Creating Healthy Communities

Contributions to creating sustainable community changes for healthy eating, physical activity, and tobacco-free living, 2015 – 2019.

Prepared for:
Ohio Department of Health
Creating Healthy Communities Program (CHC)

Prepared by:
Professional Data Analysts (PDA)

Ohio Department of Health

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Orientation to this report

The purpose of this report is to **synthesize the contributions of the Creating Healthy Communities (CHC) program from 2015 to 2019.** The data incorporated into this report includes evaluation and program documentation data collected by the Ohio Department of Health (ODH), CHC staff, CHC coordinators, and the external evaluator Professional Data Analysts (PDA). A list of all data sources is included in Appendix B.

CHC is evaluated using a **principles-focused evaluation approach** (described in more detail in Appendices B and C) to assess CHC's contribution to community change in the priority communities in which the program was implemented from 2015 to 2019. CHC is one of many initiatives in Ohio striving to reduce the statewide burden of chronic disease and is currently implemented in 23 of Ohio's 88 counties. As such, changes in surveillance across the state solely from CHC's efforts are not anticipated. Instead, evaluation efforts have focused on understanding the coordination of the program by ODH, characterizing community-level changes resulting from collective CHC efforts, and capturing both state and local-level changes in increasing access to fresh, healthy food, opportunities to be physically active, and tobacco-free living.

The systems in which CHC is implemented are complex and multi-faceted, warranting an evaluation approach that is responsive to these complexities. For example, building or repairing a playground may require involvement of the parks department and other people at the city or county level, as well as additional community partners to help fund the efforts through volunteer hours or dollars. A more detailed description of the evaluation design and methodology is provided in Appendix B and a list of acronyms and definitions is provided in Appendix A.

This report is organized in the following manner:

Section 1a: State of Chronic Disease in Ohio

Section 1b: CHC is Designed to Address Chronic Disease in Ohio

Section 2: CHC is Implemented in 23 Communities Across Ohio

Section 3: CHC's Contributions to Community Change

Section 4: CHC Sparks Lasting Change

Section 5: What Is Next for CHC?

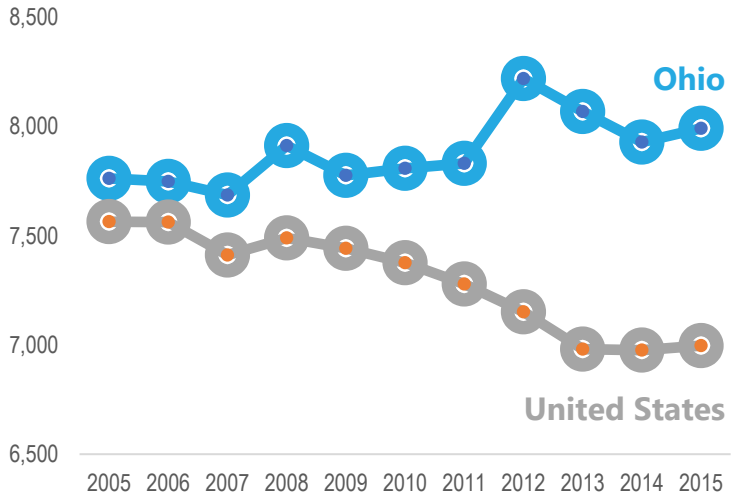
Section 1a:
State of Chronic Disease in Ohio

Overall well-being for Ohioans is falling farther behind the rest of the country

All Ohioans deserve the opportunity to reach their full health potential no matter where they are born or where they currently live. The reality is that not all Ohioans have had equitable access to resources and opportunities to support optimal health. In fact, the 2016 Ohio State Health Assessment found that **Ohio ranked in the bottom quartile of all states** for overall health, with persistent disparities by race, ethnicity, income, disability status, and geography due to lack of opportunities for all residents to reach their full health potential. The figure below shows how Ohio's rate of premature death began to diverge from the national rate in the early 2000s, generally increasing while in the United States the rate has continued to decrease. Premature deaths may be preventable through a combination of behavioral modifications and changes in social factors. (See Figure 1.)

Figure 1. Premature deaths in the U.S. and in Ohio, 2005-2015

Years of potential life lost before age 75 per 1,000 population, from America's Health Rankings analysis of the Centers for Disease Control and Prevention (CDC) WONDER Online Database.



An estimated **80% of the factors that impact health are modifiable.**

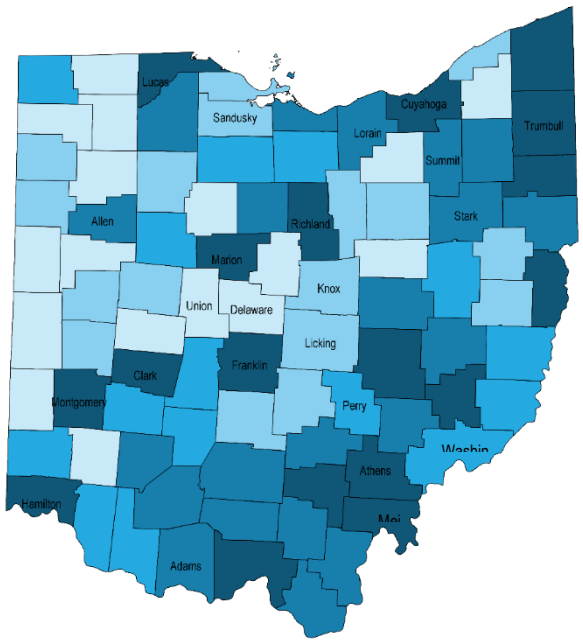
This includes health behaviors such as nutrition, physical activity, and tobacco use. It also includes improving community conditions related to transportation, built environment, and housing.

The plan to address the priorities in the 2016 State Health Assessment are detailed in the 2017-2019 State Health Improvement Plan (SHIP). **Chronic disease** prevention and management is one of three prioritized topics to improve the well-being of Ohioans, along with maternal and infant health and mental health and addiction. Promoting **healthy eating, active living, and tobacco prevention and cessation** are strategies identified to encourage cross-cutting factors that impact all three priority topics. These strategies are related to community environments and systems and require coordinated and collaborative efforts at the state and local level to improve the health of Ohioans.

Examination of county-level prevalence of food access, physical inactivity, and smoking prevalence across Ohio reveals differing priorities in different areas of the state. **Darker shades of blue indicate higher need** (e.g., less food access, higher rates of physical inactivity, higher prevalence of smoking).

Food access

The County Health Rankings measure of the food Environment (2015/2017).[1]

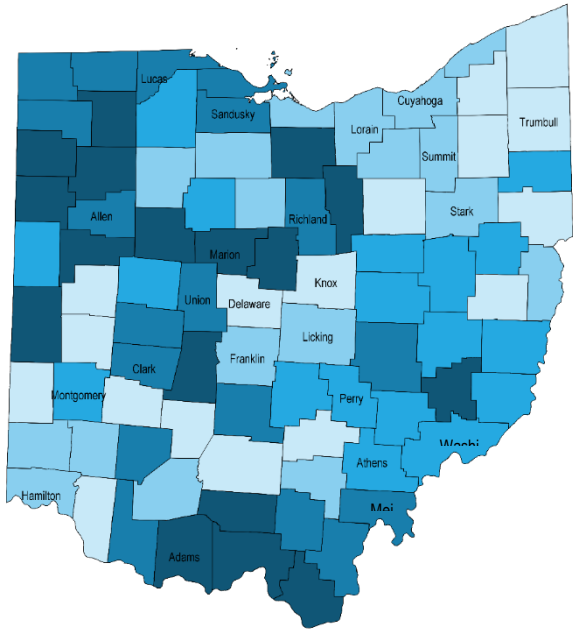


Food Environment Index (by quintiles)

- Q1: 8.3 or higher (n=17)
- Q2: 7.9-8.2 (n=17)
- Q3: 7.6-7.8 (n=15)
- Q4: 7.1-7.5 (n=21)
- Q5: <7.0 (n=18)

Physical inactivity

Percentage of county that does not meet aerobic requirements of 150 minutes per week from BRFSS (2013-2017).[2]

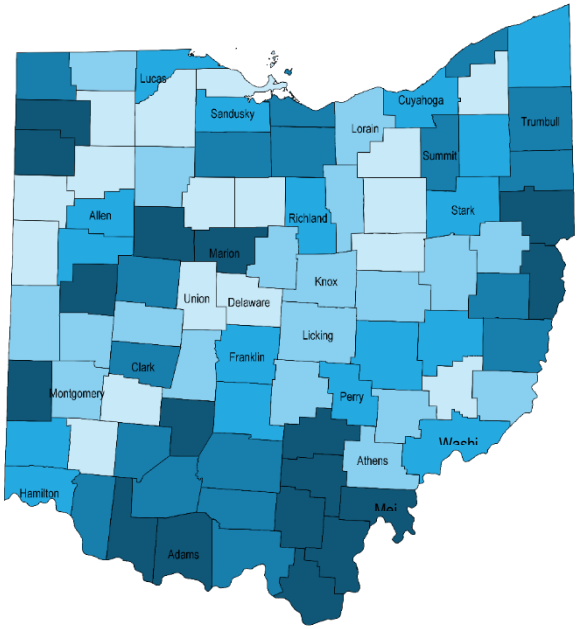


% not meeting aerobic requirements (by quintiles)

- Q1: <47.7% (n=17)
- Q2: 47.7-51.2% (n=18)
- Q3: 51.3-53.8% (n=18)
- Q4: 53.9-56.7% (n=18)
- Q5: 56.8% or higher (n=17)

Smoking prevalence

Smoking prevalence by county from BRFSS (2014-2018).[2]



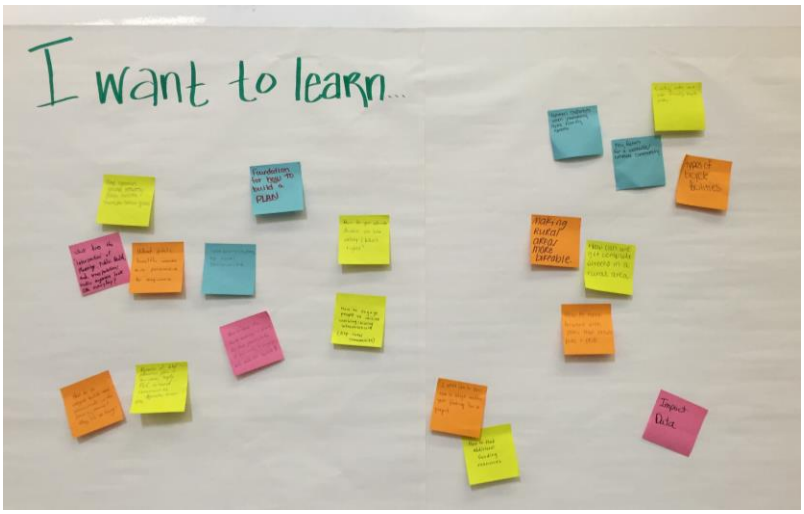
Smoking prevalence (%) (by quintiles)

- Q1: <18.1% (n=17)
- Q2: 18.1-20.5% (n=19)
- Q3: 20.6-22.7% (n=17)
- Q4: 22.8-25.4% (n=18)
- Q5: 25.5% or higher (n=17)

[1] The Food Environment Index ranges from a scale of 0 (worst) to 10 (best) and equally weights two indicators of the food environment: limited access to healthy foods and food insecurity. More information here: https://www.countyhealthrankings.org/app/ohio/2020/measure/factors/133/description.

2 Behavioral Risk Factor Surveillance System (BRFSS). Physical inactivity from 2013, 2015, 2017 three-year combined dataset. Smoking prevalence from 2014-2018 five-year combined dataset.

In addition to understanding the overall trends in the state, which consider all Ohioans, it is vital to consider disparate opportunities some Ohioans must face to reach their full health potential, including Ohioans who are African American/Black, those who have a disability, those who have lower incomes, and/or those who live in Ohio's Appalachian counties. Many of these populations struggle to access resources needed to be healthy, because of historical and contemporary inequities built into policies, systems, and environments.



Communities have some solutions to address health inequities but addressing the root causes of these inequities **requires changing policies, systems, and environments**. This type of work requires cross-sector collaboration; partnerships between public health and community residents, organizations, and leaders; and dedicated time and funding to facilitate the work. Creating Healthy Communities (CHC) is designed to address these needs.

Section 1b:

CHC is Designed to Address Chronic Disease in Ohio

CHC addresses Ohio's priority to reduce the burden of chronic disease

CHC Vision: Making the Healthy Choice the Easy Choice.

CHC Mission (2015-2019): CHC is committed to preventing and reducing chronic disease statewide. Through cross-sector collaboration, we are activating communities to improve access to and affordability of healthy food, increase opportunities for physical activity, and assure tobacco-free living where Ohioans live, work, and play. By implementing sustainable evidence-based strategies, CHC is creating a culture of health.

Ohio's Creating Healthy Communities program (CHC) addresses the risk factors identified in the previous pages. In 2015-2019, 23 communities across the state received funding to implement policies, systems, and environmental changes to address the following three priorities: access to healthy food, opportunities for physical activity, and opportunities for tobacco-free living.

How is CHC funded?

The CHC program is housed within and managed by the Bureau of Health Improvement and Wellness at the Ohio Department of Health (ODH). CHC is funded by the Centers for Disease Control and Prevention's (CDC's) Preventive Health and Health Services Block Grant (PHHSBG). The PHHSBG allows states the flexibility to address their own unique public health needs and challenges with innovative and community-driven methods, while working to meet the federal Healthy People 2020 goals. ODH used these dollars to fund 23 counties/cities (sub-awardees) to implement the CHC program from 2015-2019 (Figure 2).

What is CHC's approach to improving chronic disease?

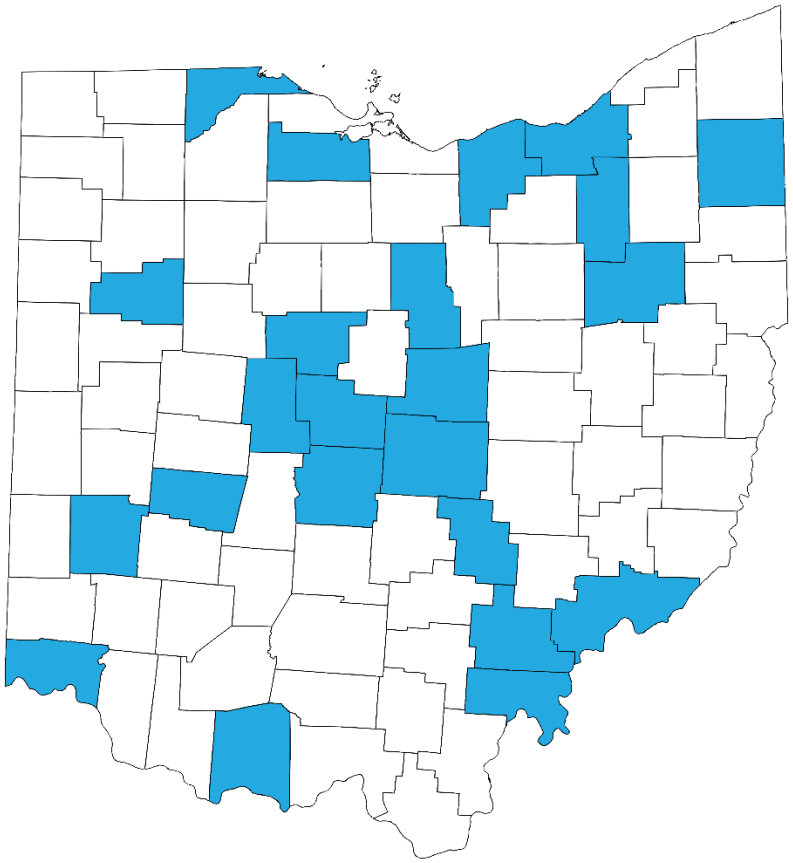
CHC intervenes on upstream policy, systems, and environmental (PSE) changes to create/expand Ohioans' opportunities for physical activity, healthy eating, and tobacco-free living (Table 1). The assumption underlying this approach is that intervening on upstream drivers of health offers the greatest potential for creating population-level change. CHC strategies address many of the cross-cutting priorities outlined in the 2016 State Health Assessment, including physical activity and access to healthy food, tobacco use, transportation, and racism (strategies listed on page 8).

Table 1. Definition of policy, systems, and environmental change from the Food Trust.

POLICY	SYSTEMS	ENVIRONMENTAL CHANGE
Policy change includes policies at the legislative or organizational level. For example, institutionalizing new rules or procedures as well as passing laws, ordinances, resolutions, mandates, or regulations, are all examples of policy change efforts.	Systems change involves change made to the rules within an organization. Often, systems change will focus on modifying infrastructure within a school, park, worksite, or health setting or instituting processes or procedures at the systems level to ensure a healthier workplace.	Environmental change is change made to the physical environment. Physical (structural changes or programs or services), social, and economic factors influence people's practices and behaviors and should reflect a population-focused effort.

CHC worked in 69 priority communities through 23 sub-awardees from 2015-2019

Figure 2. Map of CHC funded counties, 2015-2019 (in blue).



