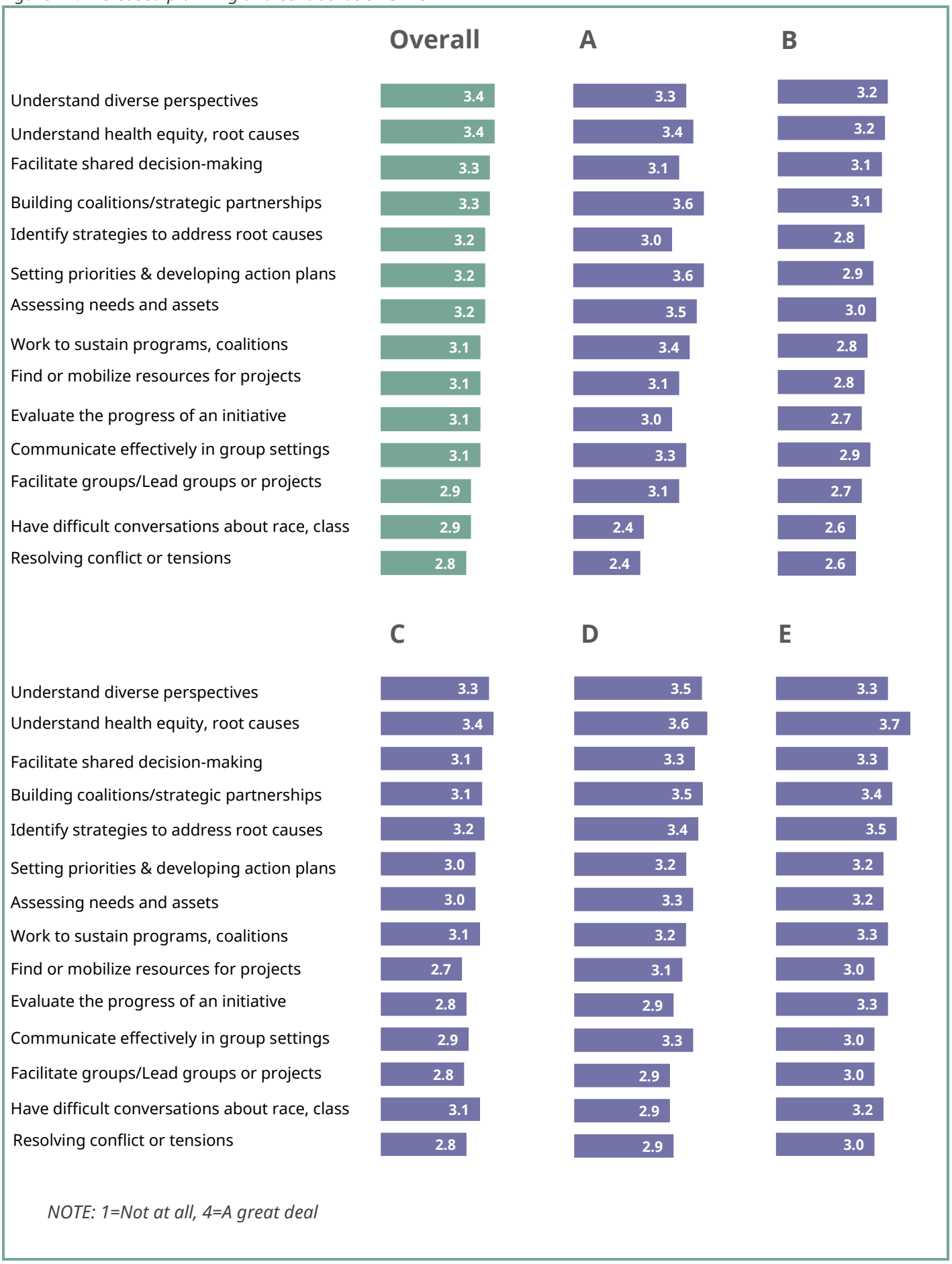
Lastly, a strong indicator of success in leadership development is the appointment or election of those affiliated with the coalitions to leadership positions beyond those created by the coalition. The most notable example of this is the new Mayor in Blakely who was emboldened to run for office, at least in part, due to his involvement with the coalition. He is the first Black Mayor in the history of the city. Other examples mainly involved those paid as staff for the Initiative, such as two coordinators in Appling County selected to participate in the Chamber of Commerce leadership program, the coordinator in Lumpkin County appointed to the county DFCS Board, a coordinator in Cook County appointed to a Census committee, and a staff person in Chattooga now chairing the local Family Connection Board.

Increased planning and collaboration skills

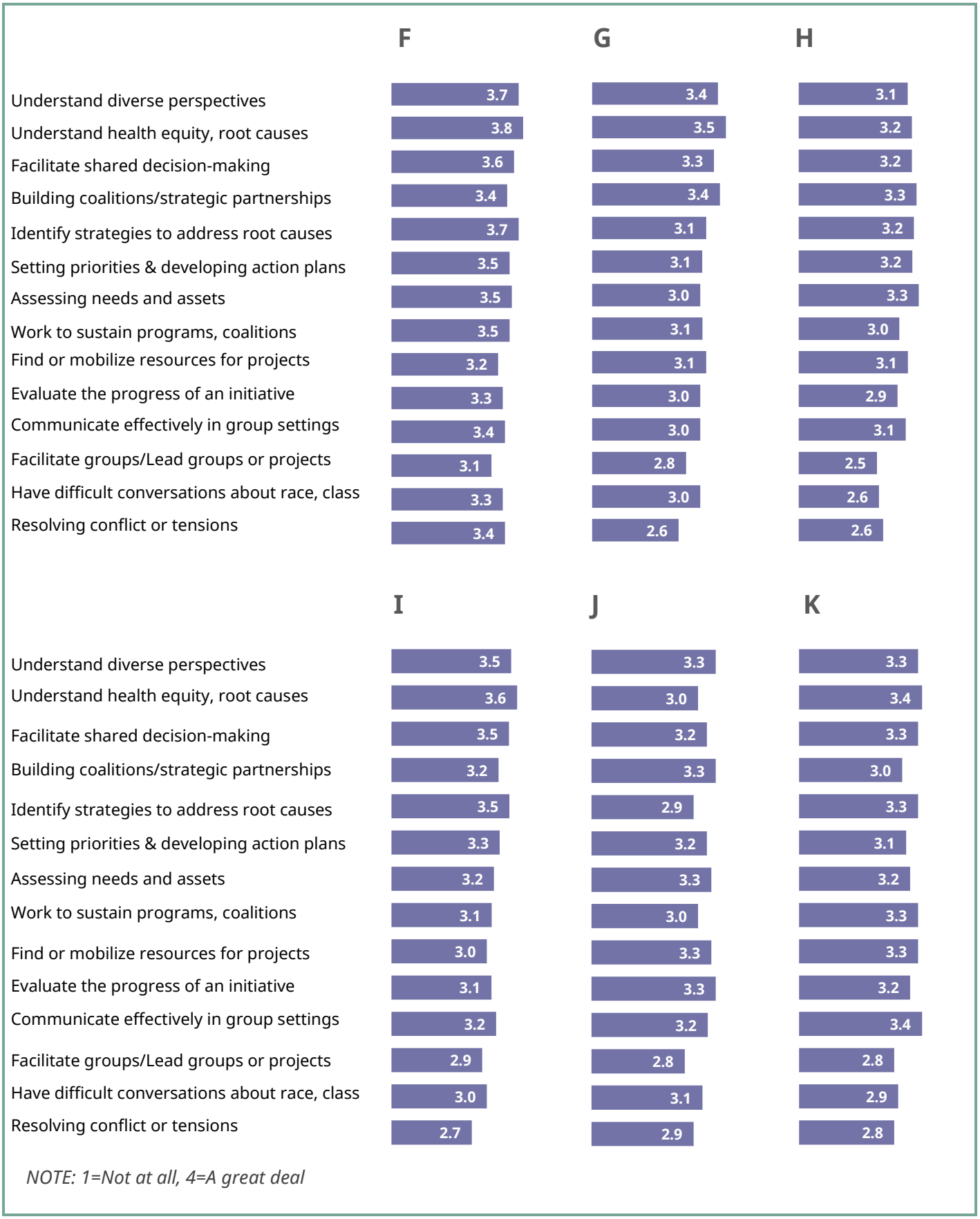
Participation in coalitions has the potential to strengthen skills that are essential to effective community problem-solving. Coalition members described their level of skill improvement in 14 categories (Figure 14). This included, but was not limited to, skills in building coalitions and strategic partnerships, assessing needs and assets, and communicating effectively in group settings. Response options ranged from 1=not at all to 4=a great deal. Overall, the greatest skill gain was reported for understanding diverse perspectives, followed by understanding health equity and its root causes.

The lowest skill gains were reported for resolving conflict or tensions, having difficult conversations about racism or social class, and facilitating groups/leading groups or projects. Skill gains in resolving conflict or tensions may have been low because most coalitions did not report much internal conflict or tension through the Initiative.

Figure 14. Increased planning and collaboration skills



NOTE: 1=Not at all, 4=A great deal



NOTE: 1=Not at all, 4=A great deal

Personal/organizational networks expanded

We asked in the Year 3 interviews about whether coordinators and coalition partners personal or professional networks had been expanded as a result of their involvement in the Initiative. Interviewees from several coalitions described numerous ways their professional networks were expanded (Table 25). Several interviewees valued the professional development and learning experiences they received through their work with the coalition and the management team. Others commented about how they appreciated networking opportunities and forming new connections with organizations and individuals throughout their county. A few interviewees were focused on how their expanded networks allowed them to work together on coalition strategies. In one instance, a coordinator described receiving calls from organizations in neighboring counties who wanted to replicate the work in their own counties. Other interview participants described gaining evaluation support from a partner organization and being better able to serve their clients because of their new relationships developed through *The Two Georgias Initiative*. Some interviewees discussed personal gains as a result of their involvement with the Initiative, including forming personal bonds and friendship with their fellow coalition members and making connections that would serve their personal endeavors/ interests.

Table 25. Networks expanded or linked as a result of Initiative

Professional networks	# coalitions
Professional development/learning	5
Networking/new connections	4
Coalition work	2
Evaluation support	1
Better serving clients	1
Personal networks	
Formed personal bonds with coalition members/partners	2
Making connections for personal endeavors/interests	1

In 2021, coalition members were asked to indicate how relationships may have changed between their organization and others as a result of participation in the *Two Georgias Initiative*. The ways organizations and groups relate to each other were examined through exchange of information, coordinating services, and undertaking joint projects, programs, or activities. Overall, county-level data indicated an average increase in groups/organizations with whom their organization collaborates (Figure 15).

These patterns largely remained the same when broken down by education and by race/ethnicity. When comparing responses of those with and without college degrees, the only difference was that those without college degrees more often said there were 1-2 more groups with whom they now undertake joint activities while those with college degrees more commonly said there were 3 or more groups. Response patterns did not differ by race or ethnicity.

Figure 15. Change in relationships between organizations, as a result of Initiative

Sense of community

In their Year 5 interviews, all nine coalition coordinators credited *The Two Georgias Initiative* with helping to strengthen a sense of community in their county (Table 26). There were a few main ways this happened. First, the coalitions created vast and expansive networks of interconnected partner organizations and members. Coordinators described how their coalition helped bring in new partners, re-engage old partners, and form relationships outside of the coalition. As one coordinator said:

> *"One of the biggest successes is just, again, programs and different things were happening in silos and different places, and it wasn't really connected. Now all of these things are interconnected and everybody kinda knows what everybody else is doing. It has created that community."*

Interviewees from several coalitions also described the importance of communicating well and working together in an effective manner. Communicating well meant reaching out on a regular basis with respect, and sometimes it meant just listening. Interview participants described how working together, brainstorming ideas and identifying solutions helped create a broader sense of belonging. Another important way that a sense of community was strengthened was through in-person events and meetings that engaged diverse groups and partners. Several interviewees discussed the importance of being together in-person, especially post-COVID, at both coalition meetings and various coalition and other community events. Interviewees described how planning events jointly with other partners helped strengthen those relationships. Events were also a valuable mechanism for reaching community members and priority populations, to raise awareness about the coalition and its work, to get their input on community needs, and to simply bring people together.

Table 26. Strengthened sense of community as a result of Initiative

How sense of community was strengthened	**# coalitions**
Expansive networks of interconnected partners/organizations and members	8
Communicating well and working effectively together	7
In-person events and meetings engaged diverse groups and partners	6
Including the community in decision-making elements	4
Increased visibility of coalition work helped people draw in	3
Volunteering across programs	3
Understanding/representing diverse perspectives/cultural awareness, health equity, root causes	2
What groups are left out	**# coalitions**
Elderly	2
Youth	1
Off-grid populations (no internet, transient)	1
Migrant population	1
Suggestions for strengthening sense of community	**# coalitions**
Prioritize relationships with key community leaders, stakeholders, priority populations	4

A few interviewees described including community members in decision-making processes as a means to build relationships. Others described how the coalition grew in visibility, which drew new partners in, *"What ended up coming together was as the coalition had some wins and had some things that were mobilized and moved forward, it really showed each of the groups like hey, I wanna be a part of this. How do I get this—how do I participate?"* Another way that coalitions helped strengthen a sense of community was through volunteer opportunities with coalition activities, giving community members a chance to bond while working to address a need in their community. Finally, a few interview participants emphasized the importance of the coalition being considerate of and also representing diverse perspectives, understanding cultural awareness, health equity, and root causes of disparities.

Given the strong emphasis on the coalition itself, as opposed to the entire county population, we also asked interviewees what groups were left out of this strengthened sense of community, if any. A majority of the nine coalitions said there were no groups left out, though a few coordinators acknowledged that level of engagement changes over time. One said, *"Sometimes you just go through ebbs and flows and the partners do a lot, and then sometimes they have personal things going on and they dip down."* Another explained how the composition of the partnership naturally changed over time:

> *"Our partnership has grown, and so the number of people, they're different than they were when we started five years ago... some on the list of five years ago probably, I don't know where they are, but then we have others that have come in. It's extended to other organizations and individuals...It's just different, it's changed, everything always changes, you know that, so it's just evolved."*

Some groups that were identified as perhaps not feeling the strengthened the sense of community were elderly residents, who may be isolated to due to COVID-19 concerns, lack of transportation, or disinterest in activities, as well as youth and geographically/culturally harder to reach groups such as those living "off-the-grid" as well as migrant populations.

Interview participants from four coalitions offered suggestions for how to strengthen a sense of community, all of which focused on the crucial role of relationships in rural communities. Specific suggestions ranged from making sure to engage local leaders including government officials was as well as key stakeholders and allies, to be present in the places where people convene (e.g., churches, schools), to increase outreach to ensure community members from all walks of life are heard, to prioritizing relationships over funding sources or projects.

> *"I think the relationship piece—it's important everywhere but I feel like it's absolutely vital in the rural community. That absolutely impacts that. They wanna know who you are as a person. They don't really care about your initiative until they know that you are really in it for the right reasons. I think that relationship-building piece is slow. I think that's something in the rural community."*

Sense of trust

We also asked coalition coordinators in their Year 5 interviews about sense of trust, an important component of social capital, built in their communities as a result of their participation in the Initiative. All interview participants discussed positive changes in the sense of trust built in their community (Table 27). However, as an acknowledgement that progress is not always linear, one coordinator noted that COVID caused some temporary setbacks in terms of community trust, because of some groups who reverted to the old ways of doing things, excluding community voices in the process. Similar to their explanation about building a sense of community, interviewees from nearly all coalitions largely credited the collaborative partnerships for the increased sense of trust. Interviewees also ascribed the continuous funding that allowed for dedicated planning and implementation of strategies and other activities. Related to these assets, interviewees also described the importance of the coalition being consistent, stable, and accountable in and to the community. These factors are connected, as one coordinator explained:

> *"When we first got there, it was very much like, well, what are you really gonna do? I think that the continued big platform, money comin' in from a state agency and being able to bring others in…and create some consistency and some stability has really created a good bit of trust."*

In addition, a few coalitions discussed how having a shared leadership framework and working toward common goals strengthened relationships and built trust, as did leveraging existing trusted figures in the community.

Again, we asked interview participants what groups might have been left out of this increased sense of trust. Interviewees from nearly half of the coalitions said that there were no groups that were left out. Those who identified some groups who are left out referred to youth and young adults, marginalized groups, especially those with disability or who live in remote areas, a few county organizations, as well as parents/families who were the prioritized populations for certain strategies.

These gains in trust are appreciated in the context of myriad reasons for low trust prior to *The Two Georgias Initiative*. Several interviewees described the impacts of historical political conflict, social structures and norms, and racial bias. The lived experience of power being limited to a certain few over generations has led to a lack of trust in institutions and their potential for doing good. In addition, one interviewee described how people who have never seen diverse leadership or progress have come to believe it isn't possible. This further reduced trust and hope that change can be created. Others talked about how groups and individuals with conservative or traditional social views may have little trust in groups that are working to address health equity. A few coalitions commented that there are some groups in the community that simply choose not to engage because of pre-conceived notions about the coalition or its members or just wanting to remain independent. Competition among groups was also cited as a barrier to trust, as was a history of other groups failing to deliver change for the community. It is notable that the coalitions were able to build trust in spite of these barriers. Interview participants from a few coalitions had suggestions for building trust in rural communities: by increasing engagement of people from diverse backgrounds, approaching people and the work transparently and without judgment, and to understand the mindset and lived experience of rural communities.

Table 27. Strengthened sense of trust as a result of Initiative

Ways trust was built	**# coalitions**
Collaborative partnerships	8
Continuous funding supported planning & implementation	6
Consistency, stability, accountability	5
Shared leadership framework/common goals	4
Leveraged existing trusted figures	4
What groups are left out	**# coalitions**
No groups left out	4
Youth & young adults	3
Marginalized groups	3
Some county organizations	2
Parents/families on receiving end of Initiative	1
Reasons for distrust before *The Two Georgias Initiative*	**# coalitions**
Historic political conflict, social structures/norms, racial bias	4
Groups that choose not to be involved	3
Lack of trust in outsiders	3
Competitive atmosphere among different groups	2
Undelivered projects and misuse of funds from outside groups	1
Suggestions for building trust	**# coalitions**
Increase engagement of people from diverse backgrounds	2
Be transparent/nonjudgmental approach	1
Understand rural mindset	1

<u>Evidence of community power redistributed toward equity</u>

A final indicator of increased community capacity to address health equity was evidence of redistributed community power. Thus, a key topic of discussion in final round of key informant interviews was evidence of community power redistributed toward equity. Coalition coordinators and evaluators shared information about historical leadership in their community and what groups of people have been in power. They also described how the work of *The Two Georgias Initiative* has helped to shape and influence more equitable community leadership both within the coalition on health-related work and in their broader communities.

Current and historical power structures

There were common themes about those in formal leadership or influential positions in the county not representing the community's thinking and even indications among some communities that those in positions of political power could not be trusted (Table 28). Often, power is centralized, by nature of a rural community only having a single dominant city or county commissioner in leadership. One coordinator, reflecting on the make-up of their county's leadership, said*, "I just think about a couple of our commissioners, they're not necessarily representative of their constituents, they are representative of themselves, and that causes conflict. One of them just got voted out because of that, they represent themselves."*

Some imbalances in power were attributed to historical influences of racism and the continuing dominance of a "good old boys club" in leadership and other informal, yet powerful influences. One interviewee said *"I think the history of systemic racism in [name] County is the same in a lotta places in Georgia where more power needs to be given to the people that are the most disenfranchised or marginalized. I think that could be done."* Similarly, another said, *"You see, we are trying very hard to break into that good ole boy mentality of our legislators, and we're trying to invite them and to share with them the value of lifting up those at the bottom so that the whole community benefits. It's a process."*

A few coalitions noted that while steps toward more equitable leadership and representation had been taken, some groups of people in the counties had still not been reached or included in decision making processes and leadership. Representation on leadership boards was often not balanced by age, gender or race, although in several communities, people did feel that the leadership's demographics accurately reflected the community.

Table 28. Current community power structures

Current community power structures	# coalitions
Leadership not representing community thinking; political mistrust	4
White individuals dominate the formal community leadership structures/good old boys club	4
Historic systemic racism has lingering effects on who is in power	3
Some groups of people have still not been reached/included	2

Coalition changes and influences on county-wide leadership

The coalitions themselves changed over the course of the 5-year Initiative. With the focus on community voice, community partners had the opportunity to become active in decision-making processes. Additionally, several coalitions noted that the coalition itself was able to test out and provide a model of a transparent way of working collaboratively. This provided new opportunities for the community at large as well as specific organizations to be motivated and take active roles in the work being done.

