Ohio | Department of Health

Mike DeWine, Governor
Jon Husted, Lt.Governor

Bruce Vanderhoff, MD, MBA, Director

MEMORANDUM

Date: June 21, 2023

To: Subrecipient agencies

From: Jennifer Voit, Bureau Chief
Bureau of Health Improvement and Wellness
Ohio Department of Health

Subject: Creating Healthy Communities CC24, Jan. 1, 2024-Sept. 30, 2024

The Ohio Department of Health (ODH), Bureau of Health Improvement and Wellness announces the availability of grant funds.

All electronic applications and attachments are due by 4 p.m., July 31, 2023. Applications received after the due date will not be considered for funding. Faxed, hand-delivered, or mailed applications will not be accepted.

Electronic application components must be submitted via the on-line Grants Management Information System (GMIS). For new staff requiring GMIS access, you must successfully complete GMIS training offered by ODH.

Any award made through this program is contingent upon the availability of funds for this purpose.The subrecipient agency must be prepared to support the costs of operating the program until receipt of grant payments.

Submission of the **continuation application** constitutes acknowledgment and acceptance of ODH Grants Administration Policies and Procedures (OGAPP) Manual rules, policy, and procedure updates posted on the GMIS Bulletin Board, and any other program-specific requirements as outlined in the competitive solicitation. Reference the competitive solicitation for more information. The competitive solicitation for this grant program can be found on the ODH website https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/ODH-Grants/. Allotments will be established in GMIS by ODH. Please refer to the GMIS bulletin board for current allotment percentage.

If you have questions, please contact Sarah Ginnetti at 614-728-6937 or e-mail at sarah.ginnetti@odh.ohio.gov

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I. CONTINUATION FUNDING APPLICATION GUIDANCE

x Base Only Funding_____Base and Deliverable Funding

A. Policy and Procedures: The Continuation Funding Application consists of three parts: Program Updates(if applicable), Program Budget and Budget Narrative, and Other Required Attachments.

Submission of the continuation application constitutes acknowledgment and acceptance of ODH GAPP (OGAPP) manual rules and any other program-specific requirements as outlined in the competitive Solicitation. This Solicitation pertains to budget period: [Monday, Jan. 1, 2024-Monday, Sept. 30, 2024] of the total project period, [Wednesday, Jan. 1, 2020-Monday, Sept. 30, 2024.] Reference the competitive solicitation for more information.

All budget justifications must include the following language and be signed by the agency head listed in GMIS. Please refer to the budget justification examples listed on the GMIS bulletin board.

- Subrecipient understands and agrees that it must follow the federal cost principle that applies to its type of organization (2 CFR, Part 225; 2 CFR, Part 220; or, 2 CFR, Part 230).
- Subrecipient's budgeted costs are reasonable, allowable, and allocable under OGAPP and federal rules and regulations.
- The OGAPP and the rules and regulations have been read and are understood.
- Subrecipient understands and agrees that costs may be disallowed if deemed unallowable or in violation of OGAPP and federal rules and regulations.
- The appropriate programmatic and administrative personnel involved in this application are aware of agency policy in regard to subawards and are prepared to establish the necessary inter-institutional agreements consistent with those policies.
- Subrecipient agrees and understands that costs incurred in the fulfillment of the deliverables must be allowable under OGAPP and federal rules and regulations to qualify for reimbursement.

B. **Number of Grants and Funds Available:** *The Centers for Disease Control and Prevention (CDC), Preventive Health and Health Services Block Grant funds the CHC Program. The twenty-two (22) grants may be awarded for a total amount of $1,850,000 for local grant awards to the currently funded CHC projects. Only those who were awarded for the 2023 grant year are eligible to apply. Each funded CHC Program may apply for up to $80,000 for a county population of less than 200,000 or $95,000 for a county population of more than 200,000. Funding levels for all applicants will depend on the number and scope of proposals received, recommendations from the review panel, quality of each application, justification for the amount of funding requested, and adherence to the goals and objectives outlined in this RFP. No applicant is guaranteed a certain percentage of the total funds available. ODH reserves the right to modify the amount of funding based on the applications and funds available.*

*No grant award will be issued for less than **$30,000**. The minimum amount is exclusive of any required matching amounts and represents only ODH funds granted. Applications submitted for less than the minimum amount will not be considered for review.*

C. Formatting Requirements for Attachments [Suggested language provided, but can be updated to reflect program-specific requirements]:

- Properly label each item of the application packet (ex. budget narrative, program narrative).
- Each section should use 1.5 spacing with one-inch margins.
- Program and budget narratives must be submitted in portrait orientation and fit on 8 ½ x 11 paperwhen printed.
- Number all pages (print on one side only). Place agency name and GMIS number on each page.
- Use a 12-point font.
- Forms must be completed and submitted in the format provided by ODH.