Sub-awardee	Priority Communities
Adams County	Adams County, Manchester, Peebles
Allen County	Allen County, Lima, Delphos
Athens County	Athens County, Nelsonville, Trimble Township
Cincinnati (city)	Southwest Millcreek Corridor, Evanston, Winton Hills
Clark County	Clark County, Springfield, New Carlisle
Columbus (city)	Linden, South Side, Westside
Cuyahoga County	Euclid, East Cleveland, Lakewood
Delaware County	Delaware City South, Oxford Township, Big Walnut
Knox County	Knox County, City of Mount Vernon, Village of Danville
Licking County	Licking County, Newark, Village of Buckeye
Lorain County	Oberlin, Elyria, City of Lorain
Lucas County	South Toledo, East Toledo, Central City Toledo
Marion County	Marion County, Marion City – North-end and West-end
Meigs County	Meigs County, Pomeroy, Middleport
Montgomery County	Old North Dayton, East Dayton, West Dayton
Perry County	Somerset, New Lexington, Roseville
Richland County	Mansfield, Shelby, North End Community
Sandusky County	Sandusky County, City of Fremont, Village of Gibsonburg
Stark County	SE Canton, NE Canton, Massillon
Summit County	Barberton, Buchtel, Lakemore/Springfield
Trumbull County	Bolindale, North Warren, South Warren
Union County	Union County, Marysville, Village of Richwood
Washington County	Washington County, Marietta Township, Belpre Township

Table 2. Full list of CHC strategies, 2015-2019. CHC sub-awardees are required to implement at least one active living and one healthy eating strategy in each priority community (tobacco-free living strategies were required in 2015-2017 and optional in 2018-2019). Note that not all the active living and healthy eating strategies were allowable to implement each grant year.

Active living	Healthy eating	Tobacco-free living

• Bike racks/infrastructure
• New/repaired parks and playgrounds
• Worksite active commute support
• Multi-use trails
• Safe Routes to School
• Bike rentals
• Crime prevention through environmental design
• Shared use agreements
• Share the Road
• Pedestrian/bicycle or transportation master plan
• Open/play streets
• Public transit improvements
• Complete Streets
• Ohio Healthy Program
• Community fitness centers
• Technical assistance (TA) for comprehensive school wellness policies
• Access or subsidized membership to onsite/offsite fitness center
• Bike lanes
• Flexible work arrangements
	• Farmers' markets
	• Small retail/supermarkets
	• Urban agriculture policies
	• Affordable transportation options for grocery stores
	• Shared use agreements
	• Food banks/pantries
	• Access to drinking water
	• Community gardens
	• Farm to -institution
	  ○ Farm to school
	  ○ Farm to early care and education
	• Community supported agriculture (CSA)
	• School gardens
	• Salad bars
	• TA for comprehensive school wellness policies
	• Ohio Healthy Program
	• Food and beverage guidelines
	• Support for breastfeeding
	• Produce prescriptions
		• Smoke-free multi-unit housing
		• Tobacco-free open spaces (parks, public places)
		• Discouragement of tobacco sales in small retail
		• School district tobacco-free policies
		• College/university tobacco-free policies
		• Trade/technical school tobacco-free policies
		• Worksite tobacco-free policies
		• Tobacco 21 (T21)
		
		Coalition strategy
		
		In addition to selecting PSE strategies, sub-awardees were also required to **organize and coordinate a multidisciplinary coalition** of key stakeholders representing the three identified priority communities. Sub-awardees were required to evaluate one coalition outcome annually: member participation, membership diversity, PSE knowledge and skills, funding leveraged, membership number, or member satisfaction.

Note: Three strategies are not included in the table because they were not completed by any of the communities: development incentives, school siting, and recreation facilities.

Who is responsible for implementing CHC?

ODH program staff provide the infrastructure to support collective CHC activities while CHC coordinators facilitate local level activities, including engaging coalitions and a cross-sector of community partners to support and implement CHC strategies. All sub-awardees are required to staff a CHC coordinator at 100% time. State and local partnerships are critical to implementing changes to food and transportation systems, for example, which require coordination among multiple sectors, including public health, transportation, environmental health, city planning, and food retail. A more detailed description of how CHC is implemented is provided in Section 2.

CHC principles provide direction for implementation

While all CHC coordinators are accountable to the same grant requirements, the unique context of each community means CHC implementation looks different in each community. In October 2017, recognizing the need to provide flexibility in implementation and evaluation, ODH embarked on a process to define the principles of the CHC program. (See Appendix C for more details on the process) The purpose of the principles is to provide direction for implementation while maintaining flexibility to allow communities to tailor activities to fit unique contexts.

Specifically, the principles:[3]

1. Inform decisions when partners face forks in the road to implementation.
2. Are grounded in values.
3. Provide direction, but not detailed prescription, so they offer opportunities to adapt to different contexts, changing understandings, and varied challenges.
4. Must be interpreted and applied contextually and situationally to ensure their relevance.
5. Are the rudder for navigating complex dynamic systems.

CHC's Five Principles

- **Activate and Engage Communities.** CHC is the conduit for motivating and driving change, through community engagement and mobilization. Activities of CHC are rooted in community priorities.
- **Cross-Sector Collaboration.** There is coordination of work and consistent messaging among partners in diverse sectors at the national, state, and local levels around policy, systems, and environmental change in healthy eating and active living.
- **Ease of Access.** By addressing barriers, CHC improves accessibility of healthy choices to Ohioans, especially for those groups facing the steepest barriers.
- **Health Equity**. CHC is invested in individuals and populations disproportionately affected by chronic disease.
- **Sustainable Change.** CHC leverages resources, forms partnerships, and builds capacity to ensure lasting policy, systems, and environmental change.

[3] Source: 10 Steps to Principles-Focused Evaluations that are Useful—and Actually Used. From Patton, M. Q. (2017). Principles-Focused Evaluation: The GUIDE, Exhibit 36.1, pp.367-377.

Section 2:

CHC Is Implemented in 23 Communities Across Ohio

State and local partners work in concert to implement CHC

Changing policies, systems, and environmental conditions to better support population health necessitates cross-sector collaboration of individuals and organizations at the state and local levels. Each group plays a critical role in supporting and implementing CHC activities (Table 3). See the box on the following page for a specific example of how state and local partners coordinated to improve opportunities for active transportation in the state.

Table 3. State and local CHC partners and their roles in implementing CHC.

State program staff Provide infrastructure to support collective CHC activities.	Local CHC coordinators Engage a cross-sector of local level partners to implement CHC activities.	Local community partners Collaborate with CHC coordinators to implement CHC strategies.
• **Administer CHC** and guide program vision and strategy (e.g., develop grant application, research evidence-based strategies to implement). • **Support learning and program improvement** through research and evaluation (e.g., needs assessments, pilot studies, program evaluation). • **Provide technical assistance** (e.g., subject matter expertise), professional development, and training to sub-awardees (e.g., Ohio Action Institute, see next page). • **Convene sub-awardees and statewide partners** through quarterly in-person meetings, monthly project calls, and issue-specific convenings. • **Facilitate communication and peer learning** (e.g., online "Engagement Hub").	• **Coordinate, convene, and connect** community partners (e.g., convene and facilitate coalition meetings). • **Provide direct resources** to support existing or jumpstart new community PSE projects (e.g., seed money, playground equipment). • **Provide technical assistance** to community partners (e.g., data collection, consulting, grant writing) and serve as a thought partner/introduce new ideas. • **Facilitate community learning** through hosting events, classes, and public health campaigns. • **Provide a framework for talking about PSE change** and how the environments in which we live influence our health.	• **Participate in coalition meetings** and recruit additional partners to contribute to CHC efforts. • **Implement PSE projects,** including advocating to pass CHC supported policies, contributing materials and resources, and volunteering time to CHC projects. • **Provide technical assistance** to support implementation of PSE projects. • **Provide educational programming** to support CHC efforts and host community workshops. • **Spread the word** about CHC in the community.

> *"We're nothing without our partners. We've kind of done this grant, and I guess, having a Coordinator here provides a frame. Not really a frame but a backbone for the work. But the work really is our partners."*
>
> *- CHC Coordinator*

Example of coordination in action: The Ohio Action Institute

In 2014, **ODH** hired a Healthy Places Coordinator to oversee active living strategies to improve the built environment to support physical activity – one of CHC's key program strategies. The coordinator connected with the **Ohio Department of Transportation** (ODOT), realizing that ODOT's support was needed if CHC was to expand active transportation (AT) efforts throughout the state. ODOT was already building capacity to support AT through the national **Safe Routes to School** (SRTS) **Program;** therefore, partnering with ODOT connected ODH to new state and national partners. ODOT and ODH participated in a national Walkability Action Institute, where they developed an AT action plan fueling momentum to prioritize AT in Ohio. ODH and ODOT then partnered to replicate the Walkability Action Institute in Ohio (the *Ohio Action Institute*), which local communities could apply to attend.

Seven CHC sub-awardees sent cross-sector teams of representatives from health, transportation, and regional planning to the **Ohio Action Institute**. The Institute provided time and space for teams to **create their own AT action plans**. Teams were able to align their local plans with the statewide plan, while tailoring it to their own communities.

Attending the Ohio Action Institute **deepened relationships between team members** from different sectors. For many participating communities, the Action Institute created relationships and **momentum for change** that resulted in subsequent collaborations.

Additionally, the Action Institute was one of many venues to implement the Your Move Campaign, a co-developed and co-branded campaign by ODH and ODOT to encourage walking biking and taking transit.

Local implementation is heavily influenced by context

Community partners implement CHC in accordance with its principles, but local implementation is influenced by community context (Table 4). Context influences availability of resources to implement activities, strategies selected, and coordinator approaches to working in and with the community. Context may facilitate or pose barriers to strategy implementation. Successful implementation requires coordinator flexibility to engage communities in ways that are responsive to community context and priorities.

> *"Each community has its own identity. Each entity works differently."*
> – CHC coordinator

Table 4. Contextual factors that influence CHC implementation.

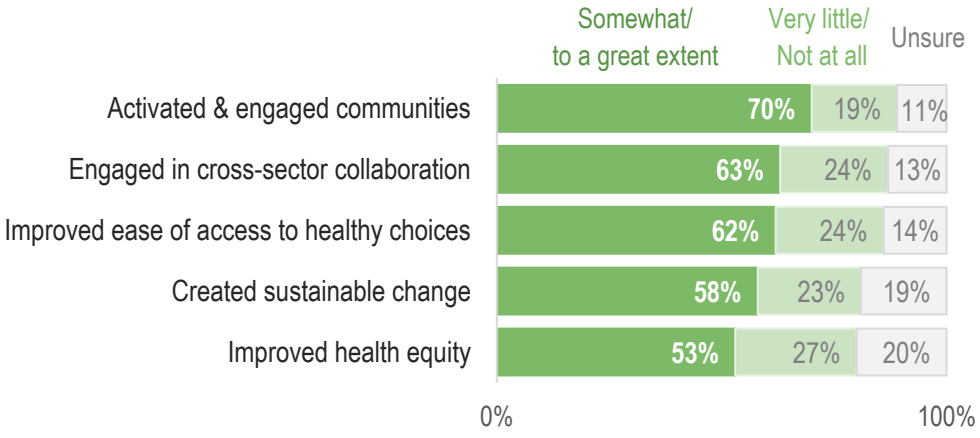
Individual context	Organizational context	Community context
Coordinators' professional, educational, and lived experiences influence their approach to and ease of implementation. Having a degree in a health-related field, existing relationships with community, experience with grant funded programs, and advocating for health equity supported implementation.	Having access to administrative, marketing, technology, and additional staff support from other chronic disease prevention programs supported implementation. Access to these organizational resources often varied by size and location of sub-awardees.	Community size, geography, culture, and resources influenced implementation. Small communities often had access to fewer resources, but longstanding community partnerships. Large communities often had access to more resources but had challenges navigating complex politics to establish and sustain partnerships.

CHC is implementing all principles with varying degrees of success

CHC's principles guide, but do not prescribe, program decision-making and implementation. While local implementation depends on community context, evaluation findings reveal some common themes that describe *how* and *how well* CHC principles are implemented in practice.

Most community partners report that their work with CHC is successfully activating and engaging communities, engaging in cross-sector collaboration, and improving ease of access to healthy choices (Figure 3). Fewer community partners report that their work with CHC is creating sustainable change or improving health opportunity.

Figure 3. CHC community partners were most likely to report that their work with CHC activated and engaged communities and least likely to report that it improved health equity.



Data source: 2019 CHC Partnership Evaluation Report, n=558 CHC community partners.

The ability of CHC to generate sustainable and equitable change is contingent upon successful activation and engagement of a cross-sector of community partners to implement PSE strategies. Because of how these principles drive outcomes, a description of how CHC has

implemented the critical principles of 1) activating and engaging communities, 2) engaging in cross-sector collaboration, and 3) health equity is described here. More details on how CHC enacts the principles of ease of access and sustainability are provided in Sections 3 and 4 respectively.

How is CHC activating and engaging communities?

By being in community. Being in community helps to ensure CHC activities are grounded in community priorities. Consistently showing up in the community by attending local meetings and events provides CHC coordinators and partners opportunities to listen to community residents and use feedback to inform program activities. Being in community also raises public awareness of the CHC program and goals. Importantly, CHC unites and leverages existing community strengths and assets as a central tenet of its work.

> *"CHC builds on the spirit of the local folks."*
> - CHC community partner

By facilitating community learning to change the narrative about what creates health. By inviting community partners to host events, classes, workshops, and demonstrations, CHC is increasing community awareness of the link between PSE and health. CHC partners reported that this increased awareness is changing community narratives and social norms around health and generating community support for PSE change.

> *"CHC has done an exemplary job in helping us to understand the link between the built environment and public health outcomes.*
> - CHC community partner

By coordinating, convening, and connecting community partners to "break down silos" and create an environment for collaboration. Whether hosting coalition meetings, town hall meetings, or public information sessions, CHC convenings provide a forum for networking and collaboration. Inside and outside of meetings, CHC connects community organizations with each other, creating new and strengthening existing partnerships.

> *"CHC is the one thing that keeps all the health-related nonprofits, community partners, agencies, and community members communicating and working together."*
> – CHC community partner

How is cross-sector collaboration supporting implementation?

Engaging across sectors increases diversity of partnerships, supports alignment of community efforts, and increases feasibility of implementation. Implementing PSE strategies is complex and necessarily involves coordination among many sectors. CHC brings together partners that do not typically work together. Many partners reported that these partnerships would not have occurred if not for their involvement with CHC. Engaging diverse partners also distributes the work so that no one organization has full responsibility for a project. Connecting people and organizations working on similar projects increases feasibility of implementation and alignment of community public health efforts toward a common purpose.

Cross-sector partnerships ensure consistent messaging and expand CHC reach. CHC provides a means for cross-marketing and promotion among diverse community partners, expanding the reach of CHC efforts. Sometimes this resulted in expanding existing programs into new areas and geographies.

The longer community partners are engaged with CHC, the more satisfied and engaged they are in the program. Surveys of CHC coalition members over multiple years found that coalition members were consistently satisfied with the activities and leadership of their coalitions and overwhelmingly agreed that the benefits of participating in the coalitions outweighed the risks. Evaluation findings also suggest that the longer community partners are involved with CHC, the higher their level of involvement in the coalition, the more likely they are to report loyalty to the coalition, and the more likely they are to report implementing all five CHC principles.

> *"CHC does an excellent job at bringing multiple agencies to the table to participate in cross-sector collaboration. Not only is each person who attends the meeting able to provide a piece of the puzzle when creating PSE changes, but CHC also does a great job connecting with other pre-existing groups… to work on implementing PSE changes throughout the community."*
>
> – CHC community partner

CHC partners represent diverse cross-sectors of the community

- Community residents
- Neighborhood associations
- Community groups
- Community centers
- Parks and recreation
- County government
- City government
- Afterschool and childcare providers
- School districts
- Higher educational institutions
- Extension services
- Arts sector
- Public libraries
- Philanthropy
- Nonprofit organizations
- Advocacy groups
- Healthcare
- Housing
- Businesses
- Disability sector
- City engineers
- Transportation
- Planning and economic development
- Farmers and growers

CHC partners contribute multiple resources to implement CHC strategies

- Physical space for meetings and events
- Food/beverages
- Fresh produce
- Gift cards
- Athletic equipment (e.g., bikes, helmets)
- Educational resources
- Transportation to programs/activities
- Volunteer time
- Funding
- Promotional materials
- Signage
- In-kind staff support
- Knowledge and expertise
- Cross-advertising

Focus on inclusive design supports inclusion of people with disabilities

In 2016, ODH added an additional focus to the CHC program of improving the built environment and opportunities for individuals with disabilities to make the healthy choice the easy choice. ODH invited David Ellsworth, MPH, CHES, a Health Services Policy Specialist with the Ohio Disability and Health Program, to provide multiple trainings for sub-awardees on how to engage community partners and implement CHC strategies through the lens of universal design. Annual surveys of coalition members between 2016 and 2018 consistently found that six out of 10 coalition members reported that their CHC coalition included organizations representing people with disabilities.

CHC partners have installed adaptive playground equipment and built trails, parking spaces, and community gardens to be accessible to people with disabilities. When surveyed in 2019, one community partner explained that CHC work promotes health equity by "involving the disability population and organizations advocating for them in meetings and projects."