Table 29. Changes in leadership practice

Changes in leadership practice	# coalitions
Collaborative and open new leaders (community oriented, communicative, race-conscious)	4
Dedicated and diverse representation on boards	3
Historical leaders lost credibility, election(s), and community trust	2

During the Initiative, communities did experience changes in leadership practice in the community as a whole (Table 29), a few counties saw that leaders who had been in power for years lost their credibility, community trust and ultimately some lost elections. One coalition leader said in regards to a formal community leader… *She "had been in power for years, and you never thought that she would lose that role. She lost it this year and she lost it drastically."*

In contrast there was an increase in dedicated and diverse representation on leadership boards, some of which was influenced by involvement in the coalition and a desire to get involved more deeply in community systems. In speaking about a local health care institution, a coalition leader said, "*…through the coalition that the representation, four out of the six are coalition members."* Several counties anecdotally saw a rise in new leaders who were more collaborative and open. They exhibited traits of good communication, consciousness towards racial equity and are more community-minded and open to community feedback. Some counties directly attribute this change in overall leadership style to the work of the coalition. In referring to the Initiative one coordinator said, "*They gave 11 counties uniquely to individually formulate and do what they needed to do by the voice of their community, and now we're looking at government doing that and it's amazing that what we are doing."*

As described earlier, a coalition member decided to run for mayor and was elected. "*Once Mayor [name] came onboard and saw interest, then of course, we always mention it because we do think that's big…Coming to [coalition] and Family Connection meetings is somewhat what did help him make his decision to even run for mayor.*"

Shifts in power towards equity

In addition to the example of a coalition member being elected as mayor, other prominent organizations shifted in power and demographics including a rotary club that welcomed historically racial minoritized members for the first time and a chamber of commerce becoming more demographically diverse as well. In addition to these powerful institutions shifting in membership, several counties saw the development of "resident boards" or other ways for community members to provide direct feedback to governmental leadership on strategic community and government planning. These included, for example, a citizen leadership program in the chamber of commerce, a community action council and the establishment of a non-profit forum.

County influence and visibility beyond formal leadership positions

One of the tangible benefits to an influential coalition over a 5-year period of time, were the ways that people and existing organizations gained visibility or credibility through associating with the coalition's work (Table 30). Partners from at least 11 different sectors, including traditional sectors such as faith, community-based organizations, and health care partners, saw a notable increase in their level of influence in the community. One of the prominent ways that this transpired was through frequent communication with the coalition which provided connectivity, information access and increased capacity for sub-sets of the community to engage with health knowledge and in healthy behaviors. Additionally, organizations shared power, both within the coalition and in the broader community through collaborative activities and developing and strengthening shared resources and networks.

> *"I think allowing the coalition to do the work of the health department shifted some of the onus off of them and allowed them to then do some of the equity work there locally. Which kind of relates back to allowing the community to do—to share power. I say all that to say I think that the health department was allowed the—trusted the community to implement things like the community gardens, for example. Like the SNAP gardens. The shared power of being able to implement something large like that really put the community in more of a role."*

Table 30. Ways partners and organizations gained visibility through Initiative

Ways partners/organizations gained visibility through the Initiative	# coalitions
Gained visibility or credibility through aligning with coalition and their work	5
Communication increased credibility, information access, and capacity	5
Shared power among coalition & community (collaborative activities, shared resources/networks)	4
Increased funding through community connection(s)-paying community for their time	3
Increased leadership training opportunities	3
New role models outside of leadership structures	1

Some organizations benefited from the community connections by gaining access to increased funding for their initiatives as well as individuals getting paid for their work rather than just needing to volunteer their time and expertise. Furthermore, the coalition was able to elevate work that was already being done in the community, including highlighting leaders and increasing leadership training opportunities. For example, one coalition leader said *"We have people that just came out of nowhere and became a partner…Well, I didn't know her from anybody and now she's well known in the community for her work".*

Change in Organizational Capacity to Address Heath Equity

The evaluation also documented changes in capacity to address health equity at the organizational-level, especially among the grantee or lead organization and organizational members of the coalitions. We examined institutional commitment to health equity, hiring practices to increase diversity, new structures for community input, and new or more frequent efforts to identify disparities [45].

Institutional commitment to address inequities among partner organizations

Interview participants described numerous ways that coalition partner organizations demonstrated an institutional commitment to address inequities (Table 31). One approach by partner organizations was to increase communication about inequities during meetings and/or to participate in meetings where health equity is the focus. Three coordinators said their own organization had made this change, as did one coalition's fiscal sponsor, as well as a key organization in at least one coalition county. Two coordinator organizations worked to address inequities by sharing information and providing resources.

Table 31. Institutional commitment to address inequities among partner organizations

Institutional commitment to address inequities among partners	# coalitions
Address and/or learn about inequities during meetings	
Coordinator's organization	3
Coalition fiscal sponsor	1
Key organizations/partners in the community	1
Address inequities by sharing information/resources	
Coordinator's organization	2
Key organizations/partners in the community	1

Changes in hiring practices among partner organizations

Coalitions also described a few changes in hiring practices among partner organizations (Table 32). A coordinator from one county said their own organization had placed an increased emphasis on the diversity of their staff. Another coordinator cited a key organization in the county that had done the same. Another coordinator described how one of their partner organizations used unconventional staffing approaches (e.g., program recipients as volunteers, organizations sharing part-time staff). A few coalitions discussed how there had not been changes in hiring practices in part because there had not been any hiring. These small, rural organizations have had relatively stable staffing in recent years. It was also noted that some of these organizations were already diverse.

Table 32. Changes in hiring practices among partner organizations

Changes in hiring practices among partners	# coalitions
Increased diversity focus	
Coordinator's organization	1
Key organizations/partners in the community	1
Unconventional staffing approaches	
Key organizations/partners in the community	1

Creation/enhancement of new structures to obtain community input among partner organizations

Interview participants were able to cite several newly created or enhanced structures to obtain community input among partner organizations (Table 33). Three coordinators discussed how their own organization increased data collection efforts through in-depth community outreach, conducting surveys and interviews, and using online data collection tools. In addition, at least one coalition's fiscal sponsor and one key partner organization did the same. Another way to obtain community input adopted by organizations was the addition of community training workshops and events, which was done by one coordinator's organization and one other community partner organization. Two coordinator's organizations developed public platforms for community input, including a kiosk for surveys in public places as well as intentional efforts to tap into the voices of community members and partners. In addition, one coordinator's organization added language to their bylaws requiring that spots on the Executive Committee be reserved for people experiencing disparities, e.g., residents of housing authority properties. By including diverse membership on the committee, this ensures opportunity for input by these members on behalf of a priority population.

Table 33. Creation/enhancement of new structures to obtain community input among partners

Creation/enhancement of new structures to obtain community input among partners	# coalitions
Increased data collection efforts	
Coordinator's organization	3
Key organizations/partners in the community	1
Added community/partner workshops and events	
Coordinator's organization	1
Key organizations/partners in the community	1
Developing public platforms for community/partner input	
Coordinator's organization	2
Bylaws specify Executive Committee must include those most impacted by inequities	
Coordinator's organization	1

Adoption of more frequent/new ways to examine disparities among partner organizations

Three coordinators said their organization added health equity to their mission statement since their participation in *The Two Georgias Initiative*. Key organizational partners in at least 3 counties also added health equity to their mission statements. In addition, one coordinator noted that their organization already had health equity as part of their mission. Finally, a coordinator described how their own organization as well as partner organizations in the community had undergone a change in mindset with respect to health equity. This coordinator explained how their own organization was likely the first to experience this mindset shift, which eventually spread to partners (Table 34).

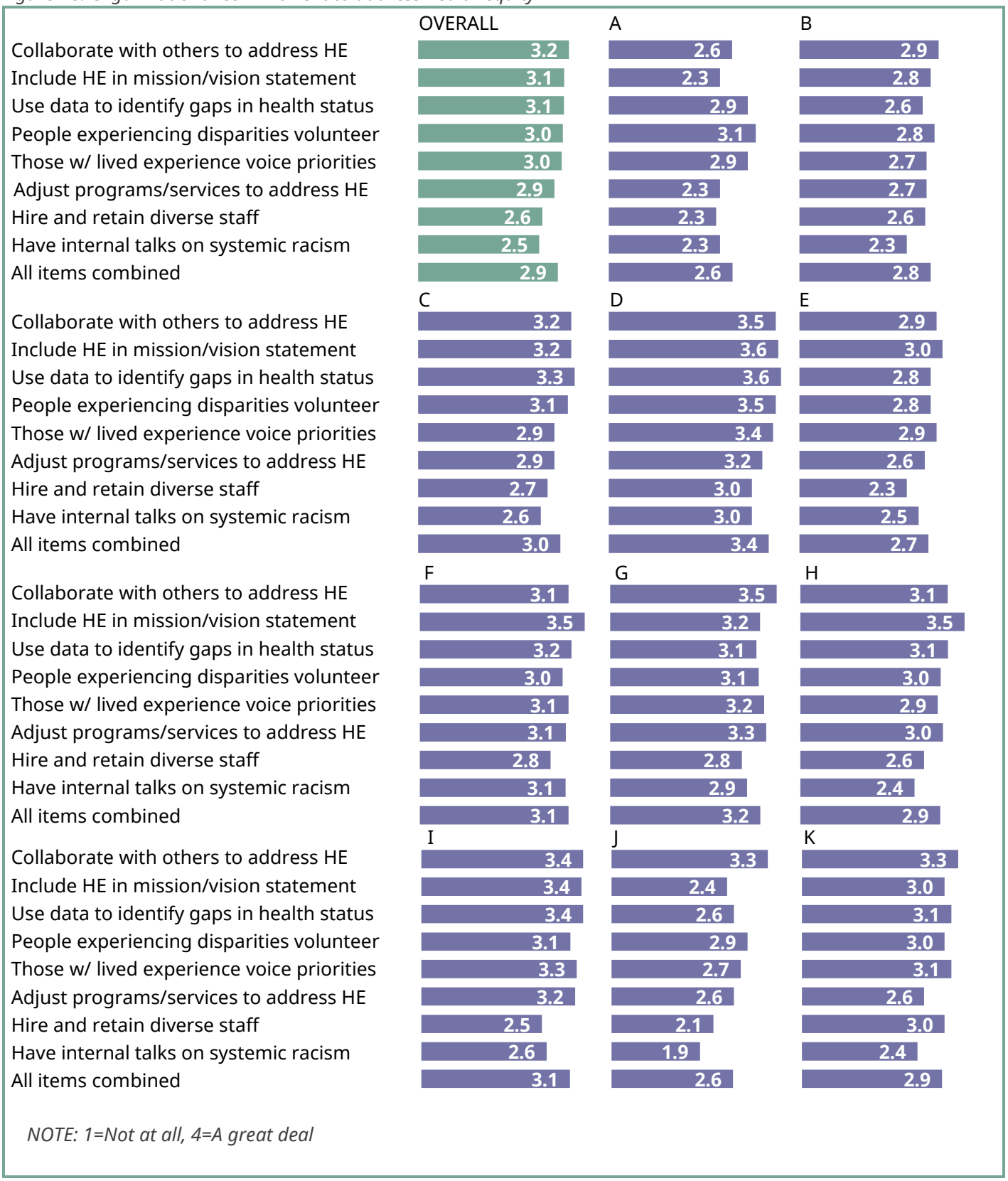
Table 34. Adoption of more frequent or new ways to examine disparities among partners

Adoption of more frequent/new ways to examine disparities among partners	# coalitions
Revised mission statement to include health equity	
Coordinator's organization	3
Key organizations/partners in the community	2
Already had health equity in mission statement	
Coordinator's organization	1
Change in mindset toward health equity - e.g., also more inclusive of families	
Coordinator's organization	1
Key organizations/partners in the community	1

In the T2 coalition member surveys, coalition members responded to eight statements that assessed to which extent participation in the *Two Georgias Initiative* increased or elevated their organization's commitment to address health equity. As Figure 16 shows, the greatest gains in organizational commitment to health equity were seen in collaborating with other organizations in the community to address health equity, including health equity in organizations' mission or vision statements, and using data to identify gaps in health status. The average response for these items was between "some" and "a great deal" of gain in organizational capacity.

The lowest gains in organizational capacity among organizational representatives on the coalitions were found in hiring and retaining diverse staff and internal conversations or trainings on racism. The average response for these items was between "not much" and "some" gains in organizational capacity. This may indicate a need for a greater understanding of different levels of vulnerability that may occur within rural communities, especially as a result of systemic racism and/or income inequality, and/or training on how to translate deeper understanding of health inequities into direct action within one's own organization.

Figure 16. Organizational commitment to address health equity



NOTE: 1=Not at all, 4=A great deal

Summary

One of the major goals of the *Two Georgias Initiative* was to strengthen community readiness and capacity to address health equity**.** On average, coalition survey data indicated that *community readiness to address health equity* increased slightly from 5.2 at T1 to 5.7 at T2 (out of 9). At T2, six coalitions had increased community readiness to address health equity, with four moving from Pre-planning to Preparation and two moving from Preparation to Initiation. One community was already in the Initiation stage by the end of the planning phase of the Initiative.

Key informant interviews captured changes in measures of *community capacity to address health equity,* including evidence of critical reflection on issues on health equity, in which participants described how coalition staff, partners, community organizations' views of health equity and related efforts evolved over the five years of the Initiative. Another measure of change in community capacity included opportunities for diverse and/or grassroots residents to have a voice in the Initiative. Community voices were solicited through community assessment, providing input through coalition events and evaluation-related activities, serving as a coalition or work group member, and involving nontraditional sectors. Opportunities for leadership development, included formal leadership positions, assistance with data collection efforts, leading implementation of a specific activity, volunteer opportunities, training opportunities, and appointment or election to leadership positions. The coalition member survey measured increased planning and collaboration skills, which showed that of 14 skills asked, the greatest increases from T1 to T2 were reported for understanding diverse perspectives, followed by understanding health equity and root causes of inequities. Coalitions described several benefits of *personal/professional networks expanded*, including professional development and learning experiences, networking and forming new connections, gaining evaluation support, and being better able to serve their clients. Interpersonal benefits included personal bonds and friendships. County-level coalition member survey data at T2 indicated an increase in the number of groups/organizations with whom their organization collaborates to exchange information, coordinate services, and undertake joint projects, programs, or activities.

Change in *organizational capacity to address heath equity* was explored in key informant interviews, specifically institutional commitment to health equity, hiring practices to increase diversity, new structures for community input, and new or more frequent efforts to identify disparities. Coalition member surveys assessed the extent to which participation in the Initiative increased or elevated their organization's commitment to address health equity, showing the greatest gains in collaborating with other organizations to address health equity, including health equity in organizations' mission or vision statements, and using data to identify gaps in health status.

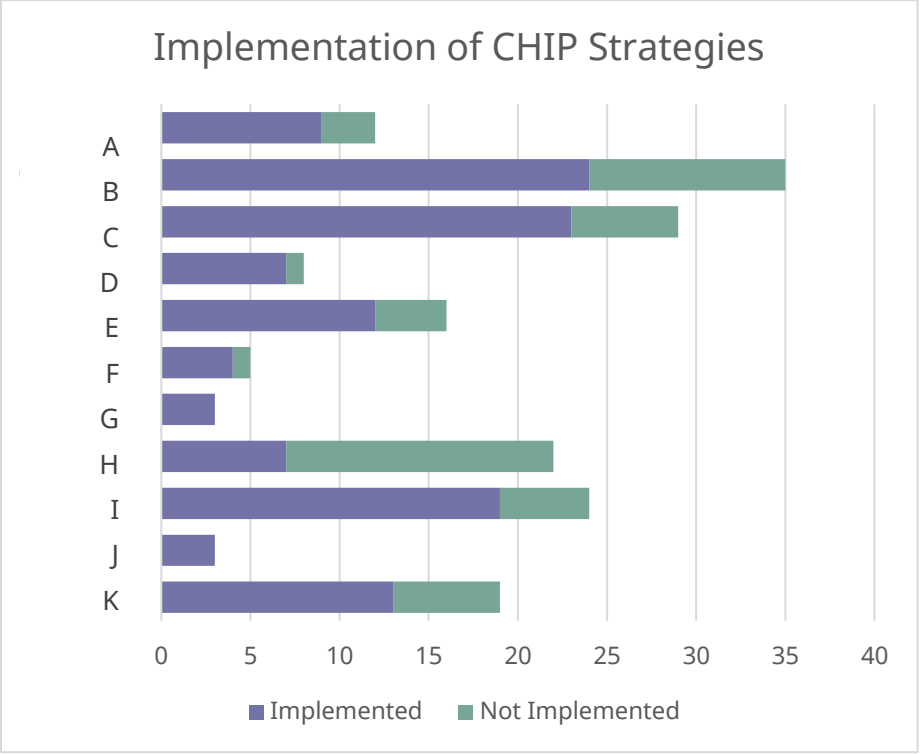
PART 4. IMPLEMENTATION OF THE CHIPs AND CONTEXTUAL FACTORS

Implementation of the CHIPs was a major component of the Initiative, with three of five years (years 2-4) dedicated to carrying out strategies that coalition partners decided would best address health equity in their communities. Implementation continued in the final year of the Initiative, with an added focus on achieving sustainability. This section describes CHIP implementation, including major priority areas and common strategies related to each. In addition, we have summarized barriers and facilitators to success at various stages of the Initiative as reported by the coalitions themselves, and other contextual factors that may have impacted coalitions and implementation.

Implementation of the Community Health Improvement Plans (CHIPs)

The coalitions developed CHIPs in the first year of the Initiative. As shown in Figure 17 below, some of the coalitions included a large number of strategies and others prioritized just a few. Overall, of the 176 strategies included in the original CHIPs and tracked by the evaluation, 124 (70.5%) were implemented and 52 were dropped or simply never gained traction. Two of the coalitions, with fewer strategies, implemented everything planned, although both of them adapted or changed their original plans to some extent (e.g., changing from one evidence-based program to another; shifting from an external partner delivering a program to in-house delivery; expanding from telehealth to a multi-pronged approach to increase health care access). The coalitions with more extensive CHIPs were less likely to implement the full CHIP. For some of these coalitions, the CHIP development process was very inclusive, meaning that if one partner suggested a priority activity, it was likely to be included in the plan. Full implementation of these more comprehensive CHIPs was then dependent on a large number of community partners to follow-through on implementation. Given the Foundation's flexible approach, tight adherence to the original CHIP was not required and adaptations and changes to the CHIP were acceptable.

Figure 17. Implementation of CHIP strategies by coalition



COVID-19 was a significant disruptor of CHIP implementation. Of strategies discussed in Year 4 interviews, 51.0% were interrupted due to COVID-19, 14.3% were expanded, and 34.7% were not impacted. By the end of the Initiative, many of these interventions had begun again or been adapted to accommodate changes precipitated by COVID (e.g., virtual delivery). An in-depth analysis of the impact of COVID-19 on the *Initiative* is available, and a brief summary is included later in this section.

The following sections discuss each of the major topics included across the CHIPs. Similar intervention strategies are grouped, and coalitions implementing each type of strategy are listed along with priority populations. General information on reach is also provided.

Food Access

Intervention strategies to address food access were the most common across coalitions (Table 35), along with healthy lifestyle education and nutrition guidelines and support. Eight coalitions were active in the food access space with seven creating or expanding community gardens. Gardens were created at a range of settings, such as schools, churches and senior housing. The number of new gardens (range 1-7 per coalition) tended to reach fewer than 25 people per garden. Mobile pantries or produce trucks were created or expanded by four coalitions, with new sites added to reach seniors and low-income households. These were estimated to reach 50 to 200 persons per site. Other strategies implemented by fewer sites included gleaning and distributing the food through food pantries, establishing mini-pantries in partnership with churches, implementation of a summer food backpack program, vouchers to a farmer's market, and building of a greenhouse for youth. Reach of these initiatives varied with the backpack program and expanded food access locations estimated to reach up to 2,000 individuals.