D. Qualified Applicants:

The following criteria must be met for grant applications to be eligible for review:

1. Applicant does not owe funds in excess of $1,000 to the ODH.
2. Applicant has not been certified to the Attorney General's (AG's) office.
3. Applicant has submitted application and all required attachments by **4 p.m. on Monday, July 31, 2023.**

II. PROGRAM UPDATES:

Program should review the Evidence of Health Equity Strategies Checklist in Appendix B when drafting the program narrative, objectives, and workplan.

A. Program Progress Report: 1) Attach the program progress report for the current grant period. If the program progress report is not scheduled to be submitted before the application due date, then it must be submitted with the application. **[<u>This is not a requirement</u> for the CHC program. 2023 Quarterly Program Reports as submitted previously are accepted.]**

B. Program Narrative: Complete and submit a narrative statement (do not exceed 10 pages) which explains any changes to program scope, personnel, partnerships with agencies or organizations, or other information the subrecipient wishes to share for continuation funding.

i. **Major Accomplishment:** Describe one major accomplishment made within the CHC grant cycle. Include both how this accomplishment was achieved and share positive community outcomes.
ii. **Community Engagement:** Describe one example of how you have engaged residents within your priority communities to complete a work plan strategy.
iii. **Inclusion:** Describe how you have included groups who have traditionally been left out of community decision-making in the past, such as communities of color, people with low incomes, people with disabilities, etc.
iv. **CHC Principles:** Describe how you have used the new CHC principles in your work.
v. **2024 Plan**: Describe the process used to select strategies in 2024. Explain the structure of your community partnerships and/or coalitions that will help accomplish each strategy. Describe any budgetary limitations to completing your proposed workplan strategies.
vi. **Sustainability:** Describe how policy, system, and environmental changes implemented in the grant cycle (2020-2024) will be sustained. What efforts will occur in year five (2024) to ensure sustainability, especially if not funded for the new grant cycle.

C. **Objectives and Work Plan:** Complete and submit a short summary of any changes in the Specific, Measurable, Achievable, Results-Oriented, and Time-Based (SMART) objectives and submit an updated work plan. Reference the competitive solicitation for information. This should be based on a review of the Progress Plans submitted to date. Provide a brief report addressing elements of each objective and activity, including current status (met, ongoing, or unmet); major findings; and barriers and how barriers were addressed. **[Complete Work Plan Attachment in Microsoft Word format downloadable from the CHC Engagement Hub Library. The Work Plan is the only required documentation for this section. Please make sure that the workplan provides enough detail for the reviewer to know what is planned for each strategy.]**

D. **Documentation and Progress on Health Equity and Disparity Reduction Activities:**
Please provide detailed updates on the goals, objectives, and deliverables specified in the competitive solicitation relating to health equity. This information must be supported by data. Continuation solicitations should prepare a summary of activities completed, during the previous funding period, to outreach to the priority populations and / or neighborhoods specified in their plan. **[Please refer to the checklist in Appendix B and provide relevant information in the Program Narrative section outlined on page 3.]**

E. **Program Budget:** Prior to completion of the budget section, reference the competitive solicitation for unallowable costs and review criteria.

1. **Budget Narrative:** Provide a detailed budget justification in a narrative that describes how categorical costs are derived. Discuss the necessity, reasonableness, and allocation of the proposed costs. Describe the specific functions of the personnel, consultants, and collaborators. Explain and justify equipment, travel, (including plans for out-of-state travel), supplies and training costs. If you have shared costs, refer to OGAPP Chapter 2 Section C2.4 Cost Allocation Plan for additional information. Please refer to the GMIS 2.0 bulletin board for attachment instructions.

For your convenience, a budget justification narrative example is available at on the GMIS Bulletin Board, posted March 13, 2020.

Match or Applicant Share is not required by this program. Do not include match or Applicant Share in the budget and/or the Applicant Share column of the Budget Summary. Only the narrative may be used to identify additional funding information from other resources.