> *"The new playground makes it possible for our kids, and their typically developing friends, to play together. It sends the message that all individuals, no matter their ability, are valued in our community."*
>
> – Inclusive playground committee member

Advancing health equity is a process and an outcome of CHC

One way that CHC advances health equity lies in *how* program partners implement activities. CHC partners who center health equity in their work intentionally create processes to expose root causes of health inequities and work to shift power in their partnerships with community. They center community voices and needs in all stages of implementation. CHC advances health equity through the following processes:

Inviting community to identify their priorities and then molding CHC strategies around those priorities ("retrofitting" approach). An alternative approach, the "recruiting" approach, involves CHC first selecting strategies and then "recruiting" community partners to work on those strategies. While both approaches have their strengths and limitations, the retrofitting approach better aligns with health equity as it acknowledges communities as their own experts and allows community members to lead work to address their actual needs and concerns.

Building community power to create solutions. This involves including members from underserved communities in decision-making or transferring decision-making power to community. Examples include supporting community meetings for residents to express their priorities directly to decision-makers and including members of the disability community in designing inclusive playgrounds.

Educating community about the root causes of health inequities. Examples include hosting health equity educational workshops or events. One CHC coordinator obtained redlining maps from the local library to share and discuss housing inequities with coalition members at a local CHC coalition meeting.

Prioritizing communities disproportionately affected by chronic disease. CHC sub-awardees referenced data about health disparities to inform their selection of priority communities. Communities with the highest rates of chronic disease and/or historically marginalized populations were prioritized for intervention. Because CHC strategies increase access to opportunities for healthy living by design, health equity is also an outcome of CHC.

Opportunities exist to improve health equity efforts

Evaluation findings during the past five years revealed several examples of CHC partners embracing a health equity approach to their work. In other cases, the language used by program partners to describe their approach to working with communities and/or to improving health equity suggested opportunities for continued education about what it means to center equity in CHC projects.

Only half of CHC partners surveyed in 2019 reported their work with CHC improves health equity (Figure 3, page 13). Some CHC partners explained that measuring the impact of health

equity efforts is difficult, especially in a short time frame. Others felt that CHC only addresses "surface issues," thus can only be expected to have a limited impact on alleviating health disparities.

Some CHC partners use language that perpetuates the harmful narrative that health inequities are attributable solely to individual actions and choice, such as healthy eating or exercise versus the systemic issues that influence access to healthy foods and exercise opportunities. While personal education and choice are important to health, the context in which choices are made, and many factors out of the control of the individual that influence health are critical to opportunities for individual and community health. The underlying premise of CHC is an approach of intervening on upstream policy, systems, and environmental drivers of health.

Facilitators and challenges of CHC implementation

Facilitators of implementation

- **Dedicated staff** to focus solely on coordinating CHC activities.
- **Flexible funding.** Allow local communities to structure activities to best fit their contexts.
- **Skills, experience, and shared interests** among CHC partners.
- **Shared vision**. Articulating mutual benefits to resonate with different audiences.
- **Dedicated champions.** Their passion and motivation provide forward momentum.
- **Opportune timing**. Political will to create change opens windows of opportunity to implement strategies.
- **Cross-sector partnerships** provide for multiple perspectives, resources, and insights.
- **Community engagement early, often, and throughout.** Prioritizing engagement with community residents directly impacted by the issues CHC works to address.
- **Intentional focus on root causes of health**. Considering health equity in defining the problem, identifying solutions, implementing strategies, and evaluating outcomes.

Challenges of implementation

- **Communicating CHC purpose and approach**. Educating community that CHC is not an individual wellness program, but rather a population-based community intervention.
- **Upfront funding needs**. Some PSE strategies, such as those to increase active transportation, may require a lot of up-front funding.
- **Changes take time**. A five-year grant cycle is not long enough to see individual-level health impact.
- **CHC is not a statewide program.** CHC funds 23 counties and cities.
- **Keeping partners engaged in CHC efforts.** Competing priorities and the volunteer nature of the work may pose challenges to engagement.
- **Staff turnover.** CHC staff and partner turnover, especially community champions, can lead to breaks in communication and momentum.

Section 3:
CHC's Contribution to Community Change

CHC increased access to opportunities for healthy eating

The CHC program implemented **473** PSE strategies over five years to increase access to opportunities for healthy eating for more than **1.2 million** Ohioans.

Table 5. Total number and relative impact of PSE strategies implemented to increase opportunities for healthy eating, 2015-2019.

	PSE strategies implemented by sub-awardees	# Completed	# Ohioans impacted
Most frequently implemented	Farmers' markets	127	
	Community gardens	68	
	Small retail/supermarkets	51	
	Access to drinking water*	44	
	Food and beverage guidelines	37	
Less frequently implemented	Food banks/pantries	31	
	School gardens	26	
	Ohio Healthy Program	21	
	Breastfeeding support	16	
	Community supported agriculture	15	
	Produce prescriptions	11	
Infrequently implemented	Farm to institution	9	
	Farm to school	7	
	Urban agriculture policies	3	
	Safe Routes to Healthy Food	3	
	Shared use agreements*	2	
	Affordable transportation options to grocery stores	1	
	Food hub	1	

** Strategies were not offered all five years.*

Key: <10,000 | 10,000 -50,000 | 50,001-100,000 | >100,000

Snapshots of success

Increasing access to and affordability of healthy foods through farmers' markets

In 2016, Canal Market District and Enterprise Hub became the first farmers' market in **Licking County** to accept payments through the Supplemental Nutrition Assistance Program (SNAP). The following year, the market implemented the Produce Perks incentive program, further increasing affordability of fresh produce for low-income residents.

In **Stark County**, StarkFresh leveraged partnerships with local growers, organizations, and governments to convert a former box truck into a refrigerated mobile farmers market. The "Veggie Mobile" delivers produce to senior living facilities, apartment complexes, libraries, and other community centers throughout the county.

Meigs County established a farmers' market board to support future sustainability of the market. The market addresses food insecurity and economic development and, in the words of the CHC coordinator, "embraces what makes Meigs County great."

> *"What we saw were people from all pockets of our community coming to visit the market. Not only were they shopping at the market, but they were staying and congregating. This was the exact atmosphere that we wanted to create."*
>
> – Market manager

Increasing access to fresh produce through community gardens and healthy retail

In **Union County**, a mental health and recovery board and greenhouse established garden programs to address food insecurity and provide job training and experience to inmates from a nearby correctional facility and people living in mental health and recovery centers.

In 2016, **Marion County** launched its first mobile produce pantry. The pantry increases food access, removes transportation barriers, reduces food insecurity, and integrates those living with disabilities into a community-wide solution.

In **Summit County**, CHC partnered with the Pit Stop in the Lakemore community to implement a healthy corner store initiative. CHC contributed by funding a refrigeration unit, connecting store owners to local farmers who could provide fruits and vegetables at wholesale cost, and providing signage to promote availability of healthy items.

CHC increased access to opportunities for active living

The CHC program implemented **443** PSE strategies over five years to increase access to opportunities for physical activity for more than **2 million** Ohioans.

Table 6. Total number and relative impact of PSE strategies to increase opportunities for active living implemented by CHC sub-awardees, 2015-2019.

	PSE strategies implemented by sub-awardees	# Completed	# Ohioans impacted
Most frequently implemented	Bicycle infrastructure	136	
	Parks and playgrounds	125	
Less frequently implemented	Active transportation commute support	31	
	Multi-use trails	29	
	Safe Routes to School	22	
	Bike rentals	16	
	Crime prevention through environmental design	15	
	Active transportation plans	13	
	Shared use agreements	13	
Infrequently implemented	Share the Road	8	
	Worksite physical activity policies	7	
	Open/play streets	6	
	Pedestrian infrastructure	5	
	Public transit improvements	4	
	Community fitness centers	5	
	Complete Streets policies	4	
	Public transit improvements	4	
	Ohio Healthy Program	4	

** Strategies were not offered all five years.*

Key: <10,000 | 10,000-50,000 | 50,001-100,000 | >100,000

Snapshots of success

Increasing access to physical activity through playgrounds and parks

In rural **Knox County**, CHC partnered with the Knox County Board of Developmental Disabilities and multiple community partners to build an inclusive playground at Mount Vernon Memorial Park. Partners formed an Inclusive Playground Committee of therapists, families, and other advocates to lead design and development. The playground raised community awareness of the need for inclusive spaces/programs, and Mount Vernon City Council members were asked to adopt a resolution calling for the consideration of inclusiveness in all future projects.

In **Perry County**, the Ludowici Community Foundation opened a centrally located park to include a splash pad, playground areas, two ballparks, a shelter house, a fishing pond, and miles of wooded trails.

Lorain County increased access to physical activity for the more than 1,300 residents of the Huntington community by using CHC resources to update Huntington Park with amenities for people of all ages (new playground, shade coverings, benches, dog cleanup stations and fresh drinking water).

> *"Through CHC…we have been able to transform a once blighted public park space into a thriving community asset."*
>
> --Community partner

Increasing access to physical activity through improved bike infrastructure

The City of Fremont in **Sandusky County** added a bike lane along the main downtown street, eliminating barriers to biking for active transportation and physical activity. CHC contributed to this success by partnering with the bike trail committee to advocate to city engineers to include bike lanes when working on city improvements.

In **Lucas County**, multiple stakeholders (We Are Traffic, Believe Center, Toledo Bikes, and Safe Kids Greater Toledo) convened to create secure bike parking, offer bike safety education, and lend bikes to youth at the Believe Center. These infrastructure improvements increased opportunities for youth to engage in bicycling as a main mode of transportation.

In the city of **Dayton**, CHC partnered with Link Dayton and Bike Miami Valley to establish a bike station in the Wolf Creek Neighborhood. The station links residents to a system of 24 stations and 225 bicycles, allowing residents the ability to be physically active while commuting to other parts of the city. CHC contributed by helping to identify a neighborhood that would benefit most from the bike station and helping to fund the station.

CHC increased access to tobacco-free living

The CHC program implemented **171** PSE strategies over five years to increase access to smoke-free air for more than **1.3 million** Ohioans.

Table 7. Total number and relative impact of PSE strategies to increase access to tobacco-free living implemented by CHC sub-awardees, 2015-2019.

	PSE strategies implemented by sub-awardees*	# Completed	# Ohioans impacted
Most frequently implemented	Tobacco-free parks and public spaces	71	
	Smoke-free multi-unit housing	50	
Less frequently implemented	Tobacco-free worksites	23	
	School district tobacco-free policies	10	
Infrequently implemented	Discouragement of tobacco sales in small retail	6	
	Tobacco 21	4	
	College/university tobacco-free policies	4	
	Tobacco-free libraries	2	
	Trade/technical school tobacco-free policies	1	

** All tobacco strategies were optional in 2018 and 2019.*

Key: <30,000 | 30,000 – 75,000 | 75,001 – 400,000 | >400,000

Snapshots of success

Increasing access to tobacco-free open spaces

As of December 2017, all seven public parks in **Adams County** have adopted 100% tobacco-free policies. CHC played an instrumental role in this accomplishment by helping the Adams County Medical Foundation secure grant funding for the work and helping to convene a Tobacco Task Force and Teen Board to lead discussions throughout the county in support of tobacco-free policies.

In **Clark County**, the City of New Carlisle passed a smoke-free ordinance prohibiting smoking within 20 feet of all playgrounds, concession and spectator areas, recreational facilities, bathrooms, swimming pools, and open-air shelters.

> *"We have noticed a significant reduction in the amount of tobacco-related waste as well as an increase in park usage. The citizens are noticing these changes and are sharing positive feedback with city officials."* – City manager

Increasing access to tobacco-free spaces in multi-unit housing

On May 1, 2018, in **Lorain County**, the Lorain Metropolitan Housing Authority (LMHA) passed a policy to make all its residential facilities smoke-free environments, banning smoking in common areas, resident units, offices, and within 25 feet of all doors and windows. CHC contributed to this accomplishment by helping to form a Healthy Homes subcommittee to draft policy language and implement enforcement and cessation activities. CHC also provided evaluation, training, community outreach, and education, including training to building managers and maintenance staff about the risks of secondhand smoke, rationale for the policy change, and how to conduct enforcement activities.

> *"To see people embrace the change has been encouraging. The smokers say, 'Maybe this is the time to stop.'"* – Building manager

In **Sandusky County**, the Sandusky Housing Authority implemented a smoke-free policy in all 48 public housing units of the Day Woods Housing Community located in Fremont. CHC supported this change by administering a resident opinion survey to gauge tenant support for smoke-free living.

Policies and environments supportive of CHC focus areas increased across multiple sectors from 2015 to 2019

CHC sub-awardees surveyed 653 community partners in 2015 and again in 2019 using the Community Health Assessment aNd Group Evaluation (CHANGE) Tool (described further in Appendix B) to measure growth in adoption of policies and environments to support healthy eating, active living, and tobacco-free living over time. Growth was seen across each of the three areas, with the largest growth in tobacco policy and environment. There was not a significant difference in growth between entities that worked with CHC and those that did not.

Limitations to consider when interpreting findings of the CHANGE Tool include lack of information about the level of involvement CHC sub-awardees had with organizations (e.g., amount and quality of the intervention), contextual information that may provide insight into influencing factors outside CHC, and qualitative information about where organizations started regarding specific policies or environmental conditions.

Figure 4. Growth in policies

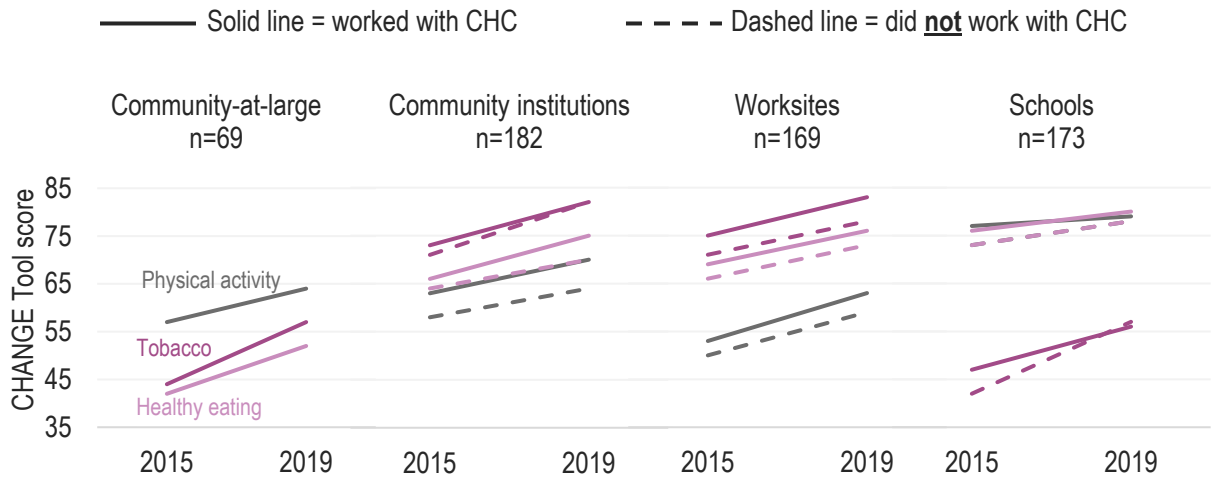
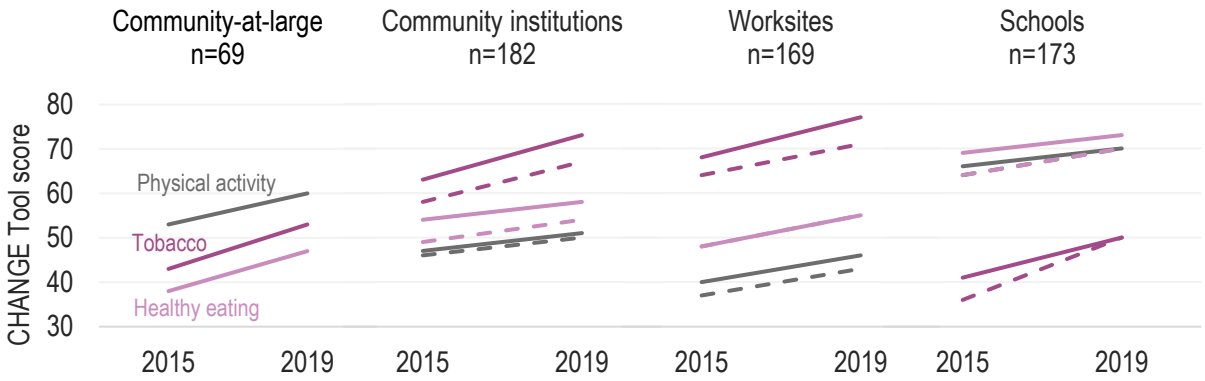


Figure 5. Growth in environment



Section 4:
CHC Sparks Lasting Change

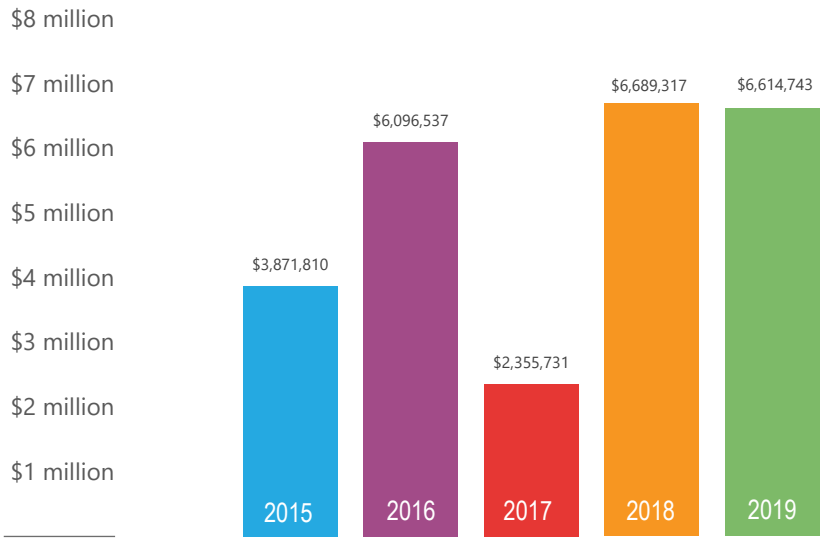
CHC leveraged more than $27.3 million of funding in five years

The total amount awarded by ODH over this funding cycle was nearly $13 million; however, this investment was more than doubled through various sources. CHC leveraged more than $27.3 million from various partners in private, public, and philanthropic sectors between 2015 and 2019.