Table 35. Food access strategies and priority populations

Common Strategies	Coalition	Priority Population or Full County (FC)
Community gardens at churches, schools and other community locations	Appling, Miller, Chattooga, Hancock, Clay, Cook, Decatur	Low-income, Seniors, Youth, Faith, FC
Mobile pantry/produce truck	Miller, Chattooga, Haralson, Cook	FC, Low-income, Seniors
Gleaning & produce distribution	Appling	Low-income, Seniors
Food pantry expansion	Clay, Cook	FC
Farmers market vouchers	Appling	Seniors
Summer food backpack programs	Haralson	Low-income youth
Youth empowerment greenhouse	Clay	Youth
Blessing boxes	Hancock	Low-income

Healthy Lifestyle Education and Nutrition Guidelines and Support

Healthy lifestyle education and nutrition guidelines/support were also commonly addressed (Table 36), with eight coalitions implementing strategies within this domain. Intervention strategies clustered into two general groupings, with the most common being healthy lifestyle and nutrition education sessions offered through churches and other organizations that reached students, seniors, employees, and others. Six coalitions offered such sessions, including the evidence-based Diabetes Prevention Program. These generally reached 25-50 people with lower-income individuals prioritized by at least one coalition. Coalitions collaborated with partners and offered their programming in several sites.

A second set of interventions focused on creating conditions in which following healthy lifestyle guidance was supported through environmental change. Three coalitions facilitated adoption of healthy eating guidelines in schools and other organizations, two established breast-feeding friendly locations, and another promoted healthy menu items in restaurants and worksite food services. Reach of these strategies varied by the size of the organization, with one coalition estimating a reach of 750 individuals through multiple organizational partners. Priority populations, when designated, tended to be lower-income individuals.

Table 36. Healthy lifestyles education & nutrition guidelines/support strategies & priority populations

Common Strategies	Coalition	Priority Population or Full County (FC)
Healthy Lifestyle Education		
Healthy lifestyle & nutrition education in churches and other organizations	Decatur, Appling, Clay	FC, Students, Low-income
National Diabetes Prevention Program	Elbert	FC
Community newsletter	Miller, Clay	FC
Successful senior living	Decatur	Seniors
Healthy lifestyle education	Haralson	FC
Supporting Hands of Decatur County- information sharing healthy lifestyles, access to health services	Decatur	Seniors
Nutrition Guidelines and Policies		
Health ministries and policies created	Clay	Faith
Adopt healthy eating guidelines in organizations	Chattooga	Low-income, Seniors
Enhance school nutrition policies	Clay, Miller	Youth
Healthy menu options in restaurants	Miller	Employees
Promote PSE change in worksites to encourage healthier lifestyles and chronic disease prevention	Early	Employees
Breastfeeding sites/ Lactation promotion	Miller, Appling	FC, Low-income
Other		
Community weight loss challenge	Decatur, Miller	FC

Health Care Access

Health care access was another common priority (Table 37), with seven coalitions implementing strategies to improve health care access. The majority of these were systems changes to improve referral systems and increase access to health care via mobile services or telehealth. Many of these efforts prioritized low-income residents, and reach varied from 25 for referral of FQHC patients to a lifestyle change program, to an estimated 5,000 with access to mobile health services.

Table 37. Health care access strategies and priority populations

Common Strategies	Coalition	Priority Population or Full County (FC)
Establish/Strengthen referral systems, including transportation		
Clinical change strategies & referrals to lifestyle change program	Early	Patients
Clinical-community linkages referral system	Haralson	Patients
Transportation pilot program	Haralson	Low-income
Partner with transportation to reduce no-shows	Chattooga	FC
Health screenings at community events	Decatur, Clay	FC
Community navigation events with referrals	Lumpkin	Low-income
Medical home & patient assistance programs to reduce ER visits	Miller	FC
Mobile health services/Telehealth		
Provide mobile health/dental services	Chattooga, Miller	Low-income
Telehealth availability	Lumpkin	Low-income
Health fairs		
Public checkup and health screenings	Miller	Low-income
Annual health fairs	Chattooga	Low-income
Other		
Provision of free and reduced cost prescription medications	Haralson	Low-income
Expand health care services among existing health partners	Cook	FC
Community resource guide	Miller, Haralson	FC, Low-income seniors, youth

Leadership Development/Youth Development

Seven coalitions addressed leadership and/or youth development (Table 38), with most of them facilitating youth development through specific programs such as Be THE Voice Anti-bullying program. Two coalitions strengthened youth leadership skills by forming youth advisory boards and providing them with a range of growth opportunities. Adult-focused leadership development was less common, with one coalition expressly engaging community members to advocate for health equity via specialized trainings beyond those provided by the Initiative. This effort prioritized impoverished and homeless populations, reaching fewer than 25 residents. Youth-focused activities typically reached between 50 and 200 youth.

Table 38. Leadership development/Youth development strategies and priority populations

Common Strategies	Coalition	Priority Population or Full County (FC)
Build community capacity to advocate for health equity	Early	Homeless, low-income
Be THE Voice Anti-bullying Program	Haralson	Youth
Implement a family coaching/mentoring program	Elbert	Youth
Increase organizations with positive youth development programs	Chattooga, Elbert	Youth
Youth empowerment group and youth advisory board	Clay, Early	Youth
Youth empowerment and education	Haralson	Youth
Career, technical, and agricultural education in high school consumer science department	Decatur	Youth
Soft skills training overcoming obstacles in school	Clay	Youth
Georgia Council of the Arts – photovoice project	Clay	Youth

Access to Physical Activity Opportunities

Initiatives to improve community's access to physical activity were also very common with six of the coalitions doing work in this area (Table 39).

Table 39. Access to physical activity opportunities strategies and priority populations

Common Strategies	Coalition	Priority Population or Full County (FC)
School policy - shared use agreement to allow supervised use of fitness center	Clay	Youth
Establish joint use agreements for school equipment use	Clay	FC
Expand adult recreation activities	Chattooga, Appling, Decatur	Mill workers, seniors
GEO-caching trails	Clay	FC
Improve or build walking trails & sidewalks (including lights)	Decatur, Miller, Clay	FC
Playground and play space improvements	Appling, Hancock, Chattooga	Youth
Recreation facilities and courts improved	Appling, Decatur, Chattooga, Clay	FC
Summer day camps	Clay	Youth
Free community exercise classes	Miller	FC
Make scholarships available for organized recreation	Chattooga	Youth
Spring Creek recreation program stipends-youth	Miller	Youth
Center for comprehensive youth activities	Clay	Youth

Several coalitions focused on improving aspects of the physical environment to enable free exercise opportunities. Examples include sidewalk and trail improvements as well as repairing or building new play and recreational spaces. Two coalitions succeeded in establishing joint use policies for increased access to places

to exercise. Three were able to expand recreation activities and one established a GEO-caching program. A day camp, free exercise classes, and financial support for organized recreation were also provided by the coalitions. Most of these opportunities prioritized youth or all county residents. Reach, when estimated, generally ranged from 25 to 500 individuals.

Behavioral Health

Four coalitions addressed behavioral health concerns (Table 40) primarily through establishing referral networks and mental health clinics, most notably in schools. One coalition also trained staff in a number of organizations in screening and referral for mental health treatment. Another coalition trained youth-serving organizations on mental health issues, and a third coalition distributed printed information on how to address mental health issues to a range of organizations. Priority populations were viewed as those needing behavioral health services and associated gatekeepers or service providers; reach of the efforts ranged from less than 25 to an estimated 350.

Table 40. Behavioral health strategies and priority populations

Common Strategies	Coalition	Priority Population or Full County (FC)
Mental health clinics - school and community	Clay, Chattooga	Youth, FC
Train organizations to screen/refer for mental illness	Chattooga	BH
Establish behavioral health screening/referral network	Chattooga	BH
Promote behavioral health through brochure and social support counseling	Appling	FC
Youth mental health first aid programming	Haralson	Adults serving youth

Note: BH refers to individuals with behavioral health challenges

Literacy and Education

Three coalitions addressed literacy and early education (Table 41). Two coalitions increased access to books by establishing "little free libraries" with the aim to support access to books for those who may not have transportation or easy access to traditional libraries. One coalition supported achievement of quality ratings for childcare centers and also implemented the Baby Hornets program. Another coalition extended Head Start hours. Priority populations included youth, with an emphasis on low-income families. Reach estimates varied from less than 25 to 750 for one of the small libraries.

Table 41. Literacy and education strategies and priority populations

Common Strategies	Coalition	Priority Population or Full County (FC)
Establish additional lobby/small libraries	Cook, Hancock	Low income youth
Achieve quality rating for childcare centers	Cook	Low-income
After school program	Clay	Youth
Extend Head Start hours	Hancock	Children
Implement the Baby Hornets program	Cook	Children

Safety

Safety initiatives were undertaken by two coalitions (Table 42). One coalition established a partnership to provide low income seniors with life alert buttons. Another expanded the reach of SafeKids by training additional specialists and also expanded school participation in Safe Routes to Schools. These efforts prioritized youth and students, and reached 25 to 200 individuals.

Table 42. Safety strategies and priority populations

Common strategies	Coalition	Priority Population or Full County (FC)
Expand reach of SafeKids for motor vehicle safety	Chattooga	FC
Provision of Life Alert Buttons	Haralson	Low-income seniors
Increase schools in Safe Routes to Schools	Chattooga	Youth

Substance Use

Two coalitions addressed substance use (Table 43), one focused on tobacco and the other on opioids. The initiatives range from naloxone trainings to schools adopting anti-tobacco programs, installing signage to prohibit smoking in public places, and establishing a referral network for tobacco cessation in a range of organizations, including mill workers. The school-based efforts reached over 3,500 students and the cessation referrals reached 50-100 persons.

Table 43. Substance use strategies and priority populations

Common strategies	Coalition	Priority Population or Full County (FC)
Naloxone policy implementation for first responders	Haralson	FC
Naloxone training in schools	Haralson	FC
Increase adoption of smoke-free park/recreation policies	Chattooga	FC
Increase schools adopting Tar Wars	Chattooga	Youth
Establish a referral network for tobacco cessation support/aids	Chattooga	Mill workers
Increase signage for no smoking/vaping	Chattooga	FC

Housing

Three coalitions worked on housing-related issues (Table 44). One collaborated with city government to establish a housing initiative with the goal of developing policies that would improve access to safe, decent and affordable housing in the county. Others focused on code enforcement and a home repair program for seniors. Low-income residents and seniors were the priority population, with the home repair program reaching less than 25 persons.

Table 44. Housing strategies and priority populations

Common strategies	Coalitions	Priority Population or Full County (FC)
Adopt and implement policy to increase access to safe, decent, affordable housing	Early	Low-income
Environment & housing code enforcement	Miller	FC
Home repair program/information	Haralson, Hancock	Seniors, FC

Economic Development

Economic development initiatives were implemented by three coalitions, with varying approaches (Table 45). One coalition focused on

Table 45. Economic development strategies and priority populations

Common strategies	Coalitions	Priority Population or Full County (FC)
Rural zone for economic development	Clay	FC
Local flea market	Hancock	FC
Workforce development at Technical College	Lumpkin	Low-income

creating a rural zone to strengthen the local business sector. Another established a flea market, while a third established a partnership to help displaced workers get referred and/or prepared to apply for new positions. Most of these efforts targeted the full county, but the workforce development effort prioritized low income individuals and reached 25-100 individuals.

Facilitators of Success

Table 46 shows facilitators of success as described in annual key informant interviews and program documents (e.g., grantee progress and final reports, annual applications). The numbers in the "# coalitions" column represents the cumulative total number of coalitions that ever cited a particular facilitator to success in any year from any source. Throughout the Initiative, coalitions described how strengths among coalition staff and partner organizations contributed to their success. Coalition staff, i.e., coordinators and local evaluators, were highly engaged and had rapport with coalition partners and community. In addition, they showed flexibility and commitment to both the work and the community. As one local evaluator described the coordinator's approach, *"[The coordinator] always kept in mind everybody. If one of the organizations wanted to write a grant or do some funding or whatever, it was never really a no. It was always let's see how we can help make this happen. I think that part really brought people to the table."* Many interview participants credited past work experience that helped them in their current roles. Working relationship between staff were also credited as a facilitating success by several coalitions.

Table 46. Staffing and partner related facilitators of coalition work

Coalition staff	# coalitions
Staff engagement, rapport with coalition members and community	11
Staff flexibility and commitment to the work and community	9
Alignment with other work, experience	9
Staff working relationships	8
Coalition/Partner organization attributes & benefits	
Partner organizations provide resources, access to priority population	11
Coalition member connection and engagement w/ the community	10
Community/resident interest (and in later years -involvement) in priority areas	10
Community willingness to come together, discuss community issues	10
Diversity of membership (includes sectors) and meetings	9
Coalition member collaboration and commitment to the work	8
Cross-site or regional collaboration (with other coalitions) provides ideas and resources	4
Coalition processes/outputs	
Relationships improved coordination, implementation, leadership and allowed coalition to better reach and serve community	11
External funding and donations sources helped advance/sustain the work	10
Technology & media (including virtual meetings) supported communications, tracking progress	9
Improved focus and prioritization of interventions	7
Coalition adaptability, flexibility, and creativity	5
Streamlining coalition processes & organization to increase efficiency	4

Several attributes and benefits of partner organizations contributed to success. Coalitions benefited from partner resources, including financial and in-kind support as well as human resources. This was mentioned by coalitions each year, but something we heard newly in Year 5 interviews was that coalitions were also able to provide resources to their partners, suggesting reciprocity and mutually beneficial partnerships. Partner organizations were able to leverage their own connections to the community to help increase the reach of coalition strategies. Nearly all coalitions also described coalition member connections and engagement with the community as helping coalitions achieve their goals. Community residents demonstrated an interest in priority areas, showing up to provide helpful support and input. A general community willingness to come together and discuss community issues was also supportive of coalition work. Coalitions discussed how the

diversity of their membership in terms of both demographics and sector representation was beneficial as it further increased their capacity and reach. A large number of coalitions also discussed the importance of members collaborating and showing their commitment to the work through taking ownership and leading activities. A few coalitions, especially those in the southwest corner of the state, benefited from being able to collaborate with other Initiative coalitions in neighboring counties who had similar needs and resources.

Beginning largely in later years, coalitions also identified how staff, coalition members, and community residents engaged in processes that helped achieve their objectives. All talked about how pre-existing and new relationships improved coordination, implementation, and leadership which resulted in coalitions better able to reach and serve the community. Nearly all coalitions also discussed how crucial additional funding and donations were to their ability to implement strategies. As one coordinator described, *"it's early in the new game essentially since our Two Georgias' funding has gone away and that whole grant process has ended. At this point, we're good because, of course, I think because of our Two Georgias' work and some of the benefits of being a Two Georgias grantee. It positioned us to look favorably for different grantors."* Partner use of technology and media supported communication among partners and with the broader community, raising awareness of coalition efforts, events, and achievements. Several coalitions described how COVID-19 forced them to work differently, which resulted in improved focus and prioritization of interventions, and adaptability to changing circumstances and creativity in coming up with solutions to problems. Finally, numerous coalitions also described how their efforts to streamline their processes and organization (e.g., in structuring meetings, realignment of work groups) increased their efficiency.

> *"We have established a community partnership that is committed to improving the health outcomes of our citizens. Such a partnership did not exist in our community at the beginning of this process. Working together, this new partnership was able to assess the concerns of our community, another significant achievement, and identify individuals who were both qualified and committed to addressing these concerns."*

Beyond strengths and benefits of staff and partners working together, coalitions identified other areas that were helpful to coalition success (Table 47).

Table 47. Other facilitators to coalition success

Evaluation	# coalitions
Small community size facilitates data collection & community engagement/rapport	8
Evaluator engagement and resources	6
Evaluator capacity increased	3
Health equity	
Data or CHIP guides implementation or increases community buy-in and input	6
Focus on Health Equity from the beginning	3
Initiative infrastructure	
Grant [& funding] establishes credibility & trust in partnership, promotes involvement	10
Involvement with 2 GAs increased capacity to address health equity	10
Overall design of Initiative	5

A majority noted that small community size facilitated data collection and the overall ease of engaging community members and building rapport in their evaluation work. Several coalitions mentioned how they valued the local evaluator who was engaged and brought additional resources to the coalition. A few local evaluators described how their own capacity as an evaluator increased through their participation in the Initiative. Coalitions also noted a few specific health equity related factors, including using data and/or the CHIP to guide implementation and increase community buy-in and input. A few coalitions also credited a continuous focus on health equity from the beginning as helping to achieve their objectives. There were also numerous aspects of Initiative infrastructure that coalitions described as helpful to their success, particularly in the 2022 interviews. Nearly all coalitions told us that the grant—and the funding that came with it—

established credibility of coalition efforts and helped increase trust and bring in new partners. Almost all coalitions discussed ways that their participation in the Initiative increased their capacity to address health equity. Finally, several coalitions pointed to specific aspects of the Initiative's design that they felt were supportive, including having structured phases for planning and sustainability, technical support liaisons, as well as flexibility to make changes when needed, especially in the aftermath of COVID-19.

Barriers to Success

The tables in this section show barriers to success as described in annual key informant interviews and program documents (e.g., grantee progress and final reports, annual applications). The numbers in the "# coalitions" column represents the cumulative total number of coalitions that ever cited a particular barrier to success in any year from any source. An exception to this is that COVID-19 related challenges, which were discussed in detail in the Year 4 key informant interviews, are presented separately, later in this section.

Table 48. Barriers to, partnership formation, community assessment, and priority setting

Stage of Initiative: Partnership Formation	# coalitions
Inability to consistently attend meetings	11
Identifying and recruiting members	11
Member engagement with partnership and its work	11
Building trust among members	8
Power struggles, competition among county factions	7
Managing "Pull yourself up by your bootstraps" mentality	5
Stage of Initiative: Community Assessment & Priority Setting	
Challenges with reaching/engaging residents & priority populations	11
Difficult to have conversations about racial/ income disparities	11
Lack of initial guidance	8
Challenge to narrow down priorities	5
Lacking or inaccurate existing county-level secondary data	5

Partnership formation, community assessment, and priority setting were major undertakings in the first year of the Initiative, although they continued to a lesser degree throughout the Initiative. We heard about challenges to partnership formation as well as community assessment and priority setting each year (Table 48). In terms of challenges to partnership formation, all coalitions described partners inability to consistently attend meetings, due to conflicting schedules and competing priorities for time, and in some cases because of transportation issues. All coalitions struggled to identify or recruit members at some point, including those from multiple sectors and demographic groups. Specific groups that were especially hard to reach included elected officials and local government and young people. Among members, all coalitions experienced challenge with member engagement, finding in many cases that partners tended to be more passive, which impacted what coalitions could do. As an evaluator explained, *"Community gardens are a good example. Those were all over the place in our original plan, but it became very evident that we were not going to have the manpower. We didn't have anybody stepping up to take the kind of initiative that it was going to require."* Most coalitions also noted that it was sometimes difficult to build trust among members and several also observed power struggles and competition prevented progress. In the first year of interviews, several coalitions discussed challenges managing those with the mentality of "pulling oneself up by their own bootstraps." Interestingly, those sorts of comments did not come up in subsequent years.

Coalitions experienced difficulty with community assessment and priority setting. All coalitions spoke at one time or another of challenges reaching and engaging residents and priority populations due geographic barriers, transportation issues, limited internet access, health literacy, lack of trust, and apathy regarding the potential for change. All coalitions also noted it was difficult to have conversations about racial and income disparities, an important part of both community assessment and priority setting. Several coalitions found they struggled initially because of a lack of guidance in the early stages, although we didn't hear these kinds of comments in later years. Several coalitions found the process of narrowing down priority areas to be difficult, with the intention of defining a set of priorities that was manageable but also maximized partner preference. A few coalitions discussed challenges related to a lack of existing local data for certain indicators, which makes

it difficult to know the extent of need in the county, let alone identify disparities. A few coordinators described challenges with data on substance misuse in particular. As one of them stated:

> *"There is no hard data on opioid addiction in our community. We don't have an emergency room, so individuals who have to have emergency services for addiction either try to travel 30 miles away to [other counties], and that data gets absorbed into those counties. So there are a few indicators like that where there's not already existing data, so we've had to create new data collection tools so that we can try to understand exactly what the needs are and what's driving some of those issues."*

Coalitions experienced several barriers specific to the implementation phase (Table 49). All coalitions faced challenges with data collection and analysis, including instrument design, addressing complex intervention design, assessment of different priority populations, and time constraints. Several coalitions noted that implementation took longer than expected, which was important for managing expectations for progress. In parallel, several coalitions had concerns about implementation fidelity and effectiveness, describing partners who weren't following agreed upon procedures and/or finding that what they were doing wasn't working. A few coalitions discussed concerns about systemic barriers that coalitions would be unlikely to be able to address, including an imbalance of community power, racism, and other root causes of issues needing to be addressed. An evaluator, summing up their concerns about the scale of the problems, said, "Too big, not enough money, not enough community change." Less common implementation related barriers were miscommunications among partners and staff and the fact that some coalitions had staff that did not live in the county, which sometimes caused communication and trust issues.