2. **2024 Budget via GMIS:** Complete requested budget information as follows:

- **Personnel, Other Direct Costs, Equipment and Contracts Sections:** Submit a new budget to support costs for the period Monday, Jan. 1, 2024 to Monday, Sept. 30, 2024. Funds may be used to support personnel, staff training, travel (see OBM website https://obm.ohio.gov/wps/portal/gov/obm/areas-of-interest/agency-overview/obm-travel-rule/obm-travel-rule, and supplies directly related to planning, organizing and conducting the program activity. Itemize, in the Equipment Section, all equipment (minimum $1,000 unit cost value) to be purchased with grant funds.

Any personnel listed in the budget must complete daily timesheets. Time & Effort reporting must be completed if staff are charged to multiple funding sources.

The applicant shall retain all original fully executed contracts on file. A completed "Confirmation of Contractual

Agreement" (CCA) must be submitted via GMIS for each contract once it has been signed by both parties. All contracts must be signed and dated by all parties prior to any services being rendered and must be attached to the CCA section in GMIS. The submitted CCA and attached contract must be approved by ODH before contractual expenditures are authorized. CCAs and attached contracts cannot be submitted until the first quarter grant payment has been issued.

- **Compliance:** Answer each question on this form. Completion of the form ensures your agency's compliance with the administrative standards of ODH and federal grants.

3. **Unallowable Costs:** Funds **may not** be used for the following:

1. To advance political or religious points of view or for fund raising or lobbying.
2. To disseminate factually incorrect or deceitful information.
3. Consulting fees for salaried program personnel to perform activities related to grant objectives.
4. Bad debts of any kind.
5. Contributions to a contingency fund.
6. Entertainment.
7. Fines and penalties.
8. Membership fees — unless related to the program and approved by ODH.
9. Interest or other financial payments (including but not limited to bank fees).
10. Contributions made by program personnel.
11. Costs to rent equipment or space owned by the funded agency.
12. Inpatient services.
13. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building.
14. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.
15. Travel and meals over the current state rates (see OBM website: http://obm.ohio.gov/TravelRule/default.aspx for the most recent Mileage Reimbursement memo.).
16. Costs related to out-of-state travel, unless otherwise approved by ODH, and described in the budget narrative.
17. Training longer than one week in duration, unless otherwise approved by ODH.
18. Contracts for compensation with advisory board members.
19. Grant-related equipment costs greater than $1,000, unless justified in the budget narrative and approved by ODH.
20. Payments to any person for influencing or attempting to influence members of Congress or theOhio General Assembly in connection with awarding of grants.
21. Promotional items.
22. Office furniture (including but not limited to desks, chairs, file cabinets) unless otherwise stated.
23. Food and beverages for coalition and partner meetings.
24. Outpatient services.

Subrecipients will not receive payment from ODH grant funds used for prohibited purposes. ODH has the right to recover funds paid to subrecipients for purposes later discovered to be prohibited. Please refer to the OGAPP manual for additional information.

4. Indirect (Facilities and Administration):

Use the indirect cost rate included in the agency's Indirect Cost Rate Agreement as negotiated with and approved by the cognizant federal funder. If the applicant chooses this option, then the agreement must be submitted in GMIS as an attachment to the application.

If the subrecipient has not executed a federally approved Indirect Cost Rate Agreement, the subrecipient may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely.

Base the budget solely upon direct costs.

For further information please see Chapter 2 Section B2.11 of OGAPP.

F. Other Application Requirements:

Program Specific Attachments: Complete and submit the following attachments.

a. Workplan

- All Word document templates are located in the CHC Engagement Hub Library. Attachments are submitted via GMIS. All attachments must clearly identify the authorized program name and program number.

b. Other Required Documentation:

- Subrecipients are required to maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form, and current address.

  This information is maintained on the following website: http://supplier.ohio.gov/.

  Note: Subrecipients future payments will be held if the agency receives a paper check due to the EFT information not being properly maintained in the supplier portal.

- **Audit:** Subrecipient agencies are responsible for submitting an audit report. Once an audit is completed, a copy must be sent to ODH via audits@odh.ohio.gov. Reference the GMIS Bulletin Board for more information.