> *"Sustained funding over many years is what will truly change the culture in our communities."*
>
> – CHC coordinator

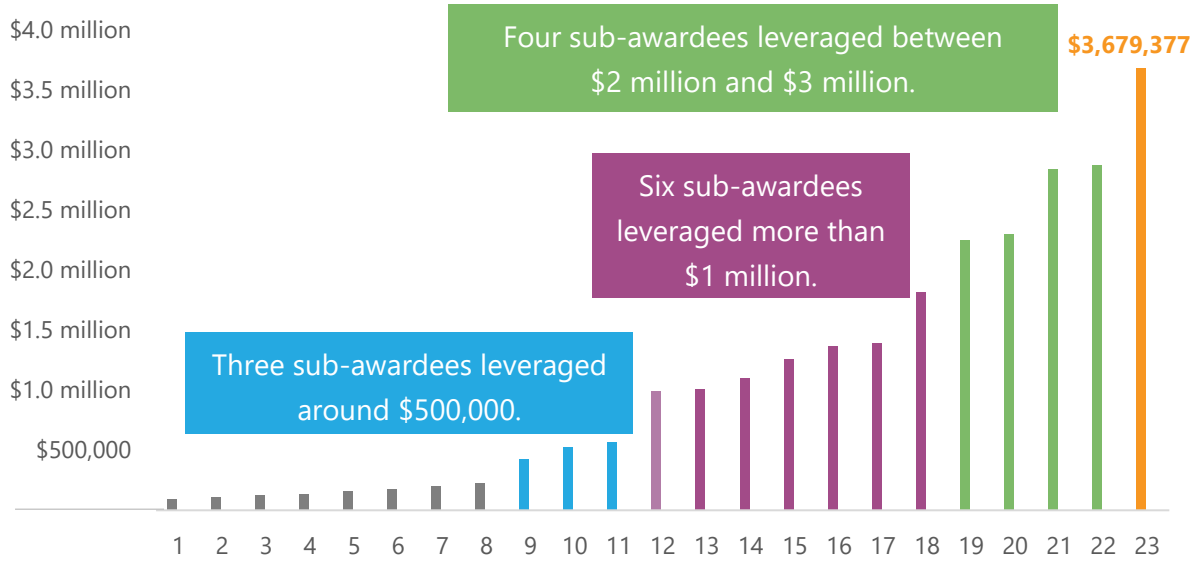
Total leveraged funding per year, across all sub-awardees, ranged from approximately $2.4 million in 2017 to more than $6.6 million in each of the last two years of the funding cycle.

Figure 6. Total leveraged funding across sub-awardees, by year



The total amounts leveraged by sub-awardees during the funding cycle ranged from about $90,000 to almost $3.7 million, with **10 sub-awardees leveraging more than $1 million** and many others leveraging nearly this amount. The average amount leveraged per grantee across the five years was approximately $1.1 million. In the figure below, the wide range of total funding leveraged is displayed.

Figure 7. Total funding leveraged by sub-awardee, which ranged from $90,000 to nearly $3.7 million



What is leveraged funding used for?

Many of the CHC strategies and activities require additional funding from varied sources to successfully implement, particularly strategies that involve infrastructure development or improvements. During the past five years, this included:

Healthy Eating
Farmers' market infrastructure
Food access programming
Community gardens
Mobile food pantry
Taste testing
Water filling station

Active Living
Paved walking paths
Playgrounds
Park improvements
On-road bike routes
Bicycle lending programs
Safe Routes to School safety equipment
Multi-use trails
Adaptive bike equipment

Tobacco-Free Environments
Tobacco-free signage
Youth tobacco prevention
Conference attendance
Tobacco retail audits
Tobacco 21 video contest
Youth tobacco prevention

Other activities funded by leveraged dollars include data collection and evaluative activities that are done in local communities, including needs assessments for physical activity and healthy food access, materials for real-time surveys, postage, and incentives. Other activities funded beyond the CHC funding include media, training, strategic planning, meeting spaces, grant writing, sponsorship of events, and administrative or other staff support.

Where does leveraged funding come from?

The types of organizations that provided funding were wide-ranging, and encompassed local, regional, and national sources, including public and private funders. The sources of funding were often driven by the needs of the specific project or strategy, and the partnerships built to implement that work.

In addition to funding, volunteer hours and spreading the word about CHC events and projects is an essential way that CHC is sparking lasting change.

Centers for Disease Control and Prevention

- State Physical Activity and Nutrition (1807)
- State and Local Public Health Actions (1422)

Grants, foundations, and membership organizations

- Extension offices, metropolitan planning organizations, YMCAs, elected bodies
- Community Development Block Grant
- National Association of Chronic Disease Directors

Community organizations and institutions

- Hospitals, universities, local restaurants and businesses

CHC seeds change

Sustainability for CHC, by design, sparks a domino effect through which one smaller change leads to a cascade of changes in priority communities.

> *"We purchased trash cans for a park, which doesn't seem super exciting. But we partnered with a church organization, and they had a night where we came and painted the trash cans really colorful and we also partnered with an artistic group and they helped us with the designs and with painting the trash cans and then what spurred from that was at that park, they decided to do a mural on the pool house. So, it was kind of cool that* ***something as simple as trash cans spurred this whole park improvement****."*
>
> – CHC coordinator

The following case example illustrates how a small amount of CHC seed money can create positive ripple effects in a community.

Case Example: Devola multi-Use trail in Washington County


Nature preserve gets improvements

CHC leveraged resources – dollars, volunteers, and in-kind support – for the development of **30 miles of multi-use trails in the** Marietta area, in Washington County. Funding came from a variety of sources, including private foundations, the Ohio Department of Natural Resources (requires a match), a local cycling club, the regional transportation planning organization, and the Ohio Department of Transportation. One of CHC's key partners on the project was Marietta Adventure Company, an outdoor recreation store.

The significance of these trails goes beyond public health. According to the local Chamber of Commerce, there has been a large increase in tourism and outdoor recreation in the county. According to the local CHC staff, ***"it started as a little trail, and has turned into part of the economy."*** CHC's dollar contributions were relatively small – such as $2,000 for folding saws to maintain the trail. However, that funding, as well as the power of partnerships spurred by CHC, means ***"that $2,000 of seed money comes back 20-fold."***

Leveraging resources through positional power

As noted in Section 1, the CHC coordinator is required to be funded 100% for CHC work to ensure their hours are dedicated to this work. Many coordinators are also supported in a synergistic manner by other local health department staff working in tobacco, healthy eating, or active transportation. Local health departments often provide administrative support to coordinators as well. These resources and synergies within some of the local health departments are not typically billed to CHC, so could be considered in-kind support to implement CHC in the community.

> *"We went to [the] city council, [where] we were able to say, 'Hey, we have a statewide funder that's interested in this. It would be great if you could really support this project in a meaningful way.' Both of those institutions kind of leveraged each other."*
>
> --CHC Coordinator

Further, some local communities were able to leverage funds due to the state-backed support of their work, allowing communities to -provide additional support for specific projects. For example, CHC partners in Cuyahoga County were able to leverage state funding for a supermarket to secure additional funding from the city. Funding was secured from Healthy Food for Ohio and the City of Euclid's storefront renovation program funded through the U.S. Department of Housing and Urban Development (HUD).

Significance of leveraged funding

The contribution of CHC often goes far beyond the millions of dollars leveraged or the thousands of volunteer hours that go into implementing a strategy. CHC generates ripple effects that expand impact beyond the scope of singular projects. There are numerous examples of how CHC work created domino effects in communities, where CHC served as a spark that contributed to a cascade of subsequent positive changes. These domino effects are captured in the following quote:

> *"We've leveraged almost a million dollars for active transportation in Lorain County. That all started with the Lorain active transportation plan being a CHC strategy."*
>
> – Lorain County CHC Coordinator

Case Example: Building relationships with local decision-makers can provide social capital for future projects

A strong relationship was established between the CHC coordinator at the Cuyahoga County Board of Health and a Ward 3 councilwoman in Euclid. They met weekly, along with supermarket owner Simon Hussain, to plan and facilitate community forums as well as a supermarket coalition that resulted in the opening of a full-service grocery store in an area that had been a food desert. The social capital developed with the councilwoman, as well as the mayor and other city council members, extended beyond the supermarket, work with the Euclid City Council passing a Tobacco 21 ordinance.

This strong relationship was referenced in a report to the National Association of County and City Health Officials (NACCHO) that recognized the Cuyahoga County Board of Health with a Model Practice Award.[4] Specifically, ***"This project demonstrated to City of Euclid leadership (a municipality that pays per capita rates for public health services) the relevance and dynamism of strong collaboration with the County Health Department. These relationships have led to strong collaboration to pass and implement Tobacco 21 policies in Euclid."***

4 Implementing High Quality Supermarkets Through Community Organizing and Public Health. https://www.ccbh.net/wp-content/uploads/2018/07/NACCHO-Model-App-2018-Supermarket.pdf.

Case Example: Marion Farmers' Market becomes a community hub

A need was identified in Marion (city) to develop an active farmers' market. The CHC coalition partners at the regional planning office volunteered to be the market manager and CHC made incremental steps to develop and build upon a farmers' market. In 2017, the market started with accepting SNAP/EBT and CHC contributed to purchasing an EBT machine. In subsequent years, the market implemented Produce Perks as well as fruit and vegetable vouchers. According to the CHC coordinator, ***"We've found success because it's not a one and done … let's think about how can we start slowly building that momentum, building that customer base, and then expand."***

After a couple of years, the market changed locations from a church parking lot to an underused communal downtown park. Once the market moved locations, ***"that park has just redefined itself … [the community] is making it a gathering space. You know, it's not the healthy eating or the physical activity per se, but it's the perception that residents feel about their community [that] is really hard to quantify."***

Visualizing CHC's "invisible" contributions to community change

While someone driving through Euclid may notice the new Simon's Supermarket standing in what was once a food desert, what they won't see is all the work that went into bringing that supermarket into existence. And so, it is with many of the PSE projects that CHC implemented from 2015 to 2019. A passerby may notice a new inclusive park or new bike lane in town, but they won't see how CHC convened partners to leverage funding or volunteer hours to make those parks and bike lanes possible. The picture on the following page is designed to make visible the "invisible" contributions of CHC program partners to the establishment of Simon's Supermarket in Euclid and highlight the positive ripple effects in the broader community. The Buckeye store is not in a CHC priority community, but its development was related to the successful Simon's Supermarket store opening in Euclid, one of Cuyahoga County's priority communities.

Simon's Supermarket: CHC's contribution to sustainable change.

Cuyahoga Supermarket Assessment identified **food deserts**, including certain Euclid neighborhoods.

Strong partnerships developed between CHC coordinator, supermarket owner, city government, and residents.

CHC coordinator wrote a **grant** to secure $650K of state funding, which was used to **leverage** an additional $125,000 from the city.

CHC partners held **six forums** to engage residents in the store design.

Coordinated media efforts drew attention to the development, launch, and anniversaries of the supermarket.

2017: Euclid Supermarket Opens! Fresh food available to 3,000 Euclid residents (23% of the target population).

2018: $2.3 million investment into the Buckeye neighborhood's Simon's Supermarket, in a former food desert in Cleveland.

2020: Bedford Simon's Supermarket opens in another former food desert.

Creation of 50 local jobs plus social capital with Euclid residents, which continues to this day with community forums.

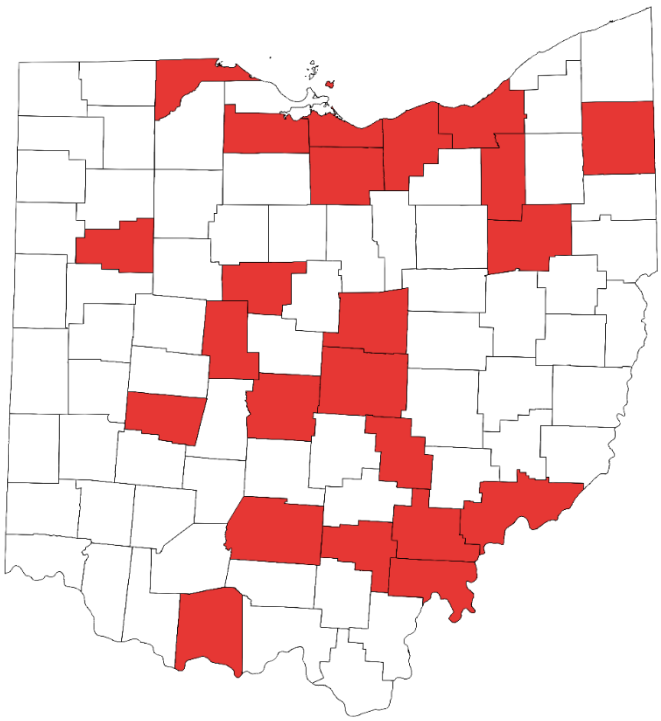
$4.6 million of revenue in the first 10 months, including $400K in fresh produce and $1.6 million in meat sales.

Photo of Simon Hussain, owner of Simon's Supermarkets

Section 5:
What Is Next for CHC?

Another five-year funding cycle is currently underway

In January 2020, ODH awarded CHC funding to four new counties (Erie, Huron, Vinton, and Ross counties) and 19 previously funded CHC communities in a competitive grant process. At the time of this report, sub-awardees were preparing their continuation applications for year two funding.



Interest and demand for CHC is growing

The Ohio Department of Health received 41 applications for the 2020-2024 CHC funding cycle – nearly twice the number of applicants the agency was able to fund. The high number of applicants demonstrates a growing demand for the CHC program. Additionally, of the previously funded CHC sub-awardees who were not funded again in 2020, many asked ODH if they could continue to attend trainings, attend CHC project calls, and access resources available to sub-awardees. Some CHC coordinators have received requests from non-CHC funded counties for access to CHC resources (e.g., resources to support active transportation planning). These requests are a testament to the high interest and need for the CHC program and the value of CHC activities and resources. ODH is currently considering how it may support requests for resources from non-funded CHC communities given existing resources and capacity of the CHC program.

CHC priorities for 2020-2024

As CHC enters another five-year funding cycle, ODH is focused on multiple priorities, many of which are informed by lessons learned from the data presented in this report. Following is a list of priorities for 2020-2024.

Align CHC activities with the State Physical Activity and Nutrition (SPAN) cooperative agreement

All current CHC sub-awardees are required to implement at least one SPAN Active Living Strategy (e.g., Complete Streets, Active Transportation Planning, or Land Use Intervention) and implement SPAN Food Service Guidelines in at least one priority community. Aligning CHC and

SPAN program activities is designed to create synergies between these two closely aligned initiatives. To support this priority, ODH hired two food service guidelines subject matter experts to support CHC coordinators with implementation of food service guidelines.

Advancing health equity

Advancing health equity is an ongoing process. Looking forward, priorities include continuing to push all CHC partners to consider how they are addressing health equity in all aspects of their work. This includes reflecting on who they are engaging in partnerships, how they engage community, and how they measure success. Additionally, CHC will continue working to shift the narrative of health equity from one solely focused on individual responsibility – to focus on the role of policies and systems in structuring opportunities for health. ODH has already begun offering health equity training to current sub-awardees and has discussed plans to revisit and revise CHC's definition of health equity.

Continue testing and refining the CHC principles

While the CHC principles were developed in 2017, it wasn't until 2019 that the principles were tested to understand how they resonate with and are implemented by CHC coordinators and partners in practice. The results of the 2019 Partnership Evaluation Survey confirmed that the principles do resonate with community partners. The survey also provided insight into opportunities for revising the principles to better align with practice. ODH and Professional Data Analysts plan to continue testing, refining, and retesting the principles over the next grant cycle to ensure they are still relevant, meaningful, and useful to program partners who will use the principles to inform their work.

Continue creating opportunities for peer learning

When interviewed in 2019, CHC coordinators mentioned "peer learning" as one of the most valuable aspects of CHC. Coordinators appreciated opportunities to learn from each other about what was working well, to troubleshoot barriers, and to share ideas. ODH will continue to prioritize opportunities for peer learning with current sub-awardees, including inviting sub-awardees to present on monthly All Project calls or at future in-person meetings.