Table 49. Implementation barriers to coalition success

Stage of Initiative: Implementation	# coalitions
Data collection & analysis challenges	11
Implementation has slow start or takes more time than expected	5
Implementation fidelity & effectiveness	5
Systemic barriers	4
Miscommunication among partners/staff	3
Challenges with staff not living in county	2

The last set of barriers described by coalitions tended to be overarching, not tied to a particular stage of the Initiative (Table 50), and we heard these throughout the Initiative period. All coalitions acknowledged that they struggled in general with the large size and scope of the grant, but they also understood that it was the nature of the work, and many expressed that there was a learning curve that they eventually overcame. Another challenge experienced by all coalitions was the setbacks that resulted from staff and partner transitions. When a staff member or coalition partner left, they took their knowledge, skills, and relationships with them, leaving the next person in that role to face a steep learning curve. A majority of coalitions described difficulties with understanding concepts that are key to understanding Initiative goals. This included concepts related to health equity and evaluation, for example. Another barrier to understanding key concepts were cultural barriers in the community, including resistance to certain ideas. Several coalitions found at different points in time that their capacity was limited, due to reliance on certain organizations that were fully volunteer-led, not having enough people to do the work, lack of grant-writing or other grant management skills, and lack of experience addressing health equity and/or working with coalitions. Funding was a constant challenge for coalitions. In the early years of the Initiative, there was an uncertainty about funding in future years of the Initiative, and coalitions worried the impact this

Table 50. Overarching barriers to coalition success

Overarching Barriers	# coalitions
Time-consuming and complex grant to manage	11
Staff and partner transitions cause setbacks	11
Understanding key ideas, resistance to new ideas	9
Lack of capacity	7
Funding challenges	6
Complexity of required technical documents	4
Scarcity of resources	4

would have on momentum. Other funding challenges included limited funding for both staff and implementation related costs and challenges with getting more funding. A few other coalitions expressed frustration with complex technical documents that were required as part of the grant process and a general scarcity of resources that are common to rural communities (e.g., people wearing many hats, young people leaving, and underinvestment compared to urban/suburban areas). A coordinator spoke of the multiple roles people play as follows:

> *"I really love the fact … that we have people in the coalition that are invested in the community, but I also (laughs) hate the fact that, you know, as you've seen, that everybody does multiple things and they're a part of multiple organizations and that makes it hard to ask more of them than they're already doing and then effectively provide more. So I try to not rely on the same people, but when it's the same people that's showing up, you really don't have too much of a choice, so that was a definite challenge."*

Other Contextual Influences on Coalitions

COVID-19 pandemic

In March 2020, COVID-19 was declared a pandemic, and Initiative coalitions felt the impacts of shutdowns immediately. We reported in detail about the impacts of COVID-19 in a special evaluation report that we prepared in March 2022 following key informant interviews with coordinators and local evaluators in mid-2021. The COVID-19 pandemic created a unique set of challenges for the Initiative coalitions (Table 51). Briefly, we observed several major categories of barriers identified by interviewees. First, virtual and in-person meetings presented a series of challenges to coalitions including difficulty with and burnout from the format as well as reduced attendance. Second, there were two types of implementation related challenges, including strategy impacts (all coalitions had to delay or cancel at least one activity) and barriers to reaching community members and priority populations (lack of internet access, reduced participation in coalition activities, transportation barriers, and challenges with reaching people, seniors especially, safely). Third, coalition member and partner engagement were hampered in several ways as a result of the pandemic: many partners made career changes and those who remained were less engaged, coalitions lacked leadership/ownership by partners, coalitions faced increased burdens, health partners were unavailable, partners passed away and program referrals decreased. Finally, communication with partners and community members was difficult during the pandemic. Despite these challenges, however, the coalitions were undeterred, as summed up by a local evaluator, *"I mean they accomplished a great deal during the pandemic because they believed in what they're doing and weren't going to let anything stop it."*

Table 51. COVID-19 related barriers

THEMES	COALITIONS
Coalition meetings	
Virtual format limited coalition growth (i.e., forming new partnerships)	5
Virtual format limited relationships among members (i.e., harder to make connections)	5
Members experienced burnout/fatigue due to overall increase in virtual meetings	5
Low attendance for both virtual and in-person meeting formats	5
Partners struggled to focus with virtual format (e.g., technology, distractions)	4
Implementation barriers	
Strategy impacts	
Strategies not implemented as desired/intended	11
Challenges with data collection	9
Reaching community & priority populations	
Limited broadband/internet access	8
Priority population members stopped utilizing services	5
Transportation barriers (for volunteers and program participants)	3
Challenging to reach seniors safely	3
Engaging coalition members & partners	
Partners leaving their position and the coalition	7
Coalition members less engaged during pandemic	6
Limited leadership capacity/lack of member ownership of coalition work	6
Increased burden on collaboratives/organizations generally	5
Health partners occupied with COVID response	4
Death of partners	3
Few partner referrals to programs	2
Communication	
Challenges with public health messaging (esp. skepticism of vaccines, public health)	5
Difficulty communicating with coalition overall (e.g., reduced engagement)	5
Difficulty communicating available services to community	5
Lack of communication channels for priority population to communicate with coalition	3

Social and racial justice movement of 2020

On May 25, 2020, Milwaukee resident George Floyd, a Black man, was arrested and ultimately murdered by a white police officer. His arrest and murder, recorded on a bystander's cell phone and uploaded to social media, set off a summer of nationwide Black Lives Matter protests and a broader social and racial justice movement. While there is not a direct connection between these events and *The Two Georgias Initiative*, the parallels are hard to ignore. Since 2017, the coalitions have worked to address inequities in their communities, including those caused by historic and contemporary systemic racism. Coalition members were having ongoing, difficult discussions about the causes of income inequality and other inequities, including those based on race, in their communities. The upsetting circumstances of George Floyd's death and the larger national conversation it ignited, amid an already polarized and tense populace, could not be avoided. Furthermore, it brought to light the urgency of the need to address social determinants and root causes of inequities and move toward justice.

Natural disasters

Multiple natural disasters impacted coalition communities during the five years of the Initiative. First, Hurricane Michael made landfall along Florida's Gulf coast as a category 5 storm in October 2018, traveling through southwest Georgia, leaving a trail of devastation behind. Of Initiative coalitions, the communities of Decatur and Miller County both saw major damage from strong winds and fallen trees, which took years to recover from. In the northern part of the state, Chattooga County experienced a water crisis in 2020 when dangerous chemicals were identified in a local creek that was a source for water supply. The northwest corner of the state

has more recently experienced severe flooding following heavy rain storms. These events added increased burden to Initiative communities already facing resource shortages and myriad other challenges.

Inflation & price increases for basic goods

Following increased prices resulting from global supply chain issues created by the COVID-19 pandemic as well as other global and domestic economic factors, the United States felt the impacts of inflation that impacted the prices of food, clothing, gas and many other categories of essential goods. Although inflation happened near the end of the Initiative, food insecurity was already a major concern for several coalitions. In addition, high gas prices were certainly felt across these rural communities where long distances are regularly traveled by motor vehicle. The rise of the cost of living and consumer goods forced hard choices by people who were already struggling to get by.

Summary

Coalitions implemented a wide variety of strategies from their CHIPs. Common domains for priority areas included food access, healthy lifestyle education and nutrition guidelines and support, health care access, leadership development/youth development, access to physical activity opportunities, behavioral health, literacy and education, safety, substance use, housing, and economic development. A diverse set of strategies across coalitions was implemented for each domain, varying in reach from less than 25 to thousands of people. Strategies with a priority population focused most commonly on low-income residents and youth, while other strategies were intended to reach the full county.

Facilitators of coalition success tended to include staff and coalition partner attributes as well the direct byproducts of their efforts. In addition, evaluation, health equity, and specific elements of Initiative infrastructure also supported coalition successes. On the flip side, coalitions also experienced numerous barriers to success when forming partnerships, in community assessment and priority-setting, and during implementation. The five years of the Initiative coincided with several global and national events that further impacted coalitions, including the COVID-19 pandemic, a social and racial justice movement in 2020, natural disasters, and inflation/price increases of essential goods.

PART 5. COMMUNITY CHANGES TO PROMOTE HEALTH EQUITY

Creating community change to address social determinants of health and promote health equity was a central aim of the Initiative. The following section describes community changes that the coalitions created through implementation of strategies that addressed key priorities for their communities over the five years of the Initiative. Data sources for these changes include the CCTT as well as one-on-one conversations with coalition leads.

Coalition-level Community Changes

The coalitions implemented a broad range of strategies to address health equity concerns in their communities. These efforts crossed 12 topical domains and can also be categorized by the type of intermediate outcome achieved which include: policy (P), system (S) and environmental (E) changes as well as new or strengthened programmatic initiatives.

In some cases, these categories of changes are interrelated. For example, policy changes, such as the adoption of new guidelines, made way for new programs to be developed or new systems to be integrated into organizational processes.

Figure 18 shows the distribution of policy changes, systems changes, environmental changes, as well as other intermediate outcomes (i.e., programs, services) by the 12 domains. This chart illustrates that there is a variety of each PSE approach across the different domains. When looking at the individual domains, a few patterns emerge. For example, a large number of health care outcomes were classified as systems change, while physical activity access and food access were most commonly categorized as environment changes. The healthy lifestyles education & nutrition guidelines domain was more of a mix of approaches, although there were not many environmental changes. Overall, systems (n=36) and environmental (n=39) changes as well as programs (n=37) were the most common approaches used, with policy changes being the least common approach (n=22).

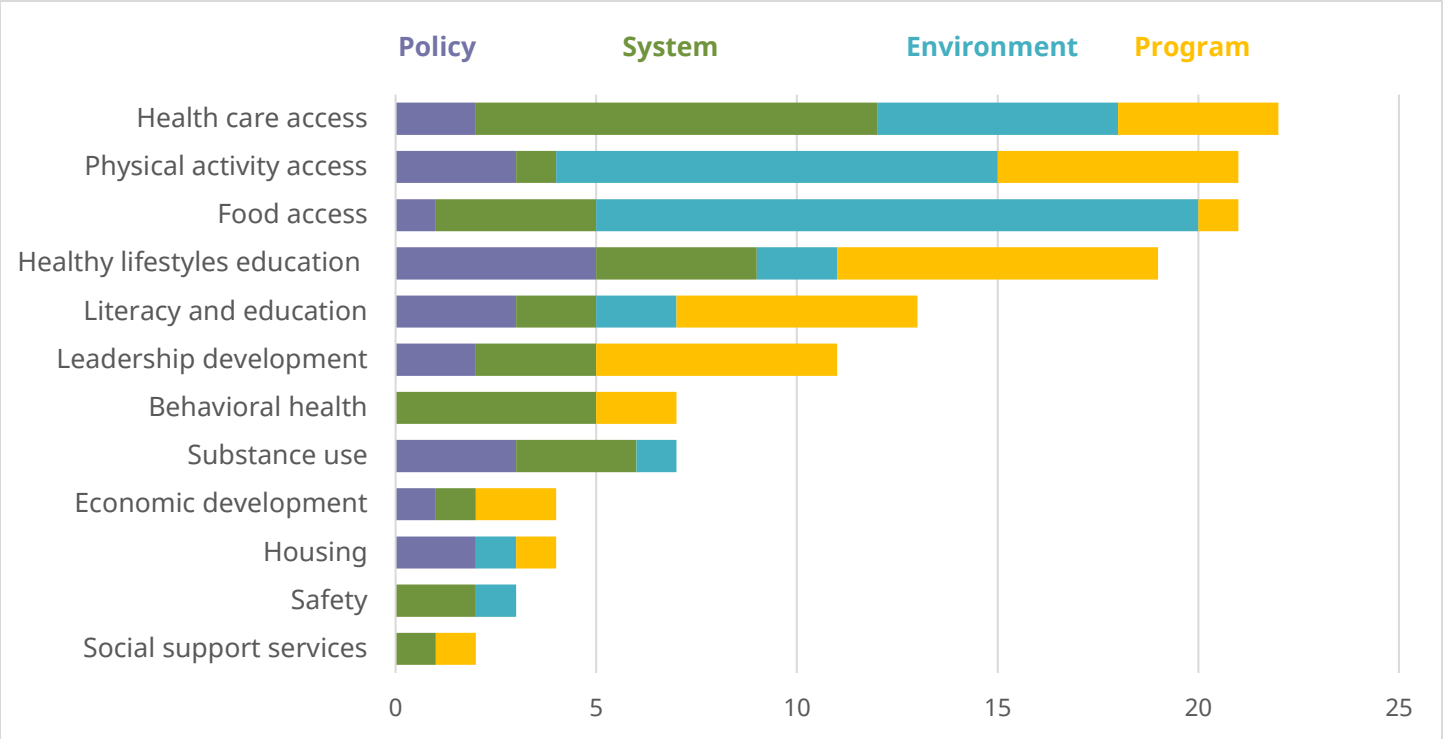
A **POLICY CHANGE** results from an intervention that targets a policy or agreement at an organizational or legislative level, examples of these are shared use agreements to increase access to physical activity spaces, guidelines established for the types of food distributed at food pantries and policies to have an area designated as smoke-free. These are denoted with "(P)" following the description of the strategy.

A **SYSTEM CHANGE** altered the functional infrastructure or process of an organization or partnerships. For example, developing a referral system or mobile health clinics to improve access to healthcare services, and mental health clinics integrated into school settings These are denoted with "(S)" following the description of the strategy.

ENVIRONMENTAL CHANGES intervene on the physical environment, as creating community gardens to improve access to vegetables for seniors and children across communities or improving park and recreation equipment to promote physical activity access. These are denoted with "(E)" following the description of the strategy.

Other efforts can be characterized as more short-term programs or events such as providing stipends to offset program costs, or soft-skills training for students.

Figure 18. Community changes achieved by domain and PSE approach



The tables below present the successfully implemented policy, systems, environmental and programmatic changes categorized by domain for each county/coalition. Unlike the Results (Part 4: Implementation & Contextual Factors), these tables also include additional projects that were added on to the coalitions' work, even after the original CHIP planning work. Coalitions were able to create lasting changes in their communities across multiple domain areas, during the Initiative and many used several PSE and program approaches, even within one domain.

Table 52. Appling County's major intervention strategies and community changes

Food Access	• Gleaning and produce distribution (S, 3 food distribution sites) • Community gardens established (E, for seniors and children) • Farmers market vouchers (S, 100 vouchers distributed to increase low income family participation in markets).
Healthy Lifestyle Education, Nutrition Guidelines & Support	• Nutrition education (S, 3 schools adopted curriculum for 2nd graders) • Cooperative extension nutrition program (S) • Breastfeeding sites (E, 2 community sites with furnished with supplies and spaces to facilitate nursing)
Physical Activity Opportunities	• Expanded adult recreation (S, New ability to refer seniors from the hospital to classes and a 12-week tai chi program was run) • New/improved recreation facilities (E, playground cleaned up, enhanced walking trail & bike track, particularly for children in a head start program & seniors)
Behavioral Health	• Brochure distribution and educational workshops on mental health issues (i.e., grief, anxiety). (developed brochure for "the safety plan" to promote behavioral health and ran four small group sessions of social support counseling each month for youth 5-K)

Table 53. Chattooga County's major intervention strategies and community changes

Food Access	• Community gardens established (E) • Mobile food pantry expanded (E) • Expanded drop sites to provide health foods for seniors (E)
Healthy Lifestyle Education, Nutrition Guidelines & Support	• Heathy eating guidelines were adopted by 7 organizations to benefit seniors and children (P)
Health Care Access	• Provided mobile health services (E, 1 mobile health unit) • Annual health fairs (S, operated 7 events with referrals to care) • Partnered with transportation to reduce no-shows (S, held 2 transportation events and distributed gas cards)
Leadership/Youth Development	• Increased organizations with positive youth development programs (S, added programming to 2 organizations
Physical Activity Opportunities	• Increased access to fitness sites (P, establish joint use MOUs for the general public's access) • Expanded adult recreation activities (E, new leagues created) • Playground and play space improvements (E) • New and improved recreation facilities (E) • Scholarships for organized recreation (program was offered through 3 sports organizations serving about 150 kids)
Behavioral Health	• Mental health clinics in schools (S, 4 schools developed clinics, health referral programs and family support systems) • Trained organizations to screen and refer for mental illness (14 training program/seminars operated) • Established behavioral health screening/referral network (S, added 2 organizations to the network)
Substance Use	• Smoke-free park/recreation policies (P, at one site) • Increased schools adopting Tar Wars (S, 13 public schools included) • Referral network established for tobacco cessation support/aids (S, across 7 organizations, particularly benefitting mill workers) • Signage installed for no smoking/vaping (E, across 11 sites)
Safety	• Promoted motor vehicle safety (S, expanded reach of SafeKids program by holding a training event to train other specialists who will continue events) • Added 4 schools to the Safe Routes to School program (E)

Table 54. Clay County's major intervention strategies and community changes

Food Access	• Food pantry (E, created in partnership with other organizations) • Community gardens at senior centers and housing authority apartments (E, MOUs signed for land, 3 gardens, along with cooking demonstrations)
Healthy Lifestyle Education, Nutrition Guidelines & Support	• Enhanced school nutrition policies (P, changes to school lunches, daily physical activity requirements and education) • Health ministries and policies created in churches (P, 3 churches created ministries, associated policies and conducted Body and Soul program) • Healthy lifestyle and nutrition education and policies using My Plate curriculum in partnership with SNAP (P) • Newspaper created to communicate health information and coalition activities
Health Care Access	• Health Screenings and referrals at community events (S, including, eye, breast exams, covid-19 screening and diabetes education) • New health clinic opened in partnership with Mercer University (E, provides mental healthcare through telehealth, x-ray services etc.) • New pharmacy opened (E)
Leadership/Youth Development	• Youth Empowerment Group & Youth Advisory Board (P, merged with recreation council and secured funding for playground updates) • Georgia Council of the Arts-photovoice project (Youth trained in photography and created gallery evets for community) • Soft Skills Training-Overcoming obstacles in schools (12-week training for middle school students) • Youth empowerment (youth trained on self-worth, civil rights, entrepreneurship)
Physical Activity Opportunities	• Access to fitness centers (P, developed shared use agreement to allow supervised use after hours for teens and community) • GEO-caching (E, system put in place along existing trail) • Expanded walking trails (E) • New and improved recreation facilities (E, including basketball courts) • Summer day camps (physical fitness programs through schools during summer for 1st-8th grade) • GA Shape program (P, policy change on nutrition & physical activity for k-7 grades) • Center for comprehensive youth activities (P, Youth centers opened with youth sports and classes)
Behavioral Health	• Mental health clinic in school (S, 1 counselor 2 days/week) • Community mental health clinic access through Clay County Medical Center (S)
Literacy/Education	• Policy created to establish after school programs, being implemented by partner organizations (P, two programs)
Economic Development	• Rural zone created (P, included grant money to refurbish historic building and credits for new businesses)
Social Services Support	• Included in United Way catchment area (S)

Table 55. Cook County's major intervention strategies and community changes

Food Access	• Community gardens established (E) • Mobile produce truck established (E) • Food pantry (E, expanded food pantry locations & operation hours across 3 programs)
Health Care Access	• Expanded health care services in existing health partners (S)
Literacy/Education	• Achieved quality rating for childcare centers (P, designation achieved for 3 centers) • Implemented Baby Hornets program (S, 1 program established for children up to age 4) • Established additional lobby/small libraries (E, 3 libraries established along with a drive through book distribution and doorstep delivery project)

Table 56. Decatur County's major intervention strategies and community changes

Food Access	• Community gardens established at several churches and a school (E) • Operated program to promote nutrition awareness and serve healthy snacks in school (one school district)
Healthy Lifestyle Education, Nutrition Guidelines & Support	• Church based Healthy lifestyle and nutrition education programs • Successful Senior Living Program (1 project conducted with a partner) • Community Weight Loss Challenge (1 event with a church partner) • Healthy food lessons through High School Consumer Science Department (1 program operated in 1 school) • Supporting Hands of Decatur County- information sharing on healthy lifestyles and how to access to health services (1 partnership to benefit seniors)
Physical Activity Opportunities	• Expanded adult recreation activities (new leagues created) • Improved lightening around walking trails (E) • Built new walking trail built as well as new outdoor fitness court for the general public (E)
Health Care Access	• Health screenings conducted at community events which informed other initiatives

Table 57. Early County's major intervention strategies and community changes

Healthy Lifestyle Education, Nutrition Guidelines & Support	• Worksite based healthier lifestyles and chronic disease prevention programming (S, 1 worksite with both leadership and employees)
Health Care Access	• Pre-diabetes testing and referrals for lifestyle education (P, 1 FQHC adopted the policy Diabetes Prevention Program)
Leadership/Youth Development	• Engaged community members to build their capacity to advocate for health equity (S, developed a community engagement platform to focus on vulnerable groups of people) • Youth development initiative providing a range of opportunities for area youth
Housing	• Initiated policy-making effort to develop a master plan for safe and affordable housing in 1 city (P)
Social Services Support	• Neighbor to Neighbor (program to support homeless individuals)

Table 58. Elbert County's major intervention strategies and community changes

Healthy Lifestyle Education, Nutrition Guidelines & Support	• Established a National Diabetes Prevention Program (S, operated 3 groups through 2 partnerships)
Leadership/Youth Development	• Implemented a "family coaching/mentoring" program (16 teachers were trained through a new partnership) • Classroom-based life skills programming to prevent risky behaviors (Several sessions completed)

Table 59. Hancock County's major intervention strategies and community changes

Food Access	• Community gardens established (E, 4 churches)
Physical Activity Opportunities	• Playground construction and play space improvements (E) • DAWG Walk program at elementary school
Literacy/Education	• Extended Head Start hours (1 site partner, impacting children 6 weeks-3 years old) • Establish additional lobby/small libraries (E, 6 libraries created at salons, housing authority and churches) • Reading club elementary school • Learning station at public library (E) • STEM workstation at public library (E)
Economic Development	• Local flea market (through 2 partnerships, 5 flea markets were held) • Historic walking tour brochures
Housing	• Lunch and learn event held for residents interested in improving housing

Table 60. Haralson County's major intervention strategies and community changes

Food Access	• Summer food backpack programs (S, partnered with other organizations to implement the program for low income children) • Developed a produce distribution site along with new partnerships and indoor pop-up produce market established at food bank (E, particularly active during the early stages of COVID-19) • 13 new garden beds established (E) • Food bank established healthy guidelines for food donated and distributed (P) • Grow a row programming (S)
Healthy Lifestyle Education, Nutrition Guidelines & Support	• Healthy lifestyle education organizational programming (13 organizations implemented the programming including elementary school nutrition lessons, nutrition education classes, seminars on dangers of vaping)
Health Care Access	• Free and reduced cost prescription medications (P, 1 MOU signed) • Clinical-community linkages referral system (S, trained 13 clinicians in the referral system) • Community resource guide developed • Transportation pilot program (S, operated 1 pilot focused on low income individuals) • Patient education at outpatient discharge to connect seniors with resources adopted by health system (S)
Leadership/Youth Development	• Policy created to adopt Be THE Voice Anti-bullying Program (P, conducted in 2 high schools) • High school youth empowerment and education (S, conducted in 2 high schools)
Behavioral Health	• Youth mental health first aid programming (S, training program for adults who work with youth)
Housing	• Home repair program operated to benefit seniors (E)
Substance Use	• Naloxone policy implemented among first responders (P, established at 4 agencies) • Naloxone training conducted in schools through school board policy (P, implemented across 2 school systems) • Disposal of medications at senior centers through DisposeRx system (S)
Safety	• Provision of life alert buttons (S, created a partnership to establish the distribution to seniors)

Table 61. Lumpkin County's major intervention strategies and community changes

Health Care Access	• Community navigation/resource events with referrals (S, included ~500 follow ups) • Telehealth availability in emergency room (S, serving about 375 new patients) • Mobile medical services and transportation (E) • New free clinic facility (E)
Economic Development	• Workforce development (S, partnerships established and two job placement events were held through a local technical college)
Literacy	• Several initiatives including Dolly Parton Imagine Library • Reading Connections in county jail (S) • Increased registration for library cards

Table 62. Miller County's major intervention strategies and community changes

Food Access	• Community gardens established (E, 3 gardens at a pre-school, childcare centers and housing authority) • Mobile pantry/produce truck established (E, mobile market with 40+ stops in town in addition to another mobile market and a farm delivery)
Healthy Lifestyle Education, Nutrition Guidelines & Support	• Healthy menu options offered in 5 restaurants & cafeterias of large employers (P) • Active living community newsletter distributed • Breastfeeding sites/ Lactation promotion (E, 4 worksites and 6 community breastfeeding facilities)
Health Care Access	• Established medical home & patient assistance programs which reduced emergency visits (S) • Public checkup and health screenings (provided at 10 events including health clinics, blood drives and wellness programs) • Mobile dental clinic (E, operated 1 clinic) • Community resource guide developed
Physical Activity Opportunities	• Improved walking trails & sidewalks (E, refreshed paint, signage & mile markers) • Free community exercise classes (program operated 6 exercise classes) • Spring Creek recreation program provided stipends to youth (program run through a community partnership)
Housing	• Environment & housing code enforcement (P, created in 1 city)

PART 6. POPULATION-BASED SURVEY FINDINGS

This section presents selected findings from the 2018-19 (T1) and 2022-23 (T2) population-based surveys that were conducted to assess equity outcomes based on resident perceptions of health promoting resources in their community and related health behaviors and how those changed over the course of the Initiative. Presented below is at least one variable or set of related variables from each of the eight modules in the survey. For each variable or set of variables, the data reflect all counties that included that module and question(s) in their survey. For example, 10 of 11 coalitions included the health care access and use module in their survey, thus the three charts included in the health care access and use section include data from those 10 coalitions. Table 7 in the Methods section shows the specific modules that each coalition chose to include in their survey. The data are presented in charts that show overall change from T1 to T2 as well as change by key demographics including race (White, Black) and income (low=≤$20,000, medium=$20,001-$50,000, high=>$50,000). The use of a red arrow pointing left indicates a decrease from T1 to T2, a blue arrow pointing to the right indicates an increase, and a brown X indicates that there was no change from T1 to T2. We were also interested in whether changes from T1 to T2 were "statistically significant." In other words, was the change from T1 to T2 likely due to chance, or more likely due to some other factor (e.g., coalition-created community changes, COVID-19 impacts). Alternatively, changes that were not statistically significant were likely due to chance. The statistically significant changes observed are indicated with an asterisk by the overall or subgroup line on the left-hand side of each chart.

The data in this section are pooled as one large group with all survey respondents combined, as opposed to shown by coalition or county. This has multiple implications for understanding the findings. First, and as mentioned above, the data presented here include respondent data from all counties who included a certain module or question in their survey. However, this approach does not account for the different strategies that coalitions implemented related to each topic. Some coalitions had more intensive efforts in certain strategy areas than others, and may have had a larger impact that is masked by pooling across counties. The EPRC is planning a series of coalition-specific reports that will present each coalitions county's data individually.

Table 63 below presents a summary of the changes observed for all population survey variables analyzed in this section. The table uses triangles to indicate T1-T2 increases or decreases that were statistically significant in a particular item for a particular group. An arrow pointing upward (▲) indicates that there was a statistically significant increase, and an arrow pointing downward (▼) indicates a statistically significant decrease. The use of color indicates whether the change (be it an increase or decrease) was in the **desired** or **undesired** direction. For example, food insecurity increased significantly overall and for a few subgroups. Because this increase was in the undesired direction, the change is represented by "▲." In contrast, use of community or home gardens saw statistically significant increases overall and for multiple groups, as illustrated by "▲." Changes are shown for the survey respondents overall, as well as for individual subgroups. By looking across table rows, one can get a sense of whether there was much change for a certain variable across groups. For example, fruit and vegetables access is the only variables that saw change overall and in each subgroup. By looking up and down table columns, one can get a sense of whether there was much change for a particular group. For example, at a glance, it appears that there were more significant changes among the overall sample than any particular subgroup, and that the subgroup that showed significant change in the greatest number of variables was the medium-income group ($20-50k).

Table 63. Summary of population survey findings

	OVERALL	WHITE	BLACK	≤$20K	$20-50K	>$50K
Fruit/vegetable access	▼	▼	▼	▼	▼	▼
Food insecurity	▲	▲	--	--	▲	--
Farmers market use	--	--	--	--	--	--
Produce truck use	▲	▲	--	--	--	--
Community/home garden use	▲	▲	X	--	--	▲
Indoor exercise areas	▼	--	▼	▼	▼	X
Outdoor exercise areas	▼	▼	--	--	▼	--
Town center walkability	--	--	--	--	--	--
Routine doctor visit, past 12mo	▲	--	--	--	--	--
Unmet mental health need, past 12mo	--	--	--	--	--	--
Care at comm. event, past 12mo	--	--	--	--	--	--
Trust in groups	▼	--	--	--	X	▼
Diversity of interactions	--	--	--	--	--	--
Reciprocity	--	--	--	--	--	--
Civic engagement	▼	▼	--	--	▼	--
General life satisfaction	X	--	--	--	--	--
Personal well-being index	▼	▼	--	--	▼	--
Poor/fair health	--	--	--	--	--	--

▼ ▲ triangle indicates change is statistically significant

– dash indicates change that was not significant

▼ ▲ – orange triangle or dash indicates change is in undesirable direction

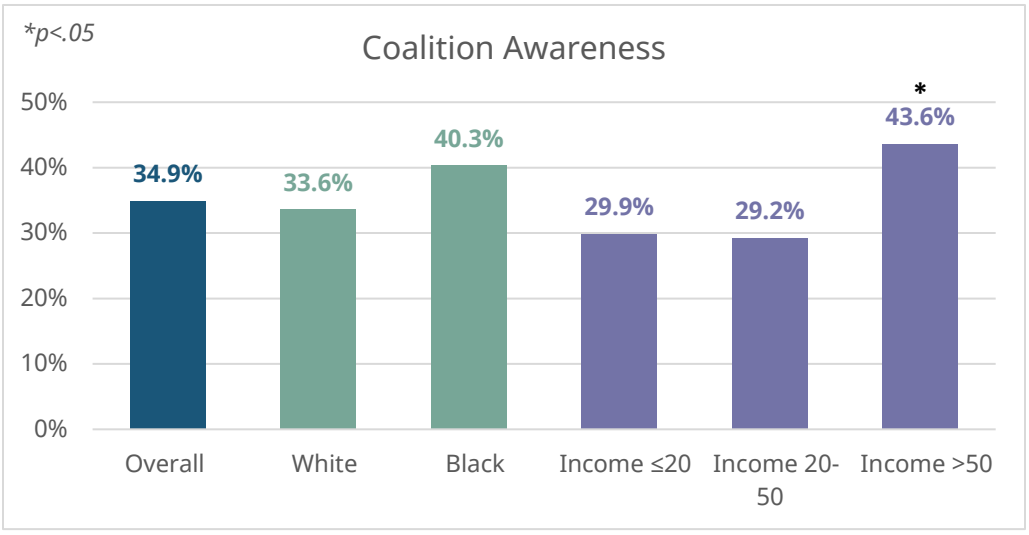
▼ ▲ – blue triangle or dash indicates change is in desirable direction

X indicates no change

Coalition awareness

At T2, we asked respondents if they had heard of the coalition that had worked in their county for the past five years. This question was included on 10 of 11 coalitions' surveys (n=959). Coalition awareness can indicate the extent to which coalitions reached the priority populations they intended to reach with messages, activities, services, and other community changes. Overall, slightly more than one-third of respondents had heard of the coalition from their county (Figure 19). Black respondents

Figure 19. Coalition awareness at follow-up



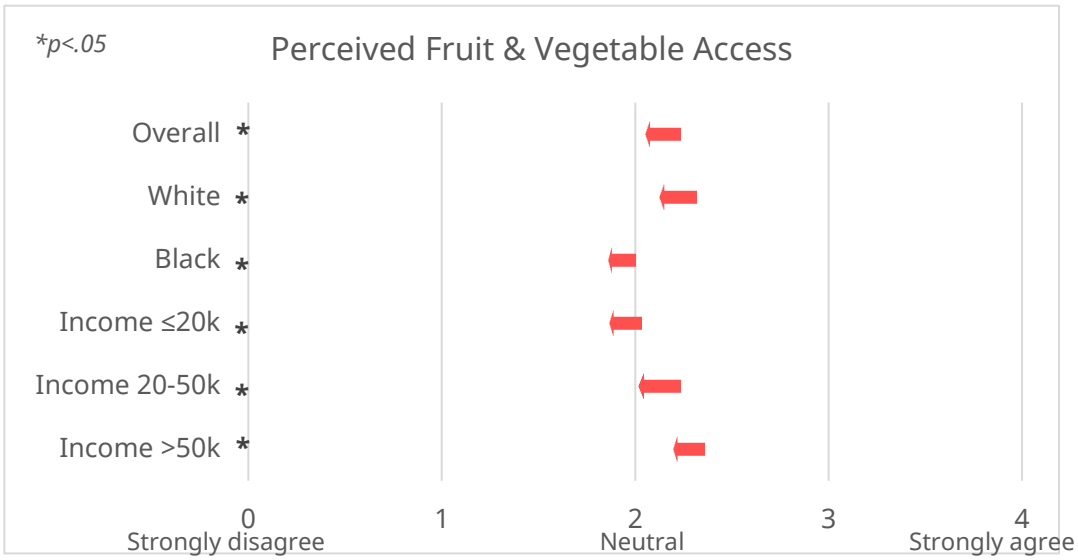
had a greater recognition than White respondents, and those with high incomes had significantly greater levels of awareness of coalitions than the middle- and low-income respondents.

Food access

Perceived fruit and vegetable (FV) access was measured by asking respondents to indicate their level of agreement with four items that asked about ease of getting, quality, cost, and selection of fresh FV in their community. Responses were neutral to somewhat positive at T1 (n=1,169), with the average of four items equal to 2.2, suggesting slight agreement with statements that it is easy to get fresh FV, that FV are of high quality, that they do not cost too much, and that there is a large selection (Figure 20). At T2 (n=1,154), overall perceived food access was slightly, but significantly, lower (average of four items equal to 2.1), closer to neutral than at T1.

There was a significant decrease in perceived FV access among all race and income groups examined. Respondents who were Black or had low incomes had the lowest perceived FV access at both time points. Respondents with high incomes or were White had the highest levels of perceived FV access at both time points. There were no significant differences in the changes between white and black respondents or when comparing the three income groups, meaning no closing of gaps between these groups.

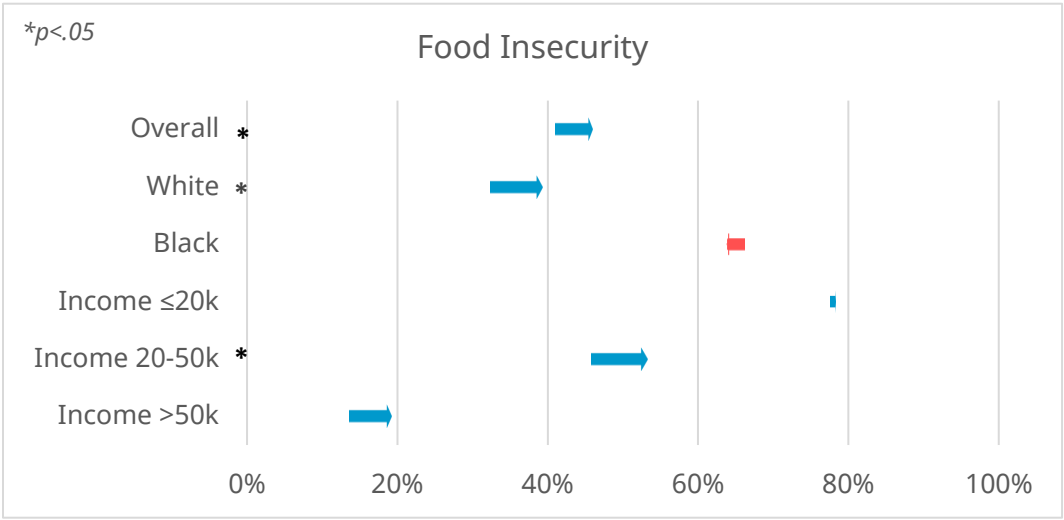
Figure 20. Change in perceived fruit & vegetable access



Food insecurity

Respondents answered two statements that were used to assess food insecurity status within the past 12 months at T1 (n=1201) and T2 (n=1365) (Figure 21). If they answered that either or both statements applied to them sometimes or often (as opposed to never), they were considered food insecure. Food insecurity overall increased significantly from 41.1% at T1 to 46.0% at T2.

Figure 21. Change in food insecurity



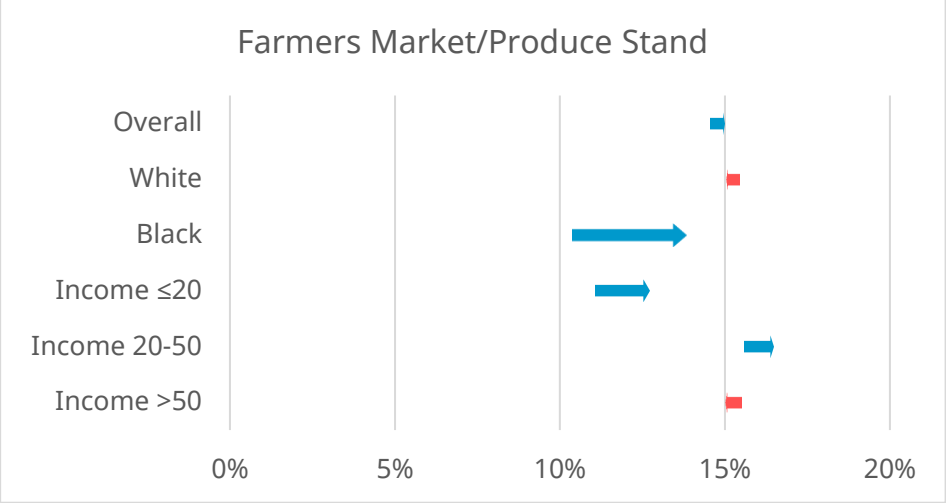
Changes in food security among the subgroups were mixed. There was a significant increase in food insecurity among White respondents and for those with medium incomes. The increase in food insecurity among those with high incomes was marginally significant (p<.10). It is notable that at both time points, there were large gaps in food insecurity between groups by race and income. Approximately two-thirds of Black respondents reported being food insecure at both time points, more than double that of White respondents at T1 and 1.7 times that of White respondents at T2. At both time points, more than three-fourths of low-income respondents were food insecure, 5.7 times the rate of food insecurity of those with high incomes at T1 and four times the rate of food insecurity of those with high incomes at T2. About half of those in the middle-income group reported food insecurity in the past year at both time points, 3.3 times the rate of the high-income group at T1 and 2.7 times of the high-income group at T2. The change in food insecurity between white and black participants was statistically significantly different, decreasing the differences in food insecurity between the two groups.

Fruit and vegetable sources

Respondents were asked to indicate where they got fresh FV in the past month (T1 & T2 n=1,421). Response options include a variety of places, including Wal-Mart and other grocery stores, gas station/convenience store, Dollar General/Family Dollar, farmers market/produce stand, FV truck/mobile market, community or home garden, and food pantry/bank. Respondents could check all that applied. The figures below show the percent of respondents who reported use of farmers market/produce stand, produce truck/mobile market, and community or home garden to get fresh FV.

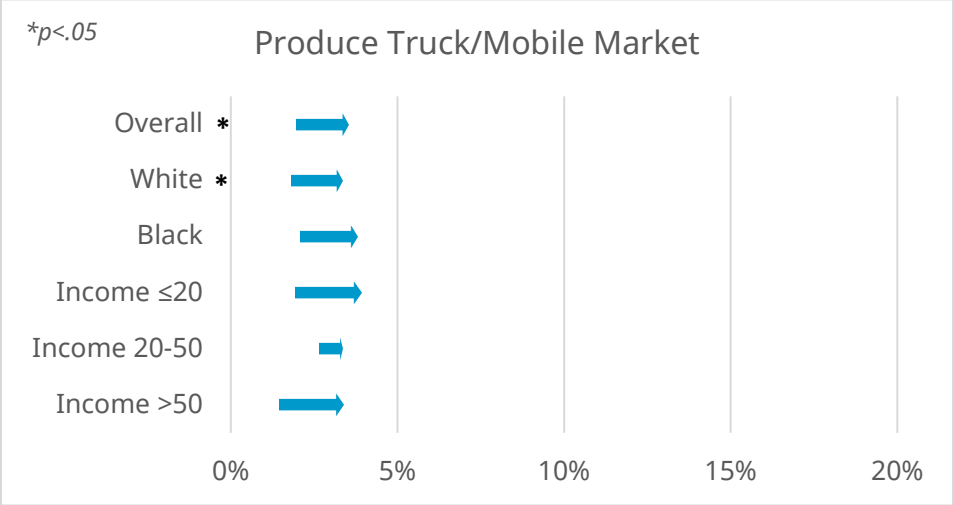
While there was no statistically significant change in farmers market/produce stand use, in general, farmers market/ produce stand use overall increased slightly from 14.6% at T1 to 15.0% at T2. Though not significant, use of farmers markets/ produce stands increased slightly for two priority groups (Black and low-income respondents), thus indicating a possible narrowing of gaps in this area where coalitions were active. (Figure 22).