Continue learning about and improving CHC

One key role of state CHC program staff is to support learning and program improvement. ODH has already used many of the evaluation findings described in this report to improve administration and design of CHC and will continue doing so in the next funding cycle. ODH relies on internal and external evaluation activities to inform learning about what is working well and where changes are needed to improve program design and/or implementation.

Appendices

Appendices

A. Acronyms and definitions

B. Methodology

C. Documentation of Evaluation Planning and the Development of the CHC Principles

D. Crosswalk of Previous Evaluation Reports

E. Acknowledgements

Not affiliated with The LEGO® Group

A. Acronyms and Definitions

Action Institute	A cross-sector training opportunity around a specific policy topic, such as walkability or other active transportation topics. Includes experiential education, team building, and action plan development and refinement.
ADA compliant/ accessible playground	Complies with the 2010 Americans with Disabilities Act (ADA) Standards for Accessible Design; offers a range of play experiences to children of varying abilities.
Active living (AL)	Changes in policy, systems, and environment that make it easier for Ohioans to get their recommended amount of daily physical activity, including active transportation, changes to the built environment, and active commute support.
Active transportation (AT)	Any form of transportation that involves increased physical activity levels, notably walking, bicycling, or taking transit.
Bicycle and/or pedestrian advisory committee	Advises government bodies on issues involving bicycle and/or pedestrian safety and infrastructure.
Built environment	This includes many aspects of the environment, including urban/city design, land use, and the transportation system. The built environment encompasses patterns of human activity within the physical environment.
Client choice model	Food pantry model in which people can choose their own items; may resemble a small grocery store.
Coalition	A formal alliance of organizations or an organized group of people in a community who come together to work for a common goal. The coalition can have individual, group, institutional, community, and/or public policy goals.
Community	A group of people who have common characteristics or shared identity. Communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar common bonds.
Community supported agriculture (CSA)	Community members buy a share of a farm's production and receive regular distributions of produce throughout the season.
Complete streets	Streets that are designed and operated to enable safe access for all users, including pedestrians, bicyclists, motorists, and transit riders of all ages and abilities.
Farm-to-institution	Initiative that gives farmers the opportunity to sell directly to local institutions (e.g., schools, early care and education, hospitals, colleges).
Fixed route transportation	Uses buses, vans, light rail, and other vehicles to operate on a predetermined route according to a predetermined schedule.
Food desert	The United States Department of Agriculture (USDA) defines a food desert as an area where at least 500 people and/or at least 33% of the census tract's population reside more than one mile from a supermarket.
Food policy council	A group that examines how the local food system operates and provides policy recommendations to improve that system.
Mixed land use	Development that blends residential, commercial, cultural, institutional, and/or entertainment uses, where those functions are physically and functionally integrated; usually incorporates pedestrian and bicycle connections and provides a more walkable environment.
Ordinance	A formally adopted law, rule, or regulation that is enacted by a governing body of a city or county and affects nutrition, physical activity, and/or tobacco use and exposure.

Priority communities (CHC)	CHC sub-awardees select three priority communities in which to focus projects based on consideration of the following factors: 1. Presence of health inequities. 2. Readiness of the priority community to advance change. 3. Stakeholder buy-in. 4. Total reach (i.e., the number of people who will be impacted by the change). 5. Adequate infrastructure for change. Sub-awardees referred to data from the Robert Wood Johnson County Health Rankings & Roadmaps to inform their selection of priority communities.
Produce prescriptions	A nutrition incentive program in which healthcare providers write prescriptions for fruits and vegetables that can be redeemed at participating farmers' markets and grocery stores
Policy, systems, and environmental change (PSE)	Increases widespread and sustainable community change with regard to public health, reaching beyond individual behavior change by creating multi-level interactions to significantly impact a community's norms and values. Focuses on improving socioeconomic factors as well as physical and social environments and has a greater impact on a community's health and economic vitality. "Policy change includes policies at the legislative or organizational level. For example, institutionalizing new rules or procedures as well as passing laws, ordinances, resolutions, mandates, regulations, are all examples of policy change efforts." "Systems change involves change made to the rules within an organization. … Often systems change focuses on changing infrastructure within a school, park, worksite, or health setting or instituting processes or procedures at the systems level that ensure a healthier workplace." "Environmental change is change made to the physical environment. Physical (structural changes or programs or service), social, and economic factors influence people's practices and behaviors… [they should] reflect a population-focused effort." (Definitions are taken from The Food Trust, 2012, http://healthtrust.org/wp-content/uploads/2013/11/2012-12-28-Policy_Systems_and_Environmental_Change.pdf.)
Recreational or mixed-use trail	Supports multiple recreation and transportation opportunities (e.g., walking, bicycling, wheelchairs).
Shared use path	Infrastructure that prohibits motorized vehicles and encourages multiple forms of non-motorized travel. This may include walking, biking, skating, and people using wheelchairs.
Safe Routes to School (SRTS)	A federally funded program with a goal of improving the safety of children walking to and from school. This program exists in all 50 states and has been federally funded since 2005. In Ohio the program is focused on kindergarten through eighth grade. The program promotes walking and bicycling to school through infrastructure improvements, enforcement, tools, safety education, and incentives.
Senior Farmers' Market Nutrition Program	Program that provides low-income seniors with access to locally grown produce.

Supplemental Nutrition Assistance Program (SNAP)	The Supplemental Nutrition Assistance Program provides nutrition benefits to supplement the food budget of low-income families to purchase food.
Strategic highway safety plan	All states must develop a strategic highway safety plan that uses crash data to identify the causes of traffic crashes, serious injuries, and fatalities on public roads. Multiple state and federal agencies as well as private sector organizations collaborated to develop Ohio's plan, which is focused on safety for all who use Ohio's roadways, http://www.dot.state.oh.us/Divisions/Planning/ProgramManagement/HighwaySafety/SHSP/Pages/default.aspx.
Women, Infants and Children (WIC)	The Special Supplemental Nutrition Program for Women, Infants, and Children that provides food, education on healthy eating, and referrals to healthcare for low-income women, infants, and children up to 5 years old.
WIC Farmers' Market Nutrition Program	Provides coupons for locally grown produce redeemable at participating farmers' markets to individuals in WIC.
Zoning codes	Written property regulations and laws that regulate the built environment and activities allowed on a site. Aspects of built environment include the building itself, the building's relationship to the street, and development standards. The permitted uses and density standards are in relation to the activities allowable at a site.

B. Methodology

Overall methods and approach for mixed methods

This evaluation takes a utilization-focused approach. This means that a high priority is placed on identifying the primary users of the evaluation, determining the questions and information needs of these users, and then engaging these users in the evaluation process. The primary users for this evaluation include: the ODH CHC team, the Centers for Disease Control and Prevention (the funder), and the CHC coordinators. Professional Data Analysts has periodically included leadership at ODH throughout this evaluation and that level of leadership is also an audience for this evaluation.

This report is an opportunity to combine and integrate various qualitative and quantitative data sources to understand the contributions of the CHC program during the 2015 through 2019 funding cycle. PDA has been the external evaluator for CHC since early 2016 and for an overlapping initiative since 2015 in which six of the CHC sub-awardees participated in efforts complementary to CHC. PDA's evaluation incorporates evaluative data collected by the ODH CHC staff, as well as (to some extent) from the CHC coordinators.

The CHC evaluation has evolved since 2016 and that progress is documented in this appendix as well as in Appendix C (Principles-Focused Evaluation). In 2016, a theory of change and key driver diagrams were created for two initiatives under one umbrella of chronic disease prevention – CHC and the Early Childhood Obesity Prevention Program (ECOPP). Over the course of six months, coordinated key driver diagrams were created, with parallel drivers for the two initiatives. The development of evaluation questions and an evaluation plan began in early 2017, when multiple staff and programmatic changes occurred for both programs.

Key driver diagrams were used to inform evaluation planning through mid-2017, when it was decided that separate key driver diagrams and evaluation questions should be created for CHC and for ECOPP. Those edits were made, but late in 2017, PDA proposed to the CHC team that the evaluation approach be shifted to better reflect the nature of the program. Instead of a more traditional evaluation approach, which includes a more traditional logic model, PDA suggested moving to a principles-focused evaluation model. Over the next six months, PDA and ODH collaborated to develop and refine the CHC principles, including brainstorming how to put those principles into action. More details about this process are in Appendix C.

A major goal of moving to principles-focused evaluation is to integrate data sources that had previously been separate. Reflections from the ODH CHC team had indicated that previous data sources had been separate and needed to better connect to tell the story about the contribution of CHC over the funding cycle. Data source and methods that were incorporated into this

principles-focused approach are described in the following section. Questions about this report can be directed to Melissa Chapman Haynes at PDA, mchapman@pdastats.com.

Data sources and analysis

Multiple data sources were used for the CHC analysis. These data sources were synthesized for inclusion in this report, using a combination of qualitative, quantitative, and programmatic (e.g., program request for proposals [RFP], meeting notes, etc.) data. Details of the methods implemented are provided below, and companion reports are referenced in Appendix D.

CHC Coordinator interviews

Twenty-four interviews were conducted with 36 individuals from 23 sub-awardees (11 individual and 12 group interviews). Interviewees were CHC coordinators from all funded counties/cities. When a coordinator was new to the position or in transition, PDA interviewed either the former coordinator, the interim coordinator, or the CHC director based on guidance from ODH.

The interview protocol for this study was codeveloped by ODH and PDA based on the purposes, intended users, uses, and overarching content of the interviews. After the first couple interviews were completed, the PDA team met to debrief the process and revise the interview protocol as needed. Revisions made to the protocol after the first couple interviews included asking interviewees about their coalition work earlier in the protocol and reframing the question asking interviewees to suggest additional documents that PDA could review to identify outcomes for a subsequent activity, an outcome harvest. (Further described below, this is an evaluation process through which outcomes are collected [harvested] and the evaluator works backward to determine whether and/or how a program contributed). Coordinators had a difficult time responding to that topic, so the protocol was revised to ask about accomplishments of which coordinators were most proud and how CHC contributed to those impacts.

ODH sent all coordinators a preliminary email to introduce PDA, introduce the interviews, and encourage coordinators to participate by responding to PDA's emails and scheduling a time for an interview. Following the introductory email from ODH, PDA sent email invitations to one coordinator (or alternate contact person) from each CHC sub-awardee inviting them to schedule a 90-minute time slot to interview with PDA. Scheduling was managed using a web-based scheduling software, Acuity Scheduling, which allowed PDA to embed a link for coordinators to schedule their interviews directly into the email invitation.

Three PDA evaluators conducted all interviews over the phone. After gaining consent from participants, interviews were audio-recorded and sent to Rev transcription service. Final transcripts were uploaded into the qualitative analysis software, NVivo, for analysis. PDA staff used high level coding to code transcripts by interview question. Doing so allowed PDA to analyze interview responses from all coordinators for each question. Thematic analysis was used

to identify themes in coordinator responses to each interview questions. The three PDA staff engaged in interview analysis met regularly to discuss themes and coordinate analysis. Analysis followed an iterative process of identifying, discussing, and revising themes.

Coalition surveys (annual, 2015-2018)

An annual coalition survey was administered to members of CHC or CHC-related coalitions through the CHC coordinators. A 29-item survey was programmed into Survey Monkey and CHC coordinators invited members of the local CHC coalitions (or the coalitions on which they sit to represent CHC) to complete the survey. PDA analyzed the annual coalition survey in 2016 and 2017. In 2015 the survey was analyzed by the previous evaluator, and in 2018 the state team used Survey Monkey to conduct the analysis.

The CHC program developed the evaluation survey tool, which consisted of 29 (primarily multiple choice) questions. There were some opportunities for respondents to specify "other" options or to provide some open-ended text. The overall guiding questions for this component of the evaluation were: To what extent are state and local coalitions effective at supporting Healthy Eating Active Living (HEAL) initiatives?

In 2017, PDA conducted various cross-tabulations to examine whether there were statistically significant variations in responses based on length of time in the coalition and other factors. The significant cross-tabulations were reported.

In 2018, PDA first examined whether there were changes in responses over the three years of administration. There was high consistency in the responses across the years, so no further analysis of this was warranted. After numerous conversations with the ODH CHC team, PDA broadened the evaluation to incorporate document review of the 2017 quarterly report and attachments related to coalition work, as well as a literature review. A framework for effective coalitions was used as a framework to evaluate the extent to which there was evidence of each CHC coalition's success in terms of effectiveness.

CHC Partner Survey (2019)

PDA and ODH worked together to co-create this survey. Evaluation questions were informed by conversations with the CHC coordinators who participated in a survey revision workgroup, findings from the CHC coordinator interviews, results of previous coalition surveys, and the evaluation's principles-focused approach. Further, once questions were drafted, PDA presented those questions on a CHC monthly call with the sub-awardees and facilitated a conversation to receive feedback from the CHC coordinators. That feedback was incorporated into the final version of the survey.

The 2019 survey was administered electronically, programmed by PDA using the LimeSurvey platform. Each sub-awardee must have a "CHC coalition," but the nature of this coalition may vary. Some CHC coordinators identify an existing coalition, whereas others build or take over a coalition that is specific to CHC (even in the coalition name). Therefore, PDA asked coordinators to share the exact name of the coalition(s) through which they do their CHC activities. The number of unique individuals in the respondent lists ranged from 31 to 220. The average number of respondents provided to PDA was 64. Respondents associated with each sub-awardee were presented only with the specific names of the coalition(s) specific to their CHC coordinator. The remaining survey items were identical for all respondents.

PDA created a unique survey link for each survey respondent to track response rates overall and by CHC sub-awardee. The survey opened Oct. 7, 2019. While PDA sent the survey invitations through LimeSurvey, they arrived in partner inboxes with the local CHC coordinator's name and email address to increase the likelihood that CHC partners would open them and complete the survey. Once a CHC partner completed the survey, their email was removed from the sample list so that they did not receive subsequent reminder emails. CHC partners who had not completed the survey received up to three reminder emails to complete the survey. The survey was open for a total of six weeks and closed on Nov. 12, 2019.

Participant demographics were analyzed in Statistical Analysis System (SAS) and are reported as frequencies. Response rate was calculated overall, as well as by sub-awardee. The response rate range by sub-awardee was from 16% to 62%. Open-ended questions were analyzed in NVivo using thematic analysis and are reported by CHC principle. Three PDA staff analyzed qualitative data to identify themes relating to each principle. After reading through qualitative responses for all survey questions, PDA determined that participant responses to questions about one principle often overlapped with other principles. Thus, each PDA staff analyzed open-ended responses to all five principles regardless of the specific principle they were reporting on. Qualitative analysis was an iterative process through which PDA staff met regularly to ensure consistency and separation between codes and themes. The analysis team created a "qualitative analysis decisions" document to communicate and document analysis decisions throughout the process.

Success case method

The success case method was developed by Robert Brinkerhoff, a highly published leader in the area of evaluating professional development and organizational change. The method is a process for using quantitative data to identify the most (and sometimes the least) successful cases. After at least one case is identified, primary and secondary data collection and analysis is conducted to take a deep dive into understanding what made the case successful. The goal is to elevate the factors that made a particular case successful, for the purpose of understanding how

that success might be replicated in other contexts. This method was translated by PDA to examine exemplary successes of CHC, with one focus on a success in implementing healthy eating strategies and the second on implementation of an active transportation (AT) strategy.

PDA worked with ODH and reviewed previously collected evaluation information to select the specific two cases. The healthy eating success case focused on the opening of a supermarket in a food desert in Cuyahoga County (Euclid). The second examined how the state-level partnership between ODH and ODOT successfully moved state-level work in AT forward and facilitated local-level partnerships between health and transportation.

Multiple sources of information were used in this success case method. For each success case, this included interviews, document review, and a literature review. Both cases looked at exemplary cases (not cases in which the initiative was not working). In general, the questions that guide a success case approach include the following (Brinkerhoff, 2003):

- What is really happening?
- What results, if any, is the program helping to produce?
- What is the value of the results?
- How could the initiative be improved?

Simon's Supermarket Success Case

Key Informant Interviews. PDA first conducted an interview with CHC coordinator for the Cuyahoga County Board of Health (CCBH), Roger Sikes. At the end of this interview, PDA employed snowball sampling to identify additional interviewees. The coordinator suggested multiple key partners and provided contact information for each. PDA was able to conduct interviews with three of these individuals: Brian Iorio, City of Euclid Planning Department; Simon Hussain, Simon's Supermarket owner; and Taneika Hill, City of Euclid City Council member. Additional partners were suggested, and PDA attempted to contact each of these individuals between three and five times. Messages were left during the first and the final attempts.

Videos from OneYear Anniversary. A video captured the panel presentations, as well as some of the community question and answer session at the Simon's in Euclid one-year anniversary forum. Since the video included some of the individuals PDA had attempted to contact, as well as additional partners and community members, PDA transcribed these videos and used that transcription as a source of data to supplement the interviews.

Document Review. The document review was extensive and included the most recent set of quarterly reports and attachments submitted by Cuyahoga County. Also reviewed was the success story submitted on the Simon's Supermarket work. Quarterly attachments included data from the community forums, pictures from the events, sales data from Simon's in Euclid, and

notes related to the planning meetings. PDA also reviewed documents related to other Cuyahoga County food access work, HIP-Cuyahoga (Health Improvement Partnership-Cuyahoga), and the CCBH values and annual reports.

Literature Review. A small literature review was conducted on the nature and outcomes of food access work in communities. Targeted searches were conducted for outcomes related to chronic disease, healthy eating habits, health literacy, and economic factors related to supermarket access. Results were incorporated into this report as appropriate.

Analysis. The data was synthesized utilizing existing taxonomies. Organizing results in a taxonomy is an approach to qualitative analysis that addresses multifaceted and oftentimes complex phenomenon.[5] The lead author was immersed in the data and organized the information into the existing taxonomy of health equity practice, as put forth by the Centers for Disease Control and Prevention's publication, "A Practitioner's Guide for Advancing Health Equity: Community Strategies for Prevention of Chronic Disease." Specifically, the seven aspects of health equity practice were used to frame one section of the report, and evidence collected that exemplified each practice summarized.

- Building organizational capacity to advance health equity.
- Meaningful community engagement.
- Developing partnerships and coalitions.
- Addressing health equity in evaluation efforts.
- Identifying and understanding health inequities.
- Health equity-oriented strategy selection, design, implementation.
- Making the case for health equity.

A summary of impact and lessons learned was the synthesis of the success case method analysis and the mapping of the Simon's Supermarket work to the seven strategies for addressing health equity.

Several brief, companion documents were created for specific audiences: CHC coordinators, residents of various communities in Cuyahoga County, and decision-makers in the county. This work was also selected to be presented at the American Evaluation Association's annual meeting in Cleveland in October 2018; PDA presented alongside the Cuyahoga County CHC coordinator (Roger Sikes) and the Buckeye Simon's Supermarket manager, Fahmeed Afzal.

[5] Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory. *Health Services Research*, *42*(4), 1758–1772. http://doi.org/10.1111/j.1475-6773.2006.00684.

Active Transportation Success Case

Key Informant Interviews. PDA first conducted an interview with the ODH Healthy Places coordinator. Next, PDA interviewed the individual who was the primary contact at the Ohio Department of Transportation (ODOT) collaborating with ODH on AT work. Third, PDA interviewed the former Ohio lead for the Safe Routes to School (SRTS) National Partnership. Finally, PDA interviewed teams from three local health departments who had experienced success in AT: Athens City-County Health Department, Lorain County Public Health, and Columbus Public Health. Each interview was recorded and transcribed, and a summary of each interview was reviewed by the interviewee before being used for the analysis.

Document Review. The document review included presentation slides from the Ohio Action Institute, a National Association of Chronic Disease Directors paper on Year 1 outcomes of the Walkability Action Institute, documents from ODOT's Bike Ped Summit, SRTS reports and guidance around school travel plans, SRTS Infrastructure Toolkit, SRTS Report Card for Ohio, and the Strategic Highway Safety Plan.

Literature Review. A small literature review was conducted on the nature and outcomes of AT work on public health outcomes. Targeted searches were conducted for outcomes related to the built environment, education around AT, and outcomes of SRTS. Results were incorporated into this report as appropriate.

Analysis. The analysis was identical to what is described above for the Simon's Supermarket Success Case.

Outcome harvesting

Outcome harvesting is useful for determining the impact of complex programs when it is difficult to draw a straight line between cause and effect. It is also useful for identifying intended and unintended outcomes and focuses on *contribution* rather than *attribution*. Outcome harvesting is well suited for evaluating CHC because it's a complex program that operates in multiple communities and changing contexts implemented by diverse partners with diverse priorities and resources.

While reporting on the number of policies passed – farmers' markets established, or community gardens planted – the results from this method provide a snapshot of discrete CHC achievements. Outcome harvesting provides a deeper understanding of impact, illuminating the rich stories behind the numbers. More specifically, outcome harvesting provides detailed information about **who** CHC has influenced to change, **what** changed, **why** the changes are significant, and **how** CHC contributed to those changes.

An outcome is defined as a demonstrated change in a community or organization's behaviors. This might include relationships, activities, actions, policies, or practices in which CHC has

contributed to the change. An outcome must be: specific, measurable, achieved, relevant, and time-bound (SMART); address PSE in the area of healthy eating, active living, or tobacco-free environments; and be traced back to CHC's activities and outputs.

The specific purposes of the outcome harvest for CHC were:

1. To identify the contribution of CHC activities to changes in policy, systems, and environmental changes in CHC communities between 2015 and 2019.
2. To communicate, in detail, what CHC does, and *how* CHC achieves impact.
3. To identify community leaders/decision makers CHC has influenced to create PSE change in communities.
4. To identify successful strategies that CHC coordinators and/or coalitions are using to make progress on CHC goals.
    - Document variation in CHC implementation between communities.
    - Identify community assets and contextual factors that influence success.
    - Identify skills and technical assistance that CHC coordinators need to be effective.

These purposes were developed during conversations between the ODH and PDA teams, and informed the development of the evaluation questions to be answered as a result of the outcome harvest:

1. How has CHC contributed to changing policies, systems, and environmental conditions to support active living, healthy eating, and tobacco-free living in CHC communities between 2015 and 2019?
2. Who are the local stakeholders and decision makers who CHC has influenced to make PSE changes that make the healthy choice the easy choice between 2015 and 2019?
3. How does community context influence community approaches to program implementation and success?

PDA documented 126 outcomes in an Excel spreadsheet, though there are several information gaps in terms of CHC contribution. As an example of the type of information collected in this harvest, the following table provides two outcomes and the related information on significance, impact, CHC contribution, and sources.

Outcome (who, when, what, where)	**Significance** (so what?)	**Impact** (now what is different?)	**CHC Contribution**	**Sources/Contacts**
On May 1, 2017, The University of Cincinnati (UC) implemented a tobacco-free policy. The American Cancer Society (ACS) provided a group-based smoking cessation support program at no cost.	The policy provides a safe and healthy environment for all students, faculty, staff, and visitors by protecting them from secondhand smoke exposure.	Through the policy, UC has also eliminated any support to and from the tobacco industry including sponsorships, advertisements, and sales.	CHC helped provide education to university community members on the dangers of tobacco, communicated policy, identified enforcement strategies, and provided cessation resources.	Source: Success Story 2017. Contacts: UC and ACS.
In 2016, Canal Market District and Enterprise Hub became the first farmers' market in Licking County to accept Supplemental Nutrition Assistance Program (SNAP) dollars.	Low-income residents now have access to affordable, local, fresh foods by using their SNAP benefits at the Canal Market District.	Survey responses indicate that SNAP customers increased their consumption of fruits and vegetables by six to eight servings per week.	CHC helped the market purchase the point-of-sale terminal and tokens needed to accept SNAP payments and helped to promote the benefits of accepting EBT. CHC staff held a training to educate vendors on the importance of the SNAP program to the community and the benefits of accepting SNAP.	Source: Success Story 2016. Contacts: Canal Market District and Licking County Job and Family Services.

Community Health Assessment aNd Group Evaluation (CHANGE Tool)

The Centers for Disease Control and Prevention's Division of Nutrition, Physical Activity, and Obesity created The CHANGE Tool, a data collection tool for community teams to document and track progress on policy and environmental changes to support CHC focus areas. The tool contained specific questions for five sectors around demographics, nutrition, physical activity, tobacco, chronic disease management, and leadership. The five sectors included:

1. Community-At-Large Sector: community efforts that change the social and built environment. This may include food access, pedestrian access, bicycle access, and tobacco-free environments.
2. Community Institution/Organization (CIO) Sector: organizations that provide a range of human services and/or facilities, such as child care providers, YMCAs, faith-based organizations, colleges and universities, and senior centers.
3. Health Care Sector: hospitals, private doctor's offices, and community clinics. (Note: this section of the tool was not completed.)
4. School Sector: primary and secondary learning institutions in the community, including public, private, and parochial.
5. Work Site Sector: places of employment.

CHC coordinators identified a community team to complete the CHANGE Tool with each priority

community at two time points. The first administration occurred within the first six months of the grant cycle, in 2015. The second administration occurred during the last six months of the grant cycle, in 2019. The CHANGE Tool was updated in 2018, but CHC coordinators and their teams used the same form that was administered in 2015 during the 2019 administration.

Four of the five sectors are of interest to and relevant to the CHC work. One of the chronic disease epidemiologists at ODH conducted analysis in early 2020 on all the sectors, except for health care. Analysis focused on PSE growth in physical activity, nutrition, and tobacco. There were some organizations that CHC Coordinators had planned to work with in 2015, but that work did not happen, so each entity was designated as either having worked with CHC or not. This was a major point of comparison in the analysis.

SECTOR	RESPONSE (2015/2019)	ANALYSIS INCLUDED
COMMUNITY-AT-LARGE	69/70	Percentage growth between 2015 and 2019 in each of the three assessment areas.
COMMUNITY INSTITUTION/ ORGANIZATION (CIO)	182/200	Number of organizations total and stratified by whether the entity worked with CHC (by strategy). The percentage growth was also calculated (but is not reported in this table).
SCHOOL	173/184	
WORKSITE	169/199	

Healthy vending pilot study

PDA conducted analysis of a healthy vending pilot conducted at five state agencies. Multiple sources of information and data were examined, including eight months of vendor sales and revenue (pre- and post-intervention), ongoing vendor feedback (qualitative), a state agency employee vending survey, vending machine product tracking, an interview with the ODH lead for this work, and a literature review. Multiple evaluation questions were addressed, but the primary purpose was to examine the extent to which the healthy vending pilot was successful in terms of sales and employee willingness to purchase healthy items from vending machines. The other question addressed was to evaluate whether this initiative should continue into the next grant cycle.

Active transportation survey

ODH and ODOT produced a statewide Active Transportation Plan that details specific strategies in the following areas: education, infrastructure, policies, and data strategies. To gather information about the interests and current work of jurisdictions and counties in Ohio, Toole

Design Group and ODH developed and implemented an online survey. Details about that survey as well as some descriptive analysis can be found in a memo created by Toole Design.

ODH asked PDA to conduct some additional analysis of the Active Transportation (AT) survey, with a specific focus on infrastructure items, funding, and cross-sector collaboration. The results of that analysis are within this document and may inform implementation of the Ohio Active Transportation Plan.

The Active Transportation survey was developed to gather information from individuals working on or interested in working on active transportation (AT) in Ohio. The information gathered included: education (e.g., bicycle or pedestrian education), encouragement/programs, collection of data that informs AT, infrastructure planning, infrastructure implementation, and policy development. Items asked about both implementation as well as planning or interest in activities surrounding various aspects of AT.

The survey was administered online, and participants were identified through snowball sampling. While this method provided a large sampling pool, we do not know how many people or who specifically was contacted. It may have missed key stakeholders or included participants without a true stake in Ohio's active transportation plan. There were 119 respondents.

The questionnaire, while thorough, showed some design limitations. First, the language and some of the AT wording may have been unfamiliar to some of the respondents. Because the survey was sent out to a wide-reaching audience, the chance for a respondent to misunderstand a question or the response options increased. Second, the questionnaire was quite long and did not include skip logic. The lack of skip logic may mean respondents received the entire questionnaire and had the opportunity to answer questions that may not have applied to them. While it captured a lot of information, respondents may have felt overly burdened and dropped out. Finally, some items were required to answer while others, which seemed to be related to primary outcomes, were not. This means some of the questions of interest cannot be answered reliably.

PDA used SAS to conduct a variety of analysis, including crosstabs to examine differences in items whether there was a capital or operating budget for AT. Analysis also examined relationships between having a pedestrian or a bicycle master plan and AT infrastructure.

Active commute survey

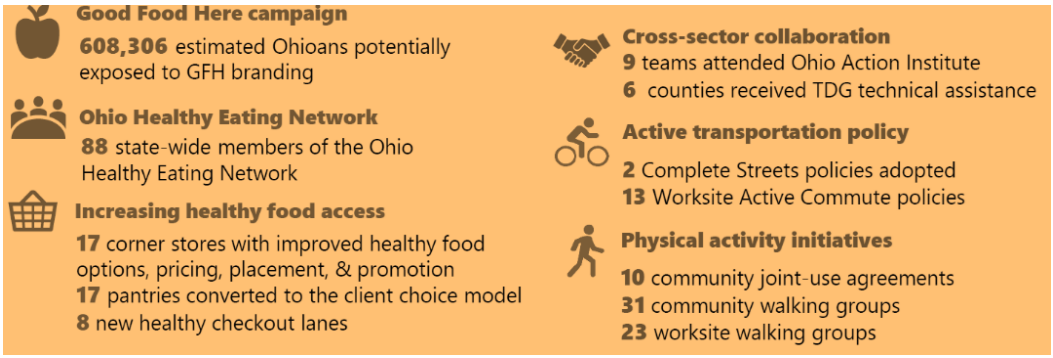
ODH developed and implemented a survey to employees at 12 state agencies to understand a variety of factors related to active transportation. The agencies involved included: Aging, Agriculture, Commerce (Downtown), Commerce (Field), Commerce (State Fire Marshal), Commerce (Tussing Road), Health, Medicaid (Central), Medicaid (Field), Rehabilitation and Corrections, Opportunities for Ohioans with Disabilities, and Veteran's Services.

This survey asked questions about how far employees lived from work, biking habits, commute habits, biker self-perception, and the like. PDA conducted analysis of frequencies and percent overall and by agency. This was used by ODH to inform where future efforts should be focused with state agency employees around active transit.

Open spaces/facilitation and interviews with the CHC sub-awardees that also had funding through 1422

During three years of the 2015-2019 CHC grant cycle, there were five sub-awardees who also received funding from "1422," a cooperative agreement funded by the CDC though which half of the funding was directed to local public health agencies to address environmental strategies, healthcare systems interventions, and community-clinical linkages. This cooperative agreement was formally known as State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke. The five CHC sub-awardees with this funding were: Athens City-County, Dayton-Montgomery County, Lorain County, Richland County, and Summit County (Washington County partnered with Athens City-County but was not the fiscal recipient).

The CHC state staff served as subject matter experts under this cooperative agreement as well, providing some support for development of the Good Food Here branding and distribution of materials, facilitation of the Ohio Healthy Food Retail Network, funding for the Ohio Action Institute, and technical assistance from Toole Design Group (TDG). A summary of the healthy eating and active living 1422-specific results includes:



PDA's role as external evaluator for 1422 informed the evaluation of CHC to the extent that PDA had multiple opportunities to conduct interviews and facilitated sessions with the 1422 local awardees. A case study was also conducted with Montgomery-Dayton County in partnership with an Ohio-based contractor. These data collection and facilitation opportunities allowed PDA to gain a deeper understanding of local-level activities in Ohio, for these local health departments that were also part of CHC.

Reports that informed this five-year CHC evaluation report are listed in Appendix D.

Data or reports by ODH

Monitoring – quarterly data tool

One requirement of the CHC award for local entities was to create an annual workplan that includes nine impact objectives; the progress on the workplan is reported quarterly. The impact objectives are evaluation, coalition, active living strategies (three strategies, one in each priority community), healthy eating strategies (three strategies, one in each priority community), and tobacco free living strategy (optional in 2018 and 2019).

Strategies are implemented in three priority communities, which are selected at the beginning of the funding cycle, and work is continued in these same communities for all five years of funding. Priority communities are selected by considering the following:

1. Differences in health outcomes.
2. Readiness of the priority community to advance change.
3. Buy-in of key stakeholders in the community.
4. Reach of the work (i.e., how many will be impacted by the strategy implementation).
5. Infrastructure to support change.

The progress on and completion of these strategies was documented and reported quarterly on an Excel form managed by ODH, titled the CHC data summary. CHC coordinators were provided guidance on measuring the "impact" of these strategies, a measurement that was revised in mid-2016. The intent of this guidance is to ensure the measured result of implementing CHC strategies is consistent across communities.

PDA summarized the number of completed CHC strategies for each year of the funding cycle. The reported impact on Ohioans was also summarized by year and across the five-year span. Results are incorporated into this document. PDA did not sum the reported training and technical assistance because the data was inconsistent across sub-awardees.

Annual leveraged funding

The CHC coordinators were required to track and report the dollars leveraged annually by CHC in a standardized Word document. Required information included the total amount leveraged, the source, and what the funds were used for. For most of the funding cycle, at least some sub-awardees also tracked and reported the number of volunteer hours, though this was not tracked consistently because it was difficult to track and to translate into estimated dollars.

PDA summarized the leveraged funding across sub-awardees for each year, and for the entire funding cycle. The total dollars leveraged by grantee was also calculated and averaged to understand the trends in leveraged funding by grantees over the funding cycle. The sources of funding and uses of the leveraged funding were also reviewed and are summarized in this report.

Success Stories (annual)

Each year, CHC sub-awardees must select one impact objective to evaluate and report on in the form of an in-depth case study. These stories cover farmers' markets, new and renovated playgrounds, multi-use trail expansions, food and beverage guidelines, and tobacco-free public spaces, among others. The number of Ohioans impacted and the dollars leveraged are also reported in an annual success stories booklet put together by ODH. The state-level work is also summarized in this booklet, organized by training and technical assistance, healthy eating, and active living. CHC uses the CDC's National Center for Chronic Disease Prevention and Health Promotion's (NCCDPHP's) Success Stories template and guidance for developing a success story. More details can be found in Appendix D.

Data or reports by other contractors

Ride Buddy

ODH contracted with YAY Bikes! to engage in one-hour bike rides with state employees to model how to ride in traffic, bicycling rules, and resources in the community such as CoGo Bike Share and Park & Pedal. Sixty-four employees from 10 state agencies participated. A survey conducted with the 10 state agencies prior to these rides collected information on bicycling attitudes and confidence. An immediate post-ride survey and a six-week follow-up was collected, along with "unsolicited feedback." Results are summarized in a 25-page report, which also features professional photos taken of an experiential ride (photos by Ben Ko).