Figure 22. Change in use of farmers market/produce stand



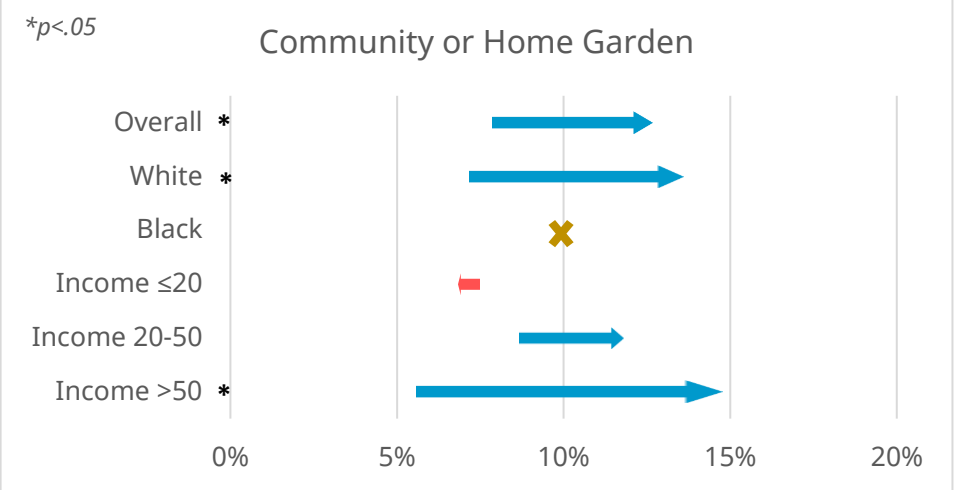
Produce truck/mobile market use was low at both time points overall and for all sub-groups, but increased from 2.0% at T1 to 3.5% at T2 overall (Figure 23). There was a statistically significant increase in use of FV truck/mobile market overall and among White respondents, and a marginally significant increase among those in the middle-income group. There were non-significant increases observed for the other subgroups.

Figure 23. Change in use of produce truck/mobile market



Use of a community or home garden showed a statistically significant increase overall from T1 (7.9%) to T2 (12.7%) (Figure 24). In addition, respondents who were White or had high incomes showed significant increases in use of community or home gardens. It is noteworthy that at T1, White respondents and those in the high-income group were the least likely to use community or home gardens, but by T2, they were the most likely to report using gardens to get fresh FV. The change in use of community and home gardens was significant in that White respondents reported a large increase while Black respondents did not. Comparing change across income groups, the increase in use of community or home gardens among high-income respondents is significantly larger than that of the medium-income respondents. The gap is even larger (significantly so) between high- and low-income groups given the large increase in high-income respondents using community and home gardens as a food source while the number of low-income respondents doing so decreased.

Figure 24. Change in use of community/home garden

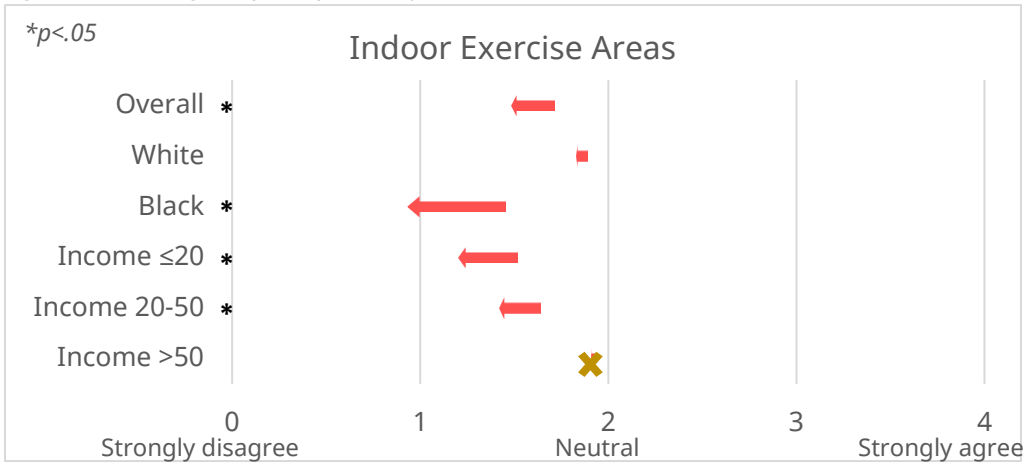


Physical activity environments

The figures below show change from T1 to T2 in perceived physical activity environments for indoor and outdoor areas as well as town center walkability. Respondents indicated their level of agreement with statements about those places. Example statements include: “My town has private indoor exercise areas (pay to use),” “Outdoor exercise areas are nice to use,” and “There are sidewalks in the town center.”

Respondents had slightly less favorable views of indoor exercise areas at T2 (mean 1.5, SD=1.30) compared to T1 (mean 1.7, SD=1.27) (Figure 25). Ratings of indoor exercise areas decreased significantly for respondents overall, as well as among Black respondents, and those with low or medium incomes. At T1, Black respondents and those in the low- and medium-income groups had a less positive view of indoor exercise areas compared to White respondents and those with high incomes, and the gap widened at T2. Comparing the change between White and Black respondents, we find that Black respondents' perceived indoor physical environments changed significantly more for the worse than for White respondents.

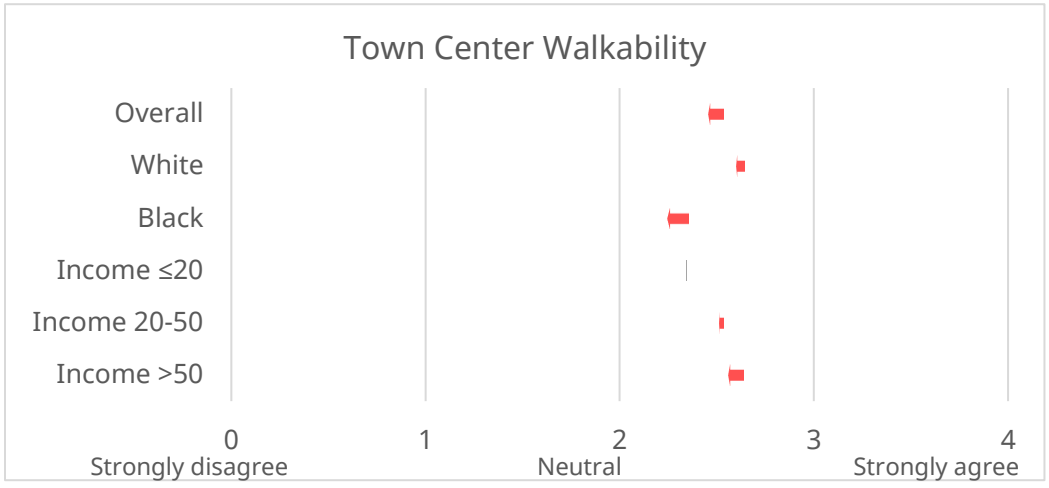
Figure 25. Change in perceptions of indoor exercise areas



Similarly, respondent ratings of outdoor exercise areas also decreased slightly from T1 (mean=1.8, SD=0.98) to T2 (mean=1.6, SD=1.06) (Figure 26). Respondents overall, White respondents, and those with medium incomes showed significant decreases in ratings of outdoor exercise areas from T1 to T2. There was a marginally significant decrease in ratings of outdoor exercise areas among Black respondents (p<.10). We also found that the decrease in outdoor exercise areas for middle-income respondents was significantly larger than for those with high incomes.

Figure 26. Change in perceptions of outdoor exercise areas

Figure 27. Change in perceptions of town center walkability



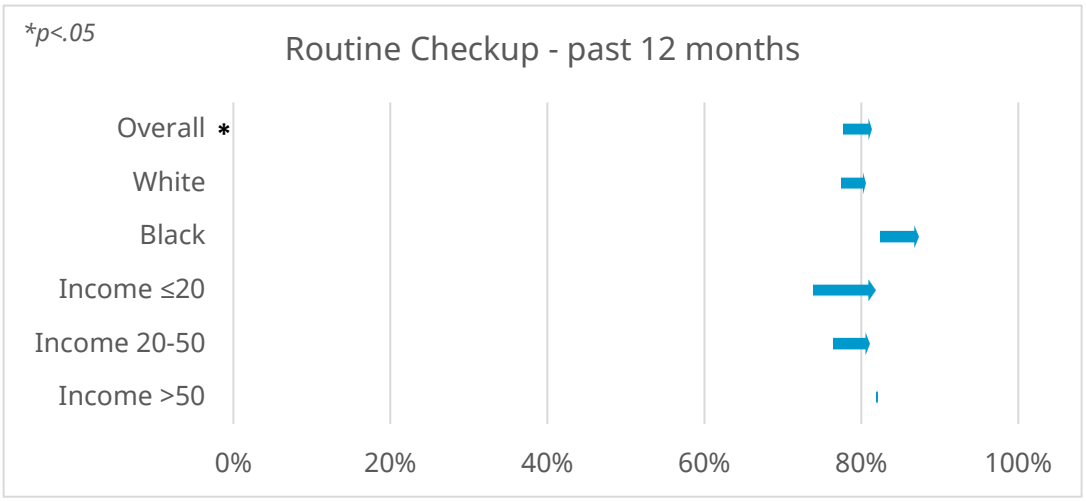
Respondents rated the town center more positively than the indoor

and outdoor areas, but their ratings showed no significant change from T1 (mean=2.5, SD=0.76) to T2 (mean=2.5, SD=0.82) overall or among the subgroups (Figure 27).

Health care access and use

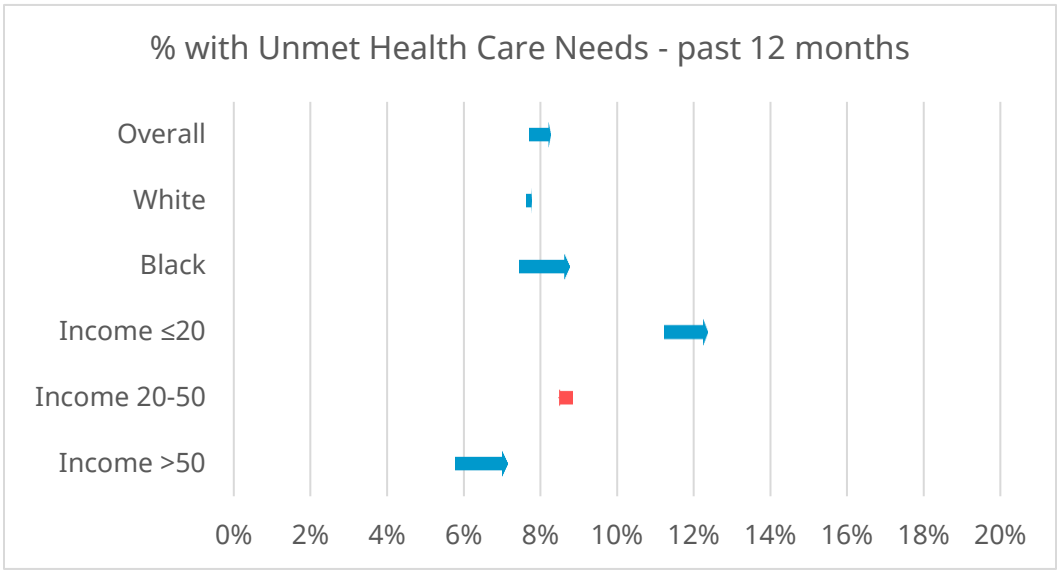
Respondents were asked to indicate how long it had been since their last visit to a doctor for a routine checkup. Figure 28 shows the percent of respondents who reported visiting a doctor for a routine checkup within the past year at T1 (n=1279) and T2 (n=1276). Overall, there was an increase from 77.7% at T1 to 81.3% at T2, meaning that a greater percent of respondents had visited a doctor for a routine checkup within the past 12 months at T2 compared to T1. There was a significant increase overall and a marginally significant (p<.10) increase among Black respondents. While there were non-significant increases among all subgroups, Black respondents had the highest rates of routine checkups in the past year at both time points (82.5% and 87.3%, respectively).

Figure 28. Change in frequency of routine checkup, past 12 months



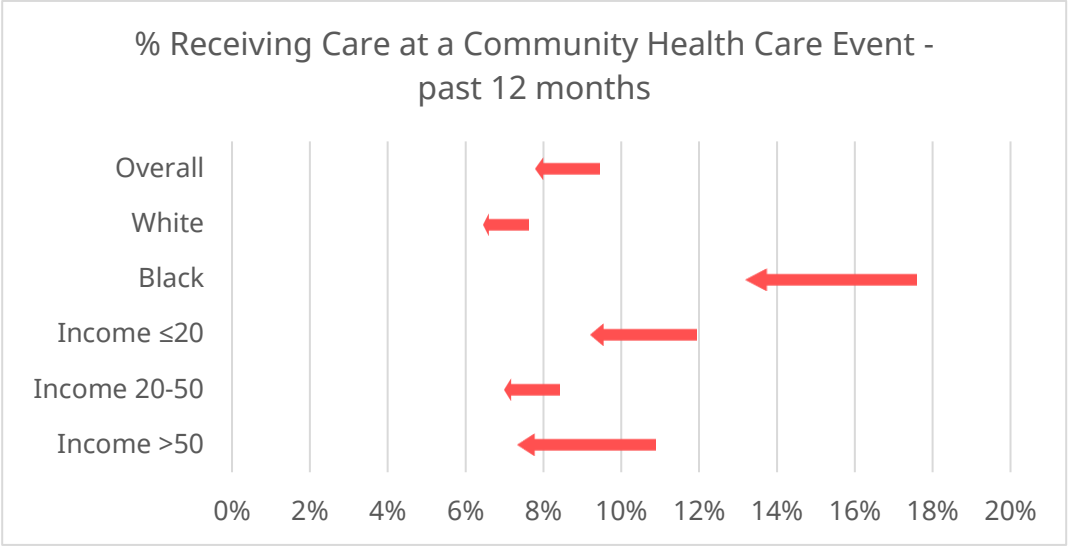
Respondents were asked at T1 (n=1,258) and T2 (n=1,236) if there was a time in the past 12 months when they needed mental health treatment or counseling but did not get it. Figure 29 shows the percent of respondents who responded to this question in the affirmative, meaning that they had unmet mental health care needs. At T1, approximately 7.7% of respondents reported unmet mental health care needs, and that number rose to 8.3% at T2. There was no significant change in unmet health care needs overall or in any subgroup from T1 to T2. Those in the low-income group had the highest rate of unmet mental health care needs at both time points (11.2% and 12.4%, respectively), approximately double the rate of unmet needs of those in the high-income group.

Figure 29. Change in percent reporting unmet mental health care needs, past 12 months



Respondents were also asked at T1 (n=1260) and T2 (n=1244) if they had received health care at a health fair or community event in the past 12 months. The percent of respondents who reported receiving health care at an event decreased from 9.4% at T1 to 7.8% T2, although the differences were not significant (Figure 30). At both time points, Black respondents were most likely to receive care at a community event in the past 12 months and White respondents were the least likely group to receive care at a community event.

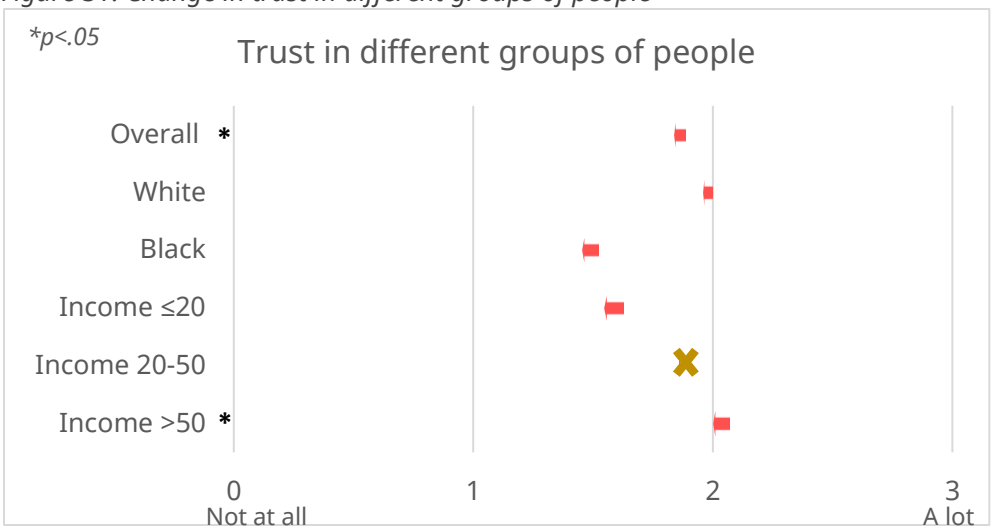
Figure 30. Change in frequency of receiving care at a community event



Social capital

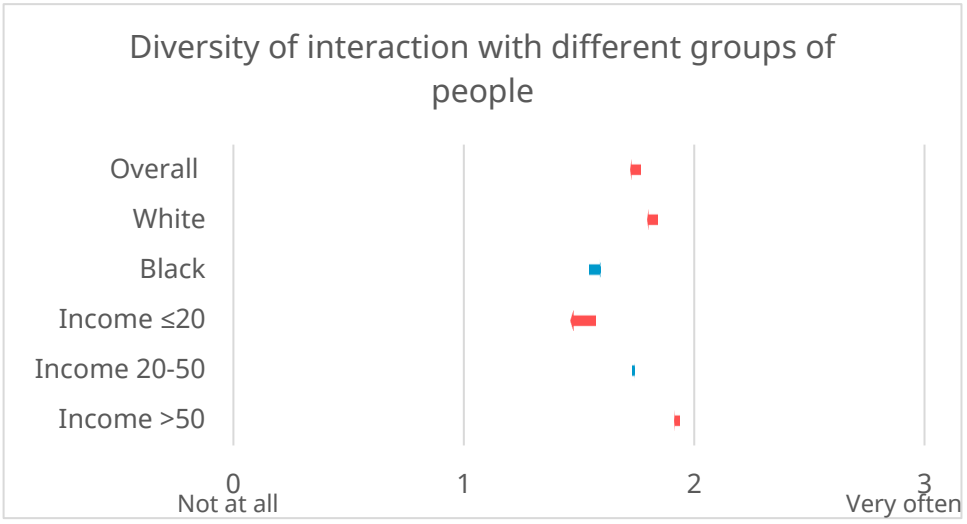
We measured social capital by asking a series of questions about trust in different groups of people, diversity of interactions with different groups of people, reciprocity, and civic engagement activities. Trust in different groups of people was measured at T1 (n=598) and T2 (n=598) by asking how much respondents trust different eight groups of people (e.g., people in general, your friends and family, people with different political views, people from a different religion than you). Overall, there was a small, significant decrease in trust from T1 (mean 1.9, SD=0.57) to T2 (mean=1.8, SD=0.59) (Figure 31). In addition, there was a significant decrease in trust in different groups of people among those in the high-income group. Black respondents and those with low incomes reported the lowest levels of trust at both time points, while White respondents and those with high incomes reported the highest levels of trust at both time points.