Land Use and Health Best Practices Report

ODH, in partnership with Toole Design, published a report in mid-2019 detailing the intersection of land use and health. This report details specific ways in which the built environment is related to health in terms of building spaces that encourage physical activity, increase opportunities for positive social interactions and time outdoors, accommodate children, and are designed for environmental justice. Equity considerations are detailed in this report as well. There are five case studies that feature the implementation and lessons learned in five communities: Columbus, Lorain, Trumbull County (city: Warren), Lucas County (city: Oregon), and Marion County. Specific strategies are provided for implementation of AT that keeps design for the health of the community as a priority.

Synthesis of various reports into this document

The planning of this report started mid-2019, including a discussion during PDA's August 2019 site visit to ODH. An outline was developed, based on that discussion, and submitted on Sept. 29, 2019. ODH reviewed that outline and provided feedback. Additional data sources were collected and/or analyzed in late 2019 and early 2020 to inform further revisions to the outline submitted in September 2019, especially the partnership evaluation survey.

When an outline was finalized, PDA documented the various evaluation and data reports into an Excel document, notated the type of information in each report, and took notes on how to integrate it into the outline of the report. In sections where both quantitative and qualitative data were synthesized (e.g., the summary of strategies implemented, leveraged funding), the quantitative data was summarized first to understand the patterns, and then qualitative data was used to paint the picture behind those numbers. For example, in leveraged funding, PDA first analyzed the dollars leveraged, and then conducted a deeper dive into the sub-awardees that had either increased funding over the five years and/or leveraged more than average.

Whenever possible, PDA used multiple sources of data to triangulate findings. There were many instances when triangulation occurred. For example, some findings from the coordinator interviews were further confirmed by other sources, including the partner survey and sometimes the success stories.

Limitations

While multiple steps have been taken to increase the credibility of the findings in this report, and to ensure the evaluation design is reflective of the CHC program, it is important to note the limitations of this evaluation.

- **Estimated number of Ohioans impacted by CHC strategies may be an overestimate.** Estimating individual-level impact of PSE strategies is challenging because the number of people who could potentially benefit from a CHC policy or environmental change is not entirely clear. If two strategies are implemented in the same neighborhood, for example, such as new bike racks and a renovated park, the estimated number of Ohioans impacted may double count the people impacted. In other words, the counts of the number of Ohioans impacted may not be mutually exclusive.
- **The engagement of partners through coalitions and other community building work varies and is difficult to evaluate across CHC.** Sometimes the language used by coordinators to describe their work was challenging to interpret. For example, when a coordinator said they "partnered" or "engaged" with an organization, it was not always clear what that meant. The coordinator could have had conversations with an organization, or co-facilitated activities, or been supported by the organization's time or resources. Some of these points were clarified in the interviews PDA conducted with CHC coordinators; future evaluation of CHC may want to dive deeper into evaluating the nuances of partnership, and implications to the outcomes of the program.
- **Representation of community residents directly impacted by CHC strategies in evaluation activities is unclear.** Most CHC evaluation activities did not uniformly collect data on participant demographics including race, ethnicity, income level, neighborhood,

etc. Thus, it is unclear how representative the sample of individuals who participated in evaluation activities are of the communities and populations CHC intends to serve. The 2019 Partnership Evaluation Survey did find that 60% of partners reported living in at least one of the priority communities in which they worked. However, representation varied such that, in multiple communities, partners reported working in those communities, but not living in those communities. It is unclear whether evaluation efforts have thoroughly captured the voices and perspectives of those populations being recruited to participate in the CHC program.

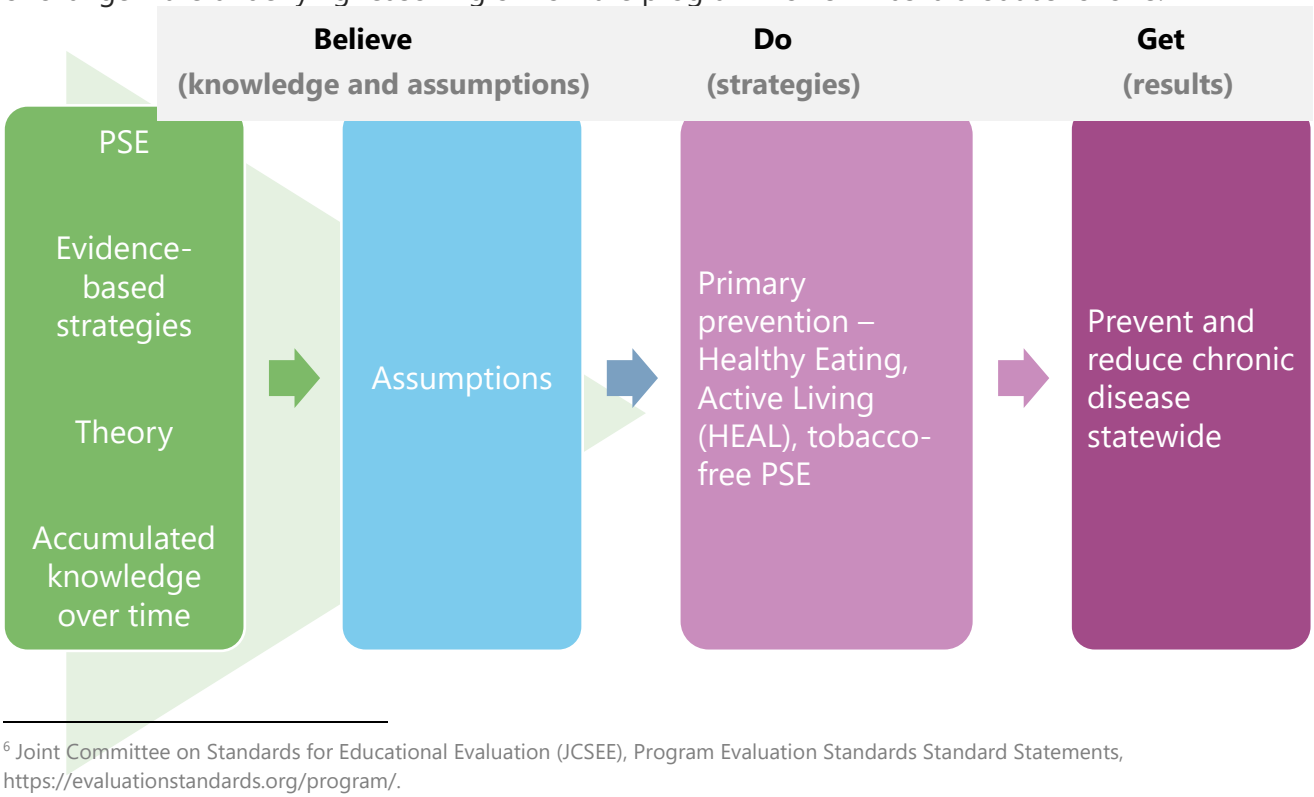
C. Documentation of Evaluation Planning and the Development of the CHC Principles

The approach to evaluating CHC has shifted over the funding cycle, moving from a more traditional evaluation framework to one that is principles focused. Further, initial evaluation planning was structured to find common values, priorities, and goals for two programs – CHC and the Early Childhood Obesity Prevention Program (ECOPP) – until it was determined in early 2018 that, for various reasons, these two programs would have separate evaluation plans and frameworks. Monthly meetings continued to include both the CHC and ECOPP teams until June 2018, when separate calls were established.

Documentation of programmatic changes as well as evaluative evolution is one important factor of evaluation practice and it is specifically highlighted as a standard in the "Program Evaluation Standards, 3rd edition" as part of evaluation accountability.[6] The purpose of this appendix is to detail the evaluation planning work that occurred during the 2015-2019 funding cycle.

Spring 2016: Theory of change and key driver diagram development

As PDA was contracted to be the external evaluator for CHC, a first task was getting up-to-speed on the program, as well as the first year of implementation, and engaging with the program managers for CHC and ECOPP to develop logic models. A high-level theory of change was developed to encompass both the CHC and ECOPP initiatives. The overall model for the theory of change – the underlying reasoning of how the program works – was laid out as follows:



[6] Joint Committee on Standards for Educational Evaluation (JCSEE), Program Evaluation Standards Standard Statements, https://evaluationstandards.org/program/.

Believe **(Knowledge)**	*Policy, systems, and environmental changes (PSE)* includes frameworks, literature, and guidance on implementing broader and more systemic changes as opposed to implementing a program of more limited scope and reach (e.g., adopting a joint/shared use agreement with a school versus hosting an annual fun run).
	Evidence-based strategies include: Minnesota State Health Improvement Plan; Task Force on Community Preventive Services; Centers for Disease Control and Prevention; Health and Medicine Division (HMD) of the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine).
	Theory includes socio-ecological theories, community-based models of prevention and health promotion, community capacity-building program theory, and community-based health promotion.
	Accumulated knowledge over time of the staff, the lessons learned over years of implementing primary prevention programs in the state, with longer-term relationships with many of the key partners
Believe **(Assumptions)**	The focus of this box is: What assumptions are we making about needs of the population, or about the programs and initiatives being implemented? • One assumption is that increased opportunities to be active and to access healthy food options will result in increased usage and purchasing. Another way to put it is, IF Ohioans have increased access to fruits and vegetables, THEN they will increase their purchase and consumption of fruits and vegetables. • Changes in societal attitudes and behaviors have been a major driver in other areas of prevention, such as tobacco and HIV. A multi-faceted strategy across geographically diverse counties in Ohio will accumulate to social norms change (culture change) around healthy eating, active living, and tobacco free lifestyles. • Community buy-in may be a mediating factor in the success of the CHC/ECOPP programs. • Increased food knowledge in the context of systems change may lead individuals to make healthier food choices, to lead more active lifestyles, or to abstain from tobacco use. • Some targeted groups will be affected by multiple strategies, policies, or environmental changes and the accumulation of these multiple interventions will increase the likelihood that individuals and communities will make healthier behavior changes.
Do **(Strategies)**	Reference the comprehensive list of strategies for HEAL and tobacco-free PSE, as well as the ECOPP components. Improve access to and affordability of healthy food, increase opportunities for physical activity, and assure tobacco-free living where Ohioans live, work, and play; by implementing sustainable evidence-based strategies, CHC is creating a culture of health.
Get **(Results)**	CHC: Community commons, success stories, coalition surveys, meeting agendas and notes, other survey and data collection and tracking. ECOPP: provider chart review tool, parent pre/post survey, site visit and phone surveys, regional training surveys, Let's Move Child Care Checklist for providers (pre/post), menu changes, policy changes, family engagement activities.

Key driver diagrams were developed for CHC (one for healthy eating and one for active living) and ECOPP using Lucid Chart, with the four drivers for these three diagrams being the same. The CHC subject matter experts reviewed drafts and provided feedback. That feedback was incorporated into revised models.

Late 2016 to Mid-2017: Early evaluation planning

With the key driver diagrams developed, PDA engaged the ODH teams in evaluation planning efforts. PDA facilitated conversations with the ODH team about constructing a utilization-focused evaluation plan for the two programs. These conversations also encouraged ways to engender buy-in and use, and to use evaluation to build relationships and communication of the program. This work was done primarily via calls with PDA and ODH, and it was a focus for a half day of PDA's site visit in May 2017.

Building on the drivers of the program diagrams, eight categories were developed, along with high-level evaluation questions. Through conversations with ODH, there was some concern about providing enough depth in the plan about each program, while still being able to encompass both initiatives. While there was a lot of overlap in the upstream strategies the programs were implementing, ECOPP also has a partnership with the Ohio chapter of the American Academy of Pediatrics to implement the Parenting at Mealtime and Playtime program with primary care providers. Another deviation for the two programs was that CHC has both a state and a local level focus, which is not the case for ECOPP.

During the May 2017 site visit, PDA went through the priorities for each component (CHC healthy eating, CHC active living, ECOPP) and then provided an overview of the drafted components of the evaluation plan to the CHC and ECOPP teams. The categories were prioritized in terms of importance, with overarching unintended consequences/outcomes being prioritized as a top priority, because sometimes these are what help propel work and create multi-sector buy-in. Examples were provided, such as improved mental health being linked with a community garden, or reduction in the incidence of flu related to increased fruit and vegetable consumption at desks in a school. There was consensus that the evaluation planning should continue with these categories.

Overarching unintended consequences	Leveraged funds	Coalition outcomes	Capacity	Behavior change	PSE	Overarching impact	Health equity
1st priority	1st priority	2nd priority	3rd priority	3rd priority	3rd priority	4th priority	4th priority

There were some critical conversations about equity among the ODH teams, including discussing concerns about strategies being evidence-based and also attending to equity. While evidence-based strategies are "proven" to work, they are often based on experiences in majority white communities. CHC strategies are evidence-based, but may not have been tested in every different priority population and require more thoughtful tailoring (for example, bike lanes perceived as gentrification).

Mid-2017: Development of a health equity statement

As part of the planning for the success case method, PDA and ODH discussed the importance of developing a specific health equity statement for CHC. Health equity language was included in the request for proposals sent to local groups and documents from various CHC "All Project" meetings referenced equity; however, it was unclear what CHC's definition of health equity was at that time.

PDA facilitated multiple, virtual sessions with the ODH and ECOPP teams with a goal of developing a definition of health equity. The immediate use of this definition by the PDA team was for the success case method, particularly the opening of Simon's Supermarket in Euclid (Cuyahoga County).

The document to the right was created for one of the earlier meetings on this topic. The idea is work that ultimately reduces health disparities often happens without being categorized as a "health equity" effort, or without formal documentation. PDA's evaluation made an explicit attempt to improve documentation and evaluation of equity work done by CHC.

Four questions were posed (detailed to the right) and three definitions of health equity were presented as a place to start thinking about CHC's definition. These definitions came from the Ohio SHIP 2017-2019, the Centers for Disease Control and Prevention, and the Health Policy Institute of Ohio. Based on feedback about what resonated and did not resonate with the ODH CHC team, PDA created multiple revisions of a health equity definition, until the team agreed upon the following definition, which was first introduced by the CHC team in the 2017 Success Stories book:

> CHC Commitment to Equity:
> Health equity is achieved when all people in a community have access to affordable, inclusive, and quality infrastructure and services that, despite historical and contemporary injustices, allows them to reach their full health potential.

Late 2017: Move to Principles-Focused approach

In December 2017, PDA proposed a shift from a more traditional evaluation framework to a principles-focused evaluation. This proposed shift was informed by conversations with the CHC ODH staff from the previous few years, interactions with the locals on CHC "All Project" calls; the 1422 Communities Prevention Chronic Disease (CPCD) in-person gatherings; and data collection (including the CHC annual coalition survey).

The goal was to implement this framework for the "impact" evaluation question and the unanticipated outcomes (both positive and negative) question to evolve the framework for the overarching evaluation.

EQ1. What is the impact and reach of CHC and ECOPP activities in preventing and reducing chronic disease?

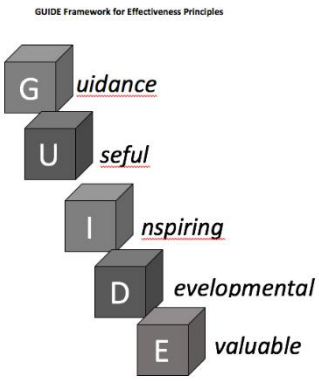
- How are the principles being implemented (formative)?
- To what extent are the principles being implemented effective in improving access to healthy food? Opportunities for physical activity (summative)?

EQ2. What are the unanticipated positive effects of the program that emerge over time, given the complex web of interactions between the program and other programs, and who benefits?

CHC is a complex, dynamic, and multi-faceted program focused on stimulating policy, systems, and environmental changes in the areas of healthy eating, active living, and tobacco-free living. The initial approach to the evaluation, with a more linear logic model, was less effective at capturing the dynamics of work at the state level and at the local levels and the interactions between the two.

A key, early activity was to ensure the team understood the principles approach. Principles are different from rules. For example, a principle around physical activity would be "create an exercise regimen that is sustainable to meet your health goals, given your age and lifestyle." A rule would be to "engage in 30 minutes of aerobic exercise each day."

PDA introduce the notion of principles, based on the work of Michael Patton. Effective principles should:[7]



- Provide direction but not detailed prescription.
- Be grounded in values about what matters.
- Be based on evidence about how to be effective.
- Be interpreted and applied contextually.
- Require judgment in application.
- Inform choices at forks in the road.
- Are the rudder for navigating complex dynamic systems.
- Point to outcomes and impacts.
- Can be evaluated for both process (implementation) and results.

7 Evaluating Impact: Principles-Focused Evaluation. https://www.tamarackcommunity.ca/evaluating-impact-principles-focused-evaluation.

Based on PDA's work in evaluating CHC and ECOPP at this point in time, including multiple site visits, evaluation planning, targeted analysis and technical assistance, and review of strategy-level documents, a first set of principles was drafted for review. PDA facilitated discussions with the ODH teams, and these initial conversations continued to have both CHC and ECOPP teams in one discussion; however, the conversations naturally separated over time until it was decided that there would be separate principles for each program.

To support the revision of the principles, PDA used a modified version of the GUIDE Framework for Effectiveness Principles (above). In a checklist-style format, PDA walked the ODH teams through each of the five components of the GUIDE framework, with two to six questions for each.

For CHC, there were six formal iterations of the principles before they were "good enough" to be final/ put into practice/tested. This means there was shared understanding of the language used in the principles by key stakeholders in the program, so that the principles may could be used and understood in a common manner.

June 2018: Full split in evaluation between CHC and ECOPP

The evaluations of CHC and ECOPP were fully separated in June 2018 to become two evaluations, with separate team meetings. The key driver diagrams were revised slightly to better represent each program.

The work on the CHC principles moved to mapping the data sources for each principle (discussed in Section 1, in the body of this report). Table C1 (on the next page) shows which data sources were used to evaluate each principle. For example, the Active commute survey was used to evaluate the principles Activate and Engage Communities, Ease of Access, and Sustainable Change.

Table C1. Data sources used to evaluate each principle

	Activate and Engage Communities	Cross-Sector Collaboration	Ease of Access	Health Equity	Sustainable Change
Active commute survey	■		■		■
Active transportation survey		■	■		■
CHANGE Tool	■	■	■		
CHC coalition evaluation survey (2015-2018)		■			
CHC quarterly data summary			■		
Coordinator interviews	■	■	■	■	■
Healthy vending pilot			■		
Land use and health			■	■	■
Leveraged funding					■
Outcome harvesting	■	■	■	■	■
Partner survey (2019)	■	■	■	■	■
Ride Buddy	■				
Success case method – Active transportation	■	■	■		■
Success case method – Simon's Supermarket	■	■	■	■	■
Success stories	■	■	■	■	■

In addition to mapping the data to each principle, PDA introduced the sensitizing concept. The development of principles, if done well and integrated into the program, can raise consciousness about the principles. In other words, the values that are raised in the principles remind us to engage with the principles throughout our work. It can keep us grounded while still allowing for some variation in response to specific contexts.

PDA walked the ODH CHC team through some thought questions to deepen understanding of how to put the principles into practice.

- To what extent are the identified principles meaningful to those meant to follow the principles?
- To what extent are the principles adhered to in practice?
- If adhered to, to what extent do the principles guide followers to the results they hope to achieve?

The ODH team generated a list of ideas for how to put the principles into practice so the evaluation could be developed to assess the extent to which the following could be addressed:

1. How are the principles informed by CHC activities (process)?
2. How are the principles informed by the results of CHC activities (outcomes)?

Future evaluation planning should reconsider the intent of the evaluation using the following purposes as possible avenues:

1. **Formative** – How can the program's adherence to principles be improved? To what extent are staff/stakeholders interpreting the principles in a similar manner?
2. **Accountability** – Is the program following principles as specified in funding and policy mandates?
3. **Knowledge-generating** – What can be learned about the effectiveness of the principles?
4. **Summative** – Are the principles currently being followed relevant and effective? Should they be maintained, changed, or dropped altogether (and replaced with a traditional or best practice approach)?
5. **Developmental** – How are principles being applied in adaptation of an innovation to new locations?

Fall 2019: Implementation of the CHC principles begins

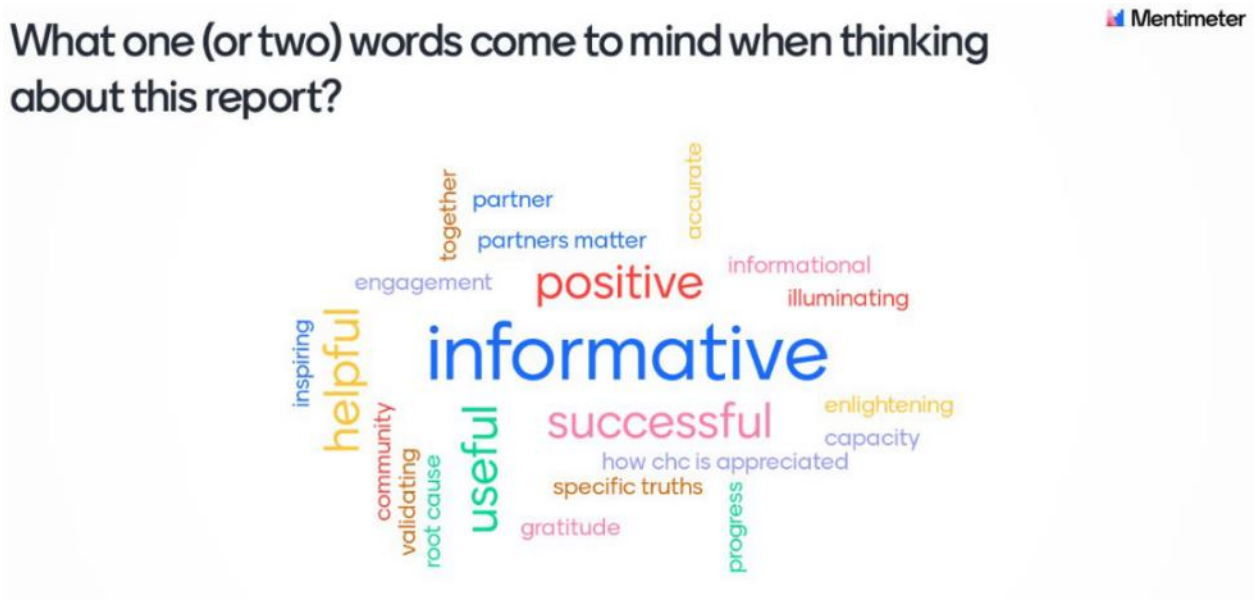
At an August 2019 site visit, PDA and ODH reaffirmed the decision to frame the evaluation using the five principles developed during the prior contract. The coordinator interviews provided rich data on how local groups were implementing CHC, and this affirmed the principles focused approach. During this site visit, ODH and PDA also decided to reframe the coalition survey into a

partner survey that asked whether and how each principle had been implemented by the responding partner.

While planning the development of the survey, PDA had an opportunity to present the principles to the CHC coordinators for the first time during the September 2019 "All Project" call. After introducing the principles, PDA walked through the Partnership Evaluation Survey and facilitated a discussion to get feedback about the survey overall, as well as on specific items. The overall feedback was positive:

- "This survey feels very inviting and shows more purpose- short and specific. I'm excited for the how implemented section!"
- "I think the new survey is much better and I like that it mentions CHC a lot."
- "I feel like we will get a better sense of impact from coalition members!"
- "I like that the survey approach relates to the fluidity of the work. Less stiff. And I like the qualitative approach."

The results of the partner survey, referred to throughout this report and in a stand-alone report under a separate cover, provide evidence that all five principles resonated with partners completing the survey. Overall, each of the five principles is being implemented by a majority of the partners. Further, when reviewing findings of the Partnership Evaluation Survey with the CHC coordinators in May 2020, the overall reflections on the report were positive. This word cloud was created in Mentimeter from coordinator's responses to the question:



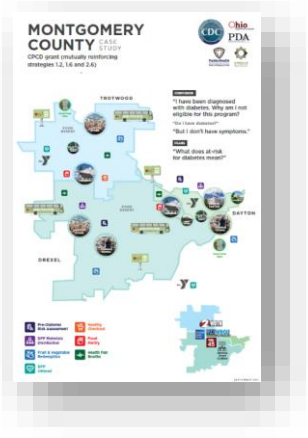
D. Previous Evaluation Reports

Numerous evaluation reports and other data-related documents were created by PDA, ODH, and other contractors during the 2015-2019 funding cycle. Methods were detailed in Appendix B, and the purpose of this appendix is to detail the data that was referenced and synthesized in the 2015-2019 evaluation report. The primary author of each report is indicated by that organization's logo, as follows:

Logo	Organization
	Ohio Department of Health, Creating Healthy Communities Program
	Professional Data Analysts (PDA), external evaluation contractor

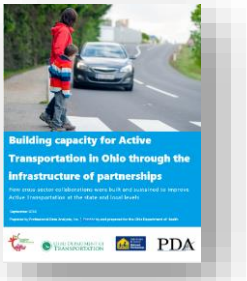
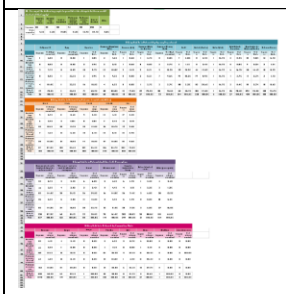
Healthy Eating

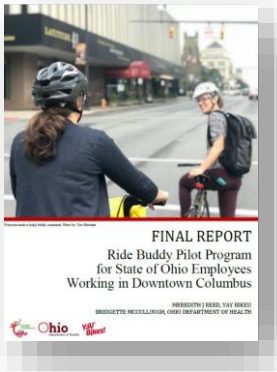
The Power of Community Engagement to Improve Food Access in an Ohio Food Desert. This success case method drove the creation of a health equity definition for CHC/commitment to equity. The success case focused on how the CHC coordinator in Cuyahoga County implemented community engagement principles and practices to work in partnership toward opening a full-service grocery store.



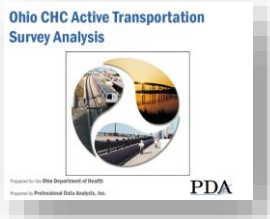
Dayton-Montgomery County Case Study (part of 1422 – mapped out some strategies). This in-depth case study specifically spotlights Dayton-Montgomery County and the ways in which the local team, a 1422 CPCD grantee and CHC sub-awardee, has
carried out the cooperative agreement's three mutually reinforcing strategies.

- **Strategy 1.2:** Strengthen healthier food access and sales in retail venues and community venues through increased availability, improved pricing, placement, and promotion.
- **Strategy 1.6:** Implement evidence-based engagement strategies to build support for lifestyle change.
- **Strategy 2.6:** Increase engagement of community health workers promote linkages between health systems and community resources for adults with high blood pressure, prediabetes, or diabetes.

	**Healthy Vending at Worksites pilot**, led by the ODH CHC staff, is one component of worksite wellness strategies implemented as part of the CHC (and 1305) initiatives.
Active Living	
	**Building capacity for Active Transportation in Ohio through the infrastructure of partnership.** This success case method focused on how state-level partnerships between ODH and ODOT facilitated local and regional-level partnership between health and transportation.
	**Lakewood Basketball Courts one-page success highlight.** This brief write-up was captured while PDA was engaged in data collection for the Simon's Supermarket success case evaluation.
	**Active Commute Survey** – ODH designed and implemented the survey with Ohio state agencies, PDA conducted the analysis and shared results with ODH to inform future programming efforts.

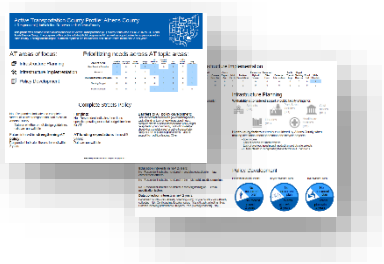


Ride Buddy Report. In 2017, ODH partnered with local nonprofit Yay Bikes! to encourage bicycle commuting by state agency employees, with the ultimate goal of increasing daily physical activity. Sixty-four employees from ten state agencies participated in one-hour bike rides led by Yay Bikes!. Ride leaders modeled how to ride in traffic, explained rules of the road, and introduced local bicycling amenities such as Park & Pedal locations and CoGo Bike Share. Multiple data collection timepoints were put in place and reported.



Active Transportation Survey. ODH and ODOT have produced a statewide Active Transportation Plan that details specific strategies in the following areas: education, infrastructure, policies, and data strategies.

To gather information about the interests and current work of jurisdictions and counties in Ohio, Toole Design Group and ODOT developed and implemented an online survey. Details about that survey and overall results are included in the report by PDA. Individual reports were also created for each jurisdiction where there was a sufficient response rate.

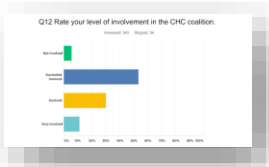
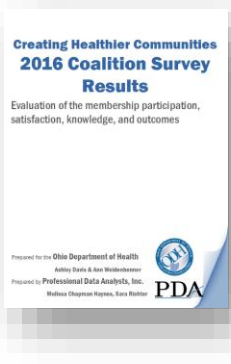


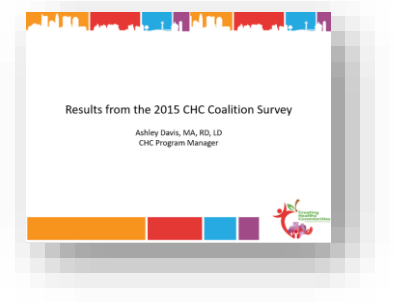
Active Transportation Survey – Respondent Profiles. PDA used statistical analysis system (SAS) to create individual reports for each jurisdiction where there was a sufficient response rate. There were 39 jurisdictions that received an individual report for their geography.

Coalition and Partnership Evaluation Survey Results

CHC Coordinator Interview Report (2019). These interviews were conducted to gather in-depth information on how CHC was implemented from 2015 to 2019 and to identify what was working well and what might be improved. The intended use was to identify ways in which ODH might improve program administration and provision of technical assistance in the next funding cycle. PDA and ODH identified three main purposes of coordinator interviews:

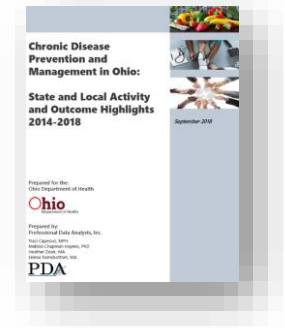
1. To identify aspects of the CHC grant program that are working well from the perspective of CHC coordinators.
2. To identify opportunities for improving administration of the grant program or providing TA to sub-awardees.
3. To identify program impacts that have not been captured by existing reporting mechanisms.

	The **2019 CHC partnership evaluation** pivoted from the four previous annual evaluation surveys by aligning with the CHC principles. Further, the process of administering the survey was centralized at PDA, in coordination with ODH and the CHC coordinators. Purpose of the survey: To better understand how CHC's local partners work with CHC in their communities and how CHC partners are implementing CHC principles. Purpose of this report: To summarize and synthesize the qualitative and quantitative results from the 2019 Partnership Evaluation Survey.
	**2018 Coalition survey results.** There was limited external evaluation capacity at this time. ODH decided to implement the coalition survey as had been done annually for this funding cycle. A coalition workgroup was also established and the ODH team discussed the uses and usefulness of the coalition survey to locals in fall 2018. The analysis was completed using Survey Monkey.
	**2017 Coalition survey results.** The first section of this report describes representation from selected priority communities on CHC coalitions. Sections 2 through 7 are organized around the six coalition strategies listed in the CHC request for proposals (RFP) for sub-awardees. Each year, the sub-awardee selects at least one of the six strategies to implement and evaluate. (Selected strategies can and do change over time.) Each of these six areas is focused on process-oriented work. The outcomes coalitions – leadership, technical skills, management, adaptivity, and culture – are discussed and reported on in the eighth section of this report. The five types of outcomes discussed in this section align with the broader literature on coalitions, which highlight variations of these broad categories.This report ends with a discussion about barriers, recommendations, and next steps for future evaluation of the CHC coalitions.
	**2016 Coalition survey results.** The purpose of this report is to provide descriptive statistics on demographics, membership, PSE knowledge, coalition outcomes, and areas of improvement to the CHC staff at ODH and for the 23 coalitions across the state of Ohio.



2015 Coalition survey results. This report was created by an ODH intern, based on the survey results and an initial report created by a previous evaluator.

Other reports and data



Various 1422 reports, including an open spaces session, Health Impact Statement, and final funding cycle report.

CHC Success Stories (annual from 2015 to 2019). Coordinators are required to submit an annual success story related to a completed healthy eating, active living, or tobacco-free living strategy. CHC uses the CDC's National Center for Chronic Disease Prevention and Health Promotion's (NCCDPHP) Success Stories template and guidance for developing success stories. Each sub-awardee's success story follows a parallel format and uses the CHC branding.

CHC coordinators work with CHC program consultants at ODH to create the success stories, and ODH combines all final success stories into a compiled report. The full report includes an annual summary of the training and technical assistance provided, the number of strategies implemented, and estimated Ohioans impacted from the year's healthy eating, active living, and tobacco-free strategies.

Each of the 23 success stories and the compiled success stories report showcase outcomes for the program. The full report also serves as a call to action around the importance of chronic disease prevention programs. The success stories are shared on listservs and by state and local decision-makers, and individual stories are shared within the communities in which the work is done.

E. Acknowledgements

The work of CHC is made possible by countless state and local staff, partners and contractors, and volunteers across the state of Ohio. Thank you for making the healthy choice the easy choice for millions of Ohioans!

We would like to acknowledge all current and past CHC staff for this report.

Thank you, especially to former CHC managers who made important contributions to the 2015-2019 funding cycle and contributions to previous CHC funding cycles:

Ashley Davis, MA, RDN, LD; former CHC Program Manager

Ann Weidenbenner, MS, RDN, LD, former Manager, Chronic Disease Prevention and Management Section and CHC Manager

The Ohio Department of Health CHC staff provide the backbone for the CHC work, including funding and time for professional development, evaluation, and technical assistance. The CHC coordinators are the backbone of the local implementation. All make CHC possible.

Ohio Department of Health CHC staff and CHC coordinators celebrate Public Health Week at a state-wide training, April 2019.