Figure 31. Change in trust in different groups of people



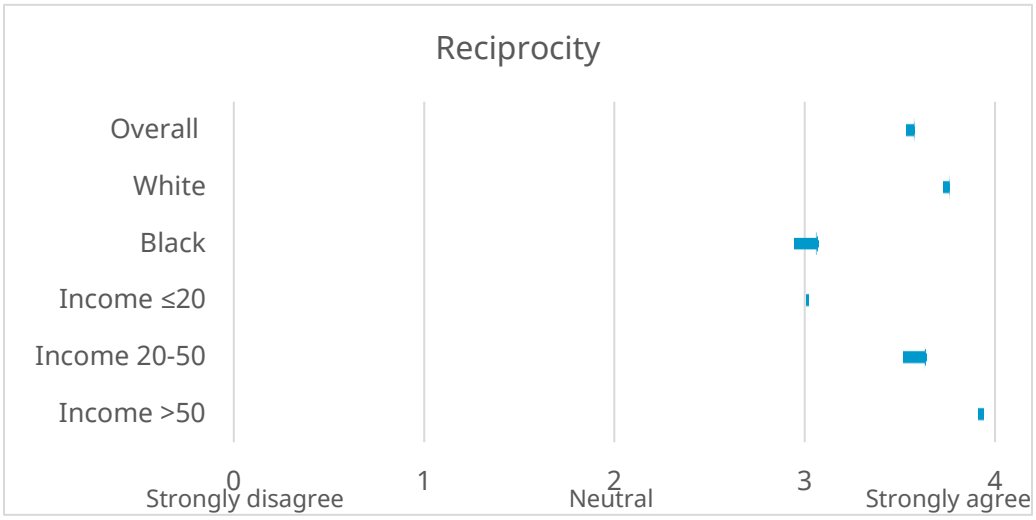
Diversity of interactions with different groups of people was measured at T1 (n=657) and T2 (n=650) by asking about the same eight groups as for trust, but the question asked how often respondents talked to or spent time with people from each group (in person, by phone, or online). Responses overall showed a very small, marginally significant decrease in diversity of interactions from T1 (mean=1.8, SD=0.61) to T2 (mean=1.7, SD=0.59) (Figure 32). There were also marginally significant decreases in diversity of interactions among White respondents and those in the low-income group. Similar to trust, the groups with the lowest diversity of interactions at each time point were Black respondents and those in the low- and medium-income groups. Those who reported the highest diversity of interactions at each time point were White respondents and those with high incomes.

Figure 32. Change in diversity of interactions with different groups of people



Reciprocity was measured at T1 (n=665) and T2 (n=683) by asking respondents to indicate their level of agreement with three statements about the extent to which they can rely on their neighbors for help in general or in times of need (e.g., borrow $30 in an emergency). There was no significant change in reciprocity overall from T1 (mean=3.5, SD=1.09) to T2 (mean=3.6, SD=1.07), or for any sub-group (Figure 33). As with trust and diversity of networks, Black respondents and those with low incomes reported the lowest levels of reciprocity at both time points, and White respondents and those with high incomes reported the highest levels of reciprocity.

Figure 33. Change in perceived reciprocity



We measured civic engagement at T1 (n=635) and T2 (n=657) by asking respondents if they had engaged in 10 specific activities in the past 12 months (e.g., attended a public meeting in which there was discussion of a local issue; belong to any groups, organizations, or associations; attend religious services at least once per month). Figure 34 shows the average total number of activities in which respondents reporting engaging. At T1, respondents overall reported participating an average of 3.5 (SD=2.73) total activities out of 10, and at T2 that number decreased significantly to 3.2 (SD=2.87). White respondents and those in the middle-income group also showed a statistically significant decrease in the number of civic activities from T1 to T2. Those in the high-income group showed a marginally significant decrease in number of civic engagement activities from T1 to T2.

Figure 34. Change in number of civic engagement activities

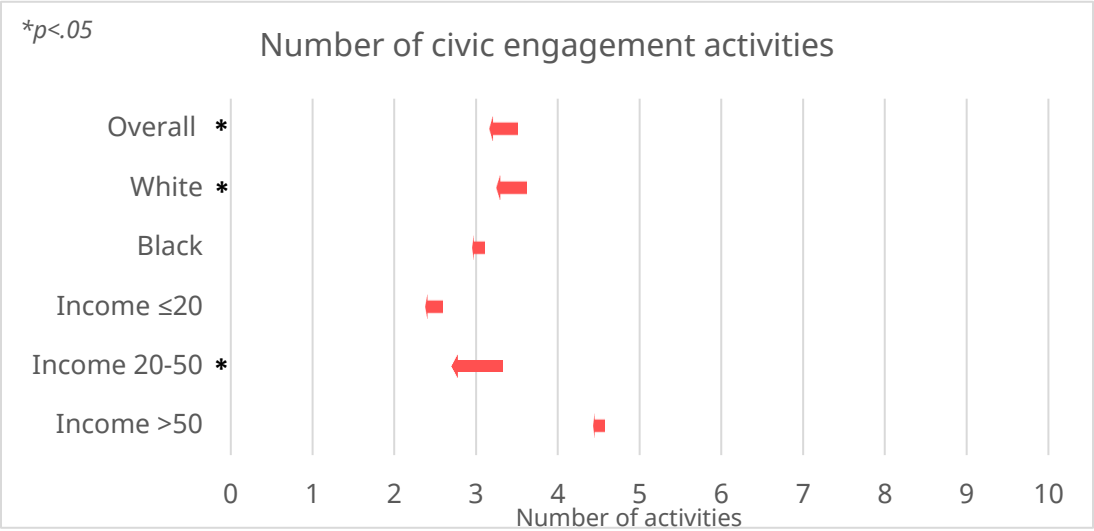
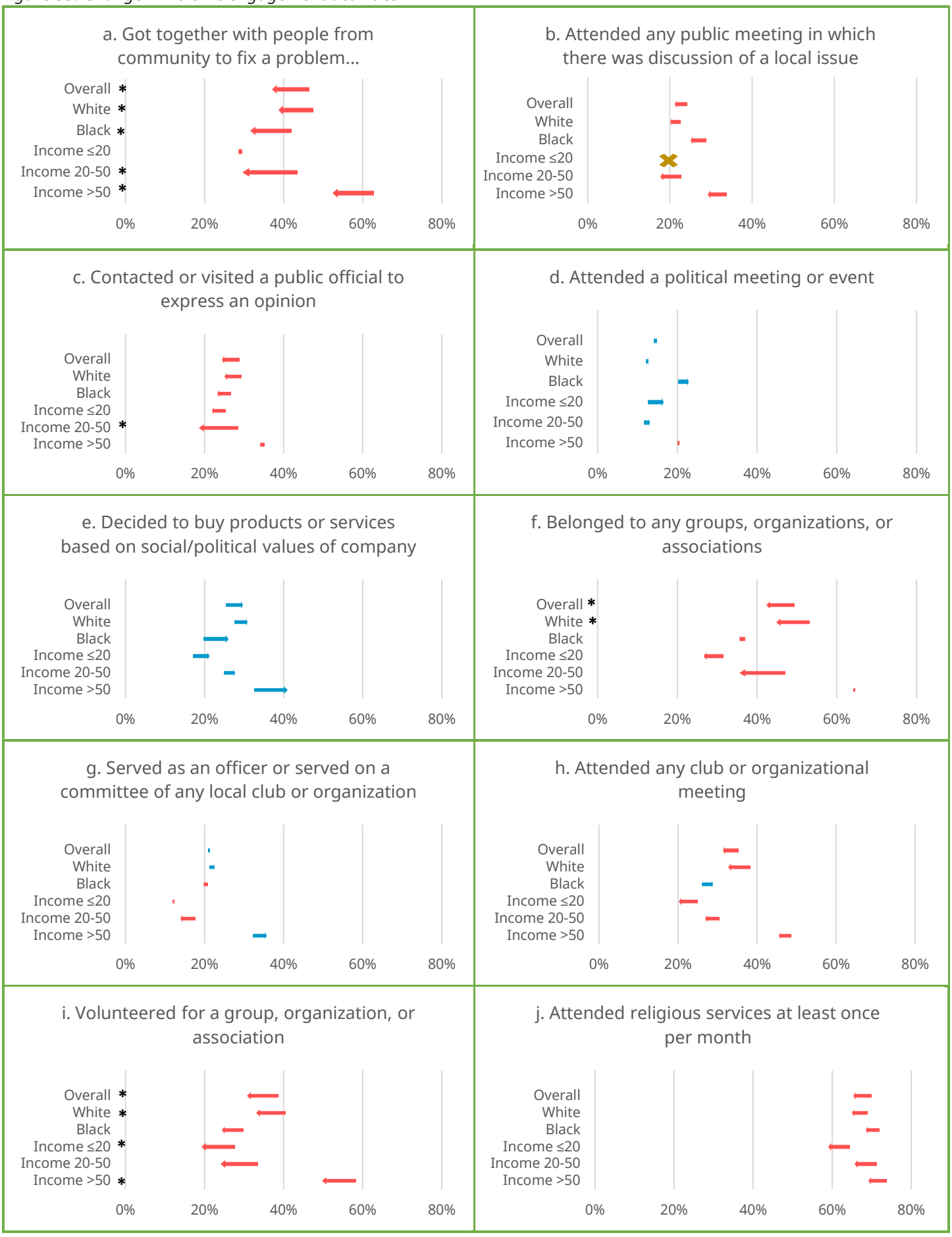


Figure 35 shows responses to the 10 individual civic engagement activities included in the survey, and change from T 1 (n=653-677) & T2 (n=653-684). At both time points, attending religious services in the past month (j) was the single most common activity respondents reported. There were significant decreases in getting together with people from the community overall and for most subgroups, for contacting or visiting a public official to express and opinion among those in the middle-income group, belonging to any group, organization, or association overall and among White respondents, and volunteering for a group, organization, or association overall and among White respondents as well as those in the low- and high-income groups.

While overall participation in civic engagement activities declined from T1 to T2 and for most activities, this figure demonstrates that there were some areas that saw small increases overall and among all/almost all groups from T1 to T2, including (d) attending a political meeting or event and (e) deciding whether or not to buy products or services based on the social or political values of the company that provides them. Other activities saw increases for some groups and decreases for others, such as (g) Served as an officer or served on a committee of any local club or organization and (h) attended any club or organizational meeting. However, none of these changes were significant.

Figure 35. Change in 10 civic engagement activities



Well-being

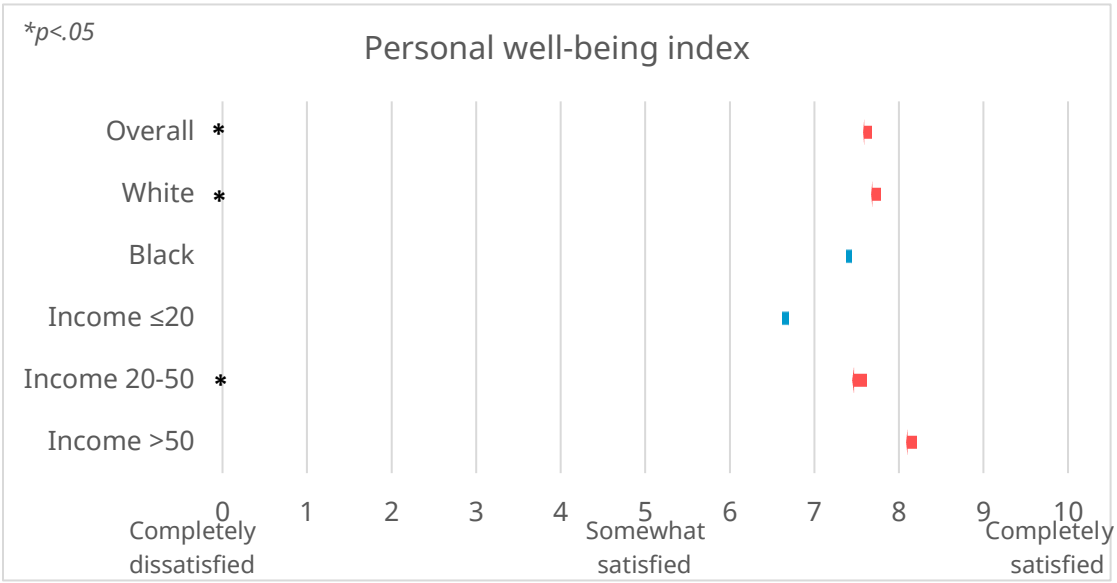
Well-being was measured at T1 and T2 through nine items that assess general life satisfaction and eight life domains (e.g., standard of living, health, personal relationships, spirituality or religion). Respondents rated each item on a scale of 0-10, with 0=not at all satisfied and 10=completely satisfied.

Figure 36 shows the change from T1 to T2 (both n=1378) in a single item measure of well-being that represents general life satisfaction (GLS). There was no change overall from T1 (mean=7.9, SD=2.03) to T2 (mean 7.9, SD=1.05). Some subgroups saw very small, non-significant changes. Although respondents with low incomes saw a small increase in GLS, they reported the lowest GLS at both time points. In contrast, those with high incomes saw a small decrease in GLS, but reported the highest GLS at both time points.

Figure 36. Change in general life satisfaction

Figure 37 shows the average score of eight life domains combined, called the Personal Well-being Index (PWI), at T1 (n=1306) and T2 (n=1299). Overall, there was a small but significant decrease in PWI from T1 (mean=7.7, SD=1.84) to T2 (mean=7.6, SD=1.88). White respondents and those in the middle-income group also showed small, significant decreases in well-being from T1 to T2. At both time points, Black respondents and those with low incomes had the lowest well-being scores. The normative range for PWI scores among Western populations on a scale of 0-100 is between 70 and 80. When these data are converted to a scale of 0-100, the overall PWI score found among Initiative county residents of 77 and 76, respectively, is well within the normal range. Respondents

Figure 37. Change in the personal well-being index

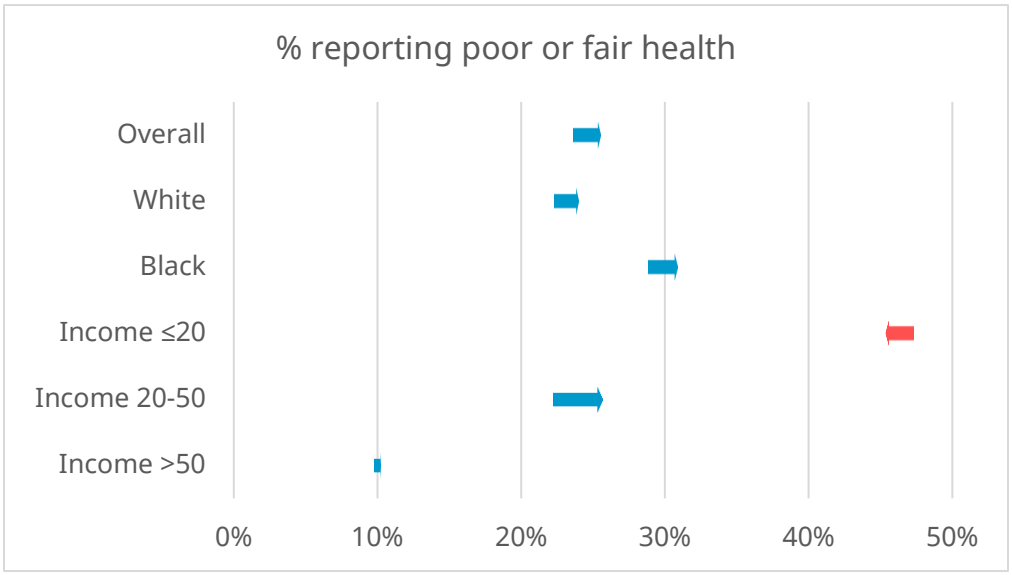


with low incomes, however, fell below the normal range at both time points, and those with high incomes were above the normal range at both time points [60].

Health status

As a measure of health status, respondents at T1 (n=1392) and T2 (n=1398) were asked to rate their health in general as excellent, very good, good, fair, or poor. Figure 38 shows the percent of respondents who reported poor or fair health. At T1 and T2, about a quarter of respondents overall reported poor/fair health (23.6% and 25.5%, respectively). There was no significant change from T1 to T2 overall or for any subgroup. Those with low-incomes had the highest rate of self-reported poor or fair health at both time points, nearly five times higher than those in the high-income group, and double that of the middle-income group. Differences between White and Black respondents were relatively small, suggesting that income has a larger impact on health status than race.

Figure 38. Change in frequency of reporting poor or fair health



Summary

With two exceptions, the majority of statistically significant changes observed from T1 to T2, though small, were in an undesired direction. The data showed declines in reported access to FV, physical activity spaces (indoor, outdoor, and town center), multiple social capital outcomes (trust, civic engagement), and the Personal Well-being Index. In addition, there were significant increases in food insecurity across multiple groups. On the positive side, we saw some significant increases in use of various sources of FV (produce trucks/mobile markets, and community/home gardens) and an overall increase in respondents reporting a routine doctor visit in the past 12 months. In general, most changes from T1 to T2 did not affect existing gaps between socioeconomically advantaged by race or annual household income. However, there are a few outcomes that indicated at least small closing of gaps, though these were not statistically significant changes. We also saw some outcomes that appeared to show gaps had widened. Use of community/home gardens was lowest among White and high-income respondents at T1 but highest in these groups at T2. In addition, while perceived access to indoor physical activity spaces declined among all groups from T1 to T2, the largest decline was seen among Black respondents and those in the middle-income group. In general, the socioeconomically advantaged groups tended to report better access and indicators of health than the disadvantaged groups, especially with respect to income where the gaps were often wider than those for race. Despite the many community changes achieved by the coalitions over the course of the five-year Initiative, the COVID-19 pandemic may have had undue influence on equity outcomes measured by this survey.

PART 7. SUSTAINABILITY

A major goal of the Initiative from the beginning was to position the coalitions to be able to sustain themselves and their work beyond the Initiative funding period. Our evaluation plan included two evaluation questions about sustainability. The first, a process-focused question, considered steps taken to ensure sustainability, including external funding and strategic partnerships. Obtaining additional funding sources, including grants, donations, and budget allocations would be especially crucial beyond the Initiative funding period to pay salaries and to pay for implementations-related expenses. In addition, just as partners have been crucial to the success of coalitions throughout the Initiative period, continuing and enhancing those partnerships are essential to sustainability.

The second sustainability-oriented question was focused on outcomes and explored which aspects of the Initiative and community changes are likely to be sustained beyond the Initiative, including the coalitions themselves as well as specific programs and policy, system, and environmental changes to be sustained. We were interested in whether and in what form the coalitions would continue to exist long-term. Finally, we were also interested in which programs and policy, system, and environmental changes would be maintained by the coalition and its network of partners and which ones would not, and why or why not. The Georgia Health Decisions led *Seeds for Sustainability* curriculum focused on many of the same concepts, thereby contributing to alignment between planning for sustainability and evaluation questions.

Steps Taken to Ensure Sustainability

External funding and other resources leveraged

The cumulative total funding leveraged by all coalitions, excluding Initiative funds, was $12,365,082 (Table 64). Funds came from grant money, donations, and various budget allocations. Of the total $9,947,839 in grant money, grants were received from federal, state and local organizations.

$12 million+

External funding raised by coalitions

Table 64. External funding sources secured by the coalitions

County	Total $	Grants	Donations	City/county budget allocations	Other allocations (e.g., school budgets)
A	$550,528	$451,000	$18,725	-	$80,853
B	$304,000	$268,000	$7,000	-	$29,000*
C	$2,525,756	$999,600	$13,656	-	$1,512,500
D	$4,642,900	$4,355,600	$281,300	-	$6,000
E	$24,700	$20,000	$4,700	-	-
F	$50,107	$24,000	-	-	$26,107
G	$106,000	$33,500	-	$72,500	-
H	$3,418,339	$3,301,349	$3,691	-	$113,299
I	$602,880	$399,790	$40,090	-	$163,000
J	$96,450	$75,500	$20,950	-	-
K	$43,422	$19,500	$23,922	-	-
Total	**$12,365,082**	**$9,947,839**	**$414,034**	**$72,500**	**$1,901,759**

*actual amount might be higher—this number includes minimum contributions from partners

Grant sources included Walmart Community Gardens, HRSA, L4GA, and USDA Community Food Projects, with funding attained for both the planning and implementation phases of various programs. For the total

$414,034 received in donations, sources include the South Georgia Charitable fund, individual donations, hospitals, and churches. Only one coalition received funds due to city/county budget allocations, specifically from the county school system to fully fund the continued staffing for a school-based program, which was originally piloted with Initiative funding and proved to be successful. Other budget allocation sources included local Boards of Education, the State of Georgia, medical centers, and other community partner organizations.

Strategic partnerships established for sustainability

Partnerships within the coalition were key to their successful implementation and in sustaining programs and initiatives. Coalition staff identified key strategic partnerships from a variety of sectors that supported the coalitions in numerous ways, both directly and indirectly.

Ways that partnerships were strengthened

Partnerships developed in strength primarily through organizations growing in terms of number and diversity of partners and leveraging that shared growth, working closely together and in some cases deciding to merge together on initiatives or through other more formal means. One coalition evaluator said, "*They also have connections, and so it really becomes this social networking process of whoever is involved within that organization can bring those partnerships to the coalition or at least potential partnerships to the coalition*". Additionally, the simple act of regularly attending coalition meetings and trainings helped to strengthen the bonds of partnership and keep organizations connected to the work. Partnerships were further strengthened when they lifted up other organizations and individual partners and provided them with a voice in the community when they previously did not have one (Table 65).

Table 65. Ways the partnerships were strengthened and supported sustainability

Ways that the partnerships were strengthened	# coalitions
Partnership growth (individual growth/merging partnerships/partnerships working together)	8
Partners actively attended coalition meetings and trainings	3
Gave partners a voice in community	2

Sectors represented

Coalition leaders and evaluators were asked to identify the two or three key partners in the sustainability of their work. Across the 11 coalitions, the top three sectors identified were education, local government/law enforcement, and faith-based organizations (Table 66). Others included community-based organizations, healthcare, social services, mental and behavioral health organizations, and lastly public health, recreation, and civic organizations. There is a lot of diversity in the organizations named, but the pattern shows that for community-wide health equity work to be sustained, established and prominent organizations that already reach much of the population need to be involved in the work. Political support is another aspect of sustainability. Many of the strategic partnerships described here are inherently political. Interestingly, of the top 2-3 most important strategic partners from the interviews, 7 of 9 coalitions identified local government/law enforcement agencies as one of their top picks. In addition, many of the other top partners are not explicitly political in nature, but are prominent organizations in the county that wield power because of their positions in the community. Implicit in these partnerships is the coalitions' need for these local leaders to support coalition efforts. Coalition staff spoke in their interviews about the importance of these partnerships and the hard work that went into nurturing them.

Table 66. Sector represented among strategic partnerships

Sectors represented	# coalitions
Education	7
Mayor/local government/law enforcement	7
Community based organization	6
Faith	6
Health care	5
Social/human services	4
Mental/behavioral health	3
Public Health	2
Recreation	1
Civic group	1

Reasons organizations were identified as strategic partners for sustainability

Organizations were listed as strategic partners for a wide variety of reasons (Table 67). Some of the key factors were that they were able to provide funding or other in-kind essential programmatic support or resources. In some cases, these organizations served as the lead on a grant to help facilitate acquiring funding for the programs. Additionally, groups were considered strategic if the work of the coalition was integrated among partners and it wasn't the coalition leading or executing the work on their own. In some cases, the partner actually took on the work and absorbed it into their organization giving the coalition the confidence that initiatives would be sustained.

Reflecting on a school-based mental health initiative, a coalition evaluator said *"In the case of the high schools and the mental health provider, …the partnership is actually going to end, but only because the school system has decided to—it's important enough to provide that service themselves."* Other organizations were also seen as deeply trustworthy. It was clear that they were seeking to benefit the community rather than just elevate their organization's reputation. This relationship went both ways. One coalition leader said in reflection of how the coalition is viewed by other community entities, *"you got a nonprofit that is just looking at the wellbeing of the community, not to benefit them. I really think that has been the biggest change."*

In an effort to promote the coalition to their own constituents, partners actively shared information about coalition work with the community. Related, a strategic partner was seen as one who was transparent in their work and had active communication channels either as an organization as a whole or through a single key contact in the organization who was reliable to work with. Often this was directly facilitated by the coalition leaders, "*My first commitment was for everyone to get and receive health equity training for old partners, merging partners, new partners, so that as we move forward with sustainability and look at other efforts that we are working on, that everyone has a direct knowledge of the way that we want things done, and with that at the forefront. Communications is excellent, sustainability is excellent*." Access to data and/or the facilitation of data tracking on initiatives was also common across coalitions. A partner who helped in this area was seen as a strategic partner for the development and sustainability of programming.

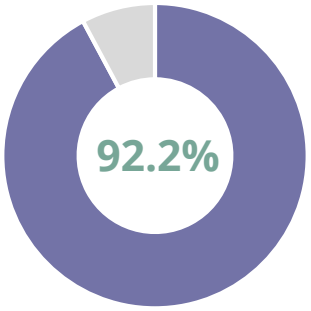
Table 67. Reasons organizations were strategic partners for sustainability

How partners were strategic	# coalitions
Funding or in-kind program support/resources including lead on grant	7
Work is integrated among partners and coalition	5
Provided essential support on intervention/program and events	4
Organizations seeking to benefit community, share coalition information	4
Provided access to key data or facilitated data tracking	4
Transparency and communication	4
Partner took on certain initiatives as their own	3
Partner organization had a reliable, key contact	3

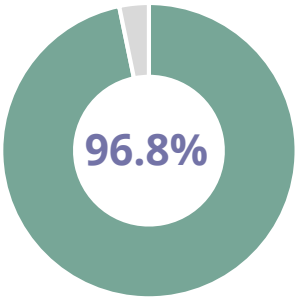
Aspects of Initiative/Community Change to be Sustained Beyond the Funding Period

In the 2021 coalition member survey, respondents indicated their level of certainty about whether certain aspects of the Initiative would continue beyond the grant period. Overall, respondents were extremely optimistic that their coalition would continue, with 92.2% saying they were either somewhat or very confident that the coalition would continue beyond the Initiative (Figure 39). Similarly, survey respondents were highly confident that programs implemented would continue, with 96.8% saying the programs implemented would continue beyond the Initiative. In this section, we will explore in detail the likelihood of coalitions being sustained as well as their intervention strategies.

Figure 39. Coalition member confidence that coalition & programs will continue beyond Initiative



% of coalition members confident that the COALITION will continue beyond Initiative



% of coalition members confident that the PROGRAMS IMPLEMENTED will continue beyond Initiative

Number of coalitions sustained beyond the funding period and how

Throughout the fourth year of the Initiative, coalitions underwent a formal sustainability planning process, guided by the GHD team. One outcome of that process was the method of sustaining the coalition beyond the five-year Initiative. The most common approach to coalition sustainability was to align with the local Family Connection organization (Table 68). At the beginning of the Initiative, only one coalition was formally aligned with Family Connection. By the end of the Initiative, a total of five coalitions had aligned with their local Family Connection. In the year 5 key informant interviews, coalition coordinators described a variety of benefits to aligning with Family Connection, including the built-in infrastructure and funding streams available to the organization which has a local chapter in every single one of Georgia's 159 counties. Other benefits included consolidating partnerships with organizations and individuals with common goals as well as streamlining meetings for partners of both Family Connection and the coalition.

Table 68. Coalition sustainability

Coalition approaches to sustainability	# coalitions
Aligning with local Family Connection organization/infrastructure	5
Using a shared leadership or governance model	2
Continuing as is in alignment with county board of health	1
Continuing as an independent 501(c)3 nonprofit organization	1
Facilitators of coalition sustainability	**# coalitions**
Community partnerships (organizations and individuals)	8
Fundraising and other resources	7
Personnel	5

The remaining coalitions opted for a variety of different approaches to sustaining their coalitions. There were two coalitions that described a shared leadership or governance model. In one community, this involved five committed partner organizations who would contribute financial and other resources to provide ongoing support for the coalition. The other coalition that adopted this approach described a shared governance model with the local hospital system. Another coalition described aligning with the local board of health and one coalition will continue to operate as an independent 501(c)3 nonprofit.

Coalitions identified three key factors that have helped – and/or will be critical to – facilitate coalition sustainability. First, nearly all coalitions identified the importance of community partnerships with a variety of organizations and committed individuals and volunteers. These partners provide invaluable implementation support, provide access to additional resources, and facilitate widespread communication throughout their individual networks. Second, and no less crucial, several coalitions identified the ability to obtain additional funding sources through grants, partner budget allocations, and donations as essential to coalition sustainability. A coalition representative said "*We've just been shocked and amazed at how well things have gone in terms of new grant funding, new projects, new partnerships, but again, I feel like the Two Georgias Initiative laid the groundwork for us to accomplish that*." Third, numerous coalitions mentioned that they were able to increase personnel dedicated to the coalition and its work – further enhancing sustainability potential. One interview

participant described how without full-time staff, the viability of their programs and initiatives would be in doubt, saying "*I think there's just different things that may or may not be looped in as much if there's not someone who's paid full-time to do it.*"

Number and types of programs sustained beyond funding period

Based on our discussions with coalition staff at the end of Year 5, more than 75% of all the different strategies implemented by the coalitions will be sustained. Almost all of the food access interventions will continue, with just one not sustained (a tornado destroyed a youth greenhouse). The sustainable strategies were largely environmental and system changes that aligned with partners priorities, including county extension, schools, and food pantries. About half of the lifestyle education and nutrition guidelines/support interventions will be sustained. All of the nutrition policy-focused efforts will continue (e.g., nutrition guidelines integrated into organizational practices; provision of healthy food options). Most of the systems changes that involved program expansion to new sites will also continue (e.g., Diabetes Prevention Program, SNAP-Ed nutrition programming). One-time events were less sustainable (e.g., weight loss challenge, offering classes to worksites).

Almost all of the physical activity opportunities classified as physical, systems or environmental will continue. The only strategies that will not continue are free exercise classes, and scholarships and stipends for recreational programs in two communities. Most of the health care access strategies will be sustained, especially those that involved systems changes such as new referral linkages, telehealth, and mobile health services. A few strategies, however, were viewed as less sustainable including gas cards for transportation to medical appointments, health fairs, and a mobile dental clinic. All of the behavioral health strategies will continue.

Over half of the leadership/youth development efforts will continue, with just a few of the specific programs offered in school settings not continuing. Among the housing related efforts, the policy-focused strategies will continue, but one home repair program for seniors may not. Lastly, all of the substance use, safety, economic development, and literacy/education interventions will be sustained.

Factors related to strategy sustainability

In the 2022 key informant interviews, coalition coordinators were asked to review which strategies they believed would continue (see above) as well as patterns related to why certain strategies would continue and others would not (Table 69). Most coordinators identified three key factors related to strategies that would continue beyond the Initiative: key partner support, good funding streams, and evaluation data. Several gave credit to key partners in helping sustain strategies as they progressed, with one coordinator saying, *"I really relied on partners to give me the—how do I say this?—the trail of where the food was going and figure out how it actually reached the community"* and *"I think everything that we've done, it'll just continue. I don't see anything not continuing because of the efforts that's not been only put by myself, but by the partners, the partners have learned a lot."* Several coordinators also described obtaining additional funding to be able to continue strategies – funding came in various forms, such as grants, donations, and budget allocations (for more on external funding sources, see Table 64).

Multiple coordinators cited evaluation data as justifying the continuation and/or enhancement of strategies. Numerous coordinators felt that the collection and analysis of community data helped determine which strategies should continue and what direction to go in, with comments such as, *"the hospitals around here all have to do a community-needs assessment. That's where our original data came from anyway. We still are privy to that information, but it's taking that to the community and saying, "Okay, this is the data. This is what the hospitals are saying. Now where do we wanna go in the community to fix these problems?"* Other patterns related to which strategies will continue included having clear purpose and communication as well as planning for sustainability from the beginning.

Table 69. Factors associated with strategy sustainability

Pattern related to which strategies will continue	# coalitions
Key partner support (interconnectedness, passionate leaders, shared goals)	9
Funding stream/s	6
Evaluation data (identify needs of community, addressing shortcomings)	4
Clear purpose & communication (vision, mission statement, goals)	2
Planning for sustainability from the beginning	1
Anticipated challenges for strategies that will continue	
COVID-19	3
Need for more funding	3
Lack of community engagement and/or support	2
Pattern related to which strategies will NOT continue	
Lack of manpower, skillset, consistency, or support among partners	3
Low community participation	1
Future plans to sustain strategies	
Building leadership capacity within groups (trust, skills, trainings)	1
Need of dedicated staff	1

Although several grantees discussed different ways that the pandemic required them to adapt to fast changing situations and responding with innovative solutions, COVID-19 was still the most common anticipated challenge to hinder future plans for sustaining strategies. In one county, a hospital-based nutrition education program was stopped due to ongoing COVID protocols, but another community partner was able to take over implementation and continue the work. Others emphasized that the need for more funding would be a challenge in sustaining strategies and a few counties indicated that the lack of community engagement, commitment, and support would challenge their future.

Coordinators also identified a few patterns related to which strategies would not continue. A few coalitions identified a lack of capacity among and consistency of effort by coalition and community partners. For example, one coordinator discussed how efforts to address daunting challenges related to transportation and economic development, saying *"...access to transportation. That was something that just kind of petered out. It wasn't something that was sustainable long term for us, and we didn't put a lot of energy into that. Same thing with economic development."* Low community engagement in implementation of strategies was a noted issue by one coalition.

Staff from a few coalitions connected future successes to the importance of addressing coalition capacity in ensuring sustainability of their efforts. One pointed to the need to build leadership capacity within groups, with examples of coalition trainings, job skills training, and building trust between community and coalitions. Another suggested a need for more dedicated staff to expand existing services, such as full-time project coordinators. Both suggestions involved taking a step towards long-term sustainability, recognizing the needs of the coalition and community. As one coordinator explained, *"I think that was the ultimate decision that was made that instead of trying to continue and invest resources towards something that really isn't successful right now, we need to take a step back and use those funds to offer technical assistance training, and so that's gonna be the next step."*

Summary

Coalitions obtained more than $12 million in total during the Initiative period. While most of the funding raised came in the form of grants that would eventually end, the coalitions clearly demonstrated the capacity to apply for and receive grants, suggesting the potential to continue doing so. In addition, coalitions received substantial funds in the form of donations and budget allocations, suggesting approval and support of coalition efforts from organizations and/or individuals. Coalition staff cited strategic partnerships from a diverse number of organizations and sectors that would continue to support coalition funding,

implementation, and messaging. By the end of the Initiative, a majority of the nine coalitions had aligned with their local Family Connection, a group that many recognized as having similar goals and partners, in addition to additional resources. The other coalitions used a variety of other approaches to sustaining their coalitions, including shared leadership, alignment with another county organization, and continuing as an independent non-profit organization. Community changes that were most likely to continue included policy, system, and environmental changes which are naturally more self-sustaining than programs and events, although many programs were likely to be sustained as well. Other factors described as leading to sustained strategies included alignment with partner objectives, funding, and evaluation data justifying their continuation.

CONCLUSION

This mixed methods evaluation assessed the process used by eleven coalitions to address health equity in rural Georgia, and documented outcomes related to changes in: 1) readiness and capacity to address health equity, 2) policies, systems and environments, and 3) population-level outcomes.

Major Findings

- Multi-sectoral coalitions were successfully formed in each of the 11 counties, with relatively high levels of coalition functioning (e.g., leadership, communication, decision-making, satisfaction, leveraging of member resources) and strong representation from education, community-based organizations, health care, social/human services, business and faith sectors.
- Coalition staff appreciated guidance received from the various support teams.
- Changes in community readiness to address health equity at the county-level were modest, with most of the coalitions in the Preparation stage at the end of the Initiative.
- Numerous indicators of community capacity to address health equity showed positive movement, including new opportunities for engagement by those with lived experience, new leadership development opportunities, strengthened planning and collaboration skills among coalition members, and expanded personal and professional networks.
- Coalition members representing organizations reported moderate institutional efforts to address health equity, with collaboration ranked most highly and internal talks on systemic racism ranked the lowest.
- The majority (70.5%) of planned intervention strategies were successfully implemented, even with major disruptions due to COVID-19.
- Efforts to address food access, physical activity, healthy lifestyle education, nutrition guidelines and policies, and health care access were the most common across coalitions.
- Coalitions contributed to a substantive amount of community change, most notably in the form of increased access to healthy foods, new or improved physical activity opportunities, and increased access to health care.
- Despite an impressive amount of community change with respect to policies, systems and environments, reach and intensity of efforts was often modest and generally did not translate to desired population-level change, likely due to the relatively short time-frame of the Initiative relative to the magnitude of the needs rural communities face and the major impact of the COVID-19 pandemic on many of the longer-term outcomes assessed. Small, but positive changes, were observed for frequency of a routine check-up in the past year and use of produce trucks/mobile markets and community/home gardens. Several of the other priority outcomes changed in a negative direction.
- Over 75% of the implemented strategies were likely to be sustained, and the coalitions were able to leverage over $12 million for community health improvement.

Overarching Observations

- Multi-sectoral coalitions are an effective way to engage a broad range of organizations in expanding and coordinating programs, and to increase access to a range of health-promoting resources.
- The strengthened relationships created between people and organizations will outlast the Initiative.
- The Initiative logic model included short, intermediate, and long-term outcomes – many short and intermediate term outcomes were achieved such as changes in community capacity to address health equity and policy, systems and environmental changes in several priority domains. Coalitions have clearly started along a path of community change that could lead to reductions in health inequity over time. Long-term (5 year) funding was instrumental in this shift.
- Sustainability planning was particularly effective. Sustainability of both the coalitions and community changes was impressive in this Initiative.
- Coalitions were successful in raising awareness and changing mindsets among coalition members about disparities and need, but also solutions.

- There is immediate need in the Initiative counties, exacerbated by the pandemic. Coalitions addressed (especially once COVID-19 became a pandemic) these urgent while still recognizing the value of pursuing longer-term change.
- Addressing health equity takes time as well as action at higher levels of government (e.g., regional, state, national). Multi-level approaches will likely be required to direct sufficient resources and create the types of policy changes needed for long-term solutions to health inequities in rural communities, both within rural communities and relative to urban areas.

What Worked Particularly Well?

- Funding the Initiative for five years.
- The inclusion of a dedicated planning year.
- Expectations for specific products such as the Community Health Improvement Plan, Community Change Tracking Tool, and Sustainability Plan.
- The focus on sustainability and incorporating a sustainability planning curriculum.
- Prioritizing evaluation throughout the Initiative, at the local level as well as across sites.
- The core management team (PSE, GHD, EPRC) bringing different skill sets to the coalitions.
- Providing opportunities for the coalitions and coordinators to network.
- Flexibility with funding as local needs and situations evolved.

Considerations for Future Initiatives

- ***If equity remains a focus, build it in from the beginning***. Coalitions might have benefited from experts guiding them in building and maintaining their coalitions for health equity earlier in the process (e.g., weekend/evening meetings, resident councils, one-on-one organizing, shared decision-making to avoid core group making most of the decisions).
- ***Ensure TA is practical and skills-based***. Coalitions expressed a need for "how to" advice and tools, especially related to grant-writing and other technical skills (e.g., evaluation, equity).
- ***Consider complementary approaches to addressing health equity (e.g., beyond community coalitions)***. Health equity messages did not reach deeply beyond coalition membership and changes in overall community readiness to address health equity were modest. Special attention to the best way to frame unfairness and justice in rural contexts may be needed.
- ***To the extent possible given changing circumstances, offer consistent guidance throughout an Initiative***. Coalitions expressed a desire for more clear guidance and feedback throughout the Initiative, examples include evidence-based intervention versus flexibility and choice, equity within county or rural versus urban inequities.
- ***In locally-driven initiatives, consider where to draw boundaries/level of flexibility***. Given the early commitment to flexibility and choice, strategies varied widely across coalitions. In future efforts, guidance could be given regarding the change approach (i.e., policy/organizational approach vs. education and awareness efforts, evidence-based programs versus creative but untested strategies, whether to address downstream effects or upstream drivers, and the number of priorities or strategies (broad or targeted).
- ***Consider how to define "local."*** It was not uncommon for coalition coordinators and local evaluators to live outside of the coalition county; in addition, about 30-35% of coalition members lived outside their county, according to the coalition member surveys. Additionally, some of the grantees (e.g., fiscal sponsors) were based outside of the prioritized counties.

Limitations of the Evaluation

- Heavy reliance on a limited number of data sources, especially the local coordinator for some of the key indicators.
- Lack of comparison communities making it challenging to attribute outcomes solely to the local coalitions and to know whether the coalitions were successful in staving off some of the harms from the COVID-19 pandemic (i.e., did neighboring counties experience more backsliding on some of the population-based measures?).

- Possible social desirability bias in that respondents may have shared mostly positive viewpoints about the coalitions and their efforts to not jeopardize future funding and/or reputations.

Concluding Thoughts

The Two Georgias Initiative was successful in creating and sustaining a broad array of community health improvements and laying the groundwork for continued efforts to address health equity in rural Georgia. The Initiative developed a model for creating, guiding and/or animating a collaborative spirit within participating communities in combination with strengthening capacity to address health equity. Leadership, mechanisms for interaction and alignment, inter-organizational and personal networks, skill-building, and an ability to leverage resources were seeded and nurtured for growth. Given that current inequities have been shaped and sustained over decades, and in some cases, centuries, it will take time to achieve the ultimate goal of health equity. Continued investment in rural communities will accelerate progress toward the shared goal of eliminating barriers to health for all.

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