- **Civil Rights Review Questionnaire — EEO Survey:** The Civil Rights Review Questionnaire (EEO) Survey is a part of the Application Section of GMIS. Subrecipients must complete the questionnaire as part of the application process. This questionnaire is submitted automatically with each application via the Internet.

- **Assurances Certification:** Each subrecipient must acknowledge the Assurances (Federal and State Assurances for Sub-grantees) form in GMIS. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive, and any omission of other statutes does not mean such statutes arenot assimilated under this certification. Review the form and then press the "Complete" button. By submission of an application, the subrecipient agency agrees by electronic acknowledgment tothe financial standards of conduct as stated therein.

- **Federal Funding Accountability and Transparency Act (FFATA):** All applicants applying for ODH grant funds are required to complete the FFATA reporting form in GMIS. Applicants must ensurethat the information contained in SAM.gov, DUN & Bradstreet and the FFATA reporting form match. ODH will hold all payments if an applicant's information does not successfully upload intothe federal system.

  All applicants for ODH grants are required to obtain a Data Universal Number System (DUNS), register in SAM.gov and submit the information in the grant application. For information about the DUNS, go to www.dnb.com. For information about System for Award Management (SAM) go to https://beta.sam.gov/.

  Information on Federal Spending Transparency can be located at www.usaspending.gov or the Office of Management and Budget's website for Federal Spending Transparency at https://www. whitehouse.gov/.

  (Required by all applicants, the FFATA form is located on the GMIS Application page and must be completed in order to submit the application.)

- **For Non-Profit Organizations Only:**

  1. **Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations must submit documentation validating current liability coverage. Attach the current Certificate of Insurance Liability in GMIS.

  2. **Non-Profit Organization Status:** Non-profit organizations must submit documentation validating current status. If changed, attach in GMIS the Internal Revenue Services (IRS) letter approving non-tax exempt status.

G. Human Trafficking:

The ODH is committed to the elimination of human trafficking in Ohio. If applicable to the subrecipient program, ODH will give priority consideration to those subrecipients who can demonstrate the following:

a. Victims of human trafficking are included in your agency's target population.
   1. At-risk population.
   2. Mental health population.
   3. Homeless population.

b. Agency promotes the expansion of services to identify and serve those affected by human trafficking.

c. x applicable (Creating Healthy Communities).

H. Post Submission Requirements: Continuation applicants are required to submit subrecipient program and expenditure reports.

Note: Failure to assure quality of reporting such as submitting incomplete and/or late program or expenditure reports will jeopardize the receipt of future agency payments.

Reports shall be submitted as follows:

a. Program Reports: Subrecipient Program Reports must be completed and submitted via GMIS bythe following dates. **Program reports that do not include required attachments (non-Internet submitted) will not be approved.** All program report attachments must clearly identify the authorized program name and grant number.

x Program Reports Required _____ No Program Reports Required

Period	Report Due Date
Jan. 1-March 31, 2024	April 10, 2024
April 1-June 30, 2024	July 10, 2024
July 1-Sept. 30, 2024	Oct. 10, 2024

b. **Subrecipient Reimbursement Expenditure Reports:** Subrecipient Monthly Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

Period	Report Due Date
Jan. 1 – 31, 2024	Feb. 10, 2024
Feb. 1 – 29, 2024	March 10, 2024
March 1 – 31, 2024	April 10, 2024
April 1 – 30, 2024	May 10, 2024
May 1 – 31, 2024	June 10, 2024
June 1 – 30, 2024	July 10, 2024
July 1 – 31, 2024	Aug. 10, 2024
Aug. 1 – 31, 2024	Sept. 10, 2024
Sept. 1 – 30, 2024	Oct. 10, 2024

Subrecipient Quarterly Reimbursement Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

Period	Report Due Date
Jan. 1 – March 31, 2024	April 10, 2024
April 1 – June 30, 2024	July 10, 2024
July 1 – Sept. 30, 2024	Oct. 10, 2024

Note: Obligations not reported on the final monthly or quarterly expenditure report will not be considered for payment with the final expenditure report.

c. **Final Expenditure Reports:** A Subrecipient Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS** by 4 p.m. on or before Nov. 5, 2024. The information contained in this report must reflect the program's accounting records and supportive documentation. Any cash balances mustbe returned with the Subrecipient Final Expense Report. The Subrecipient Final Expense Report serves as an invoice to return unused funds.

Submission of ALL Subrecipient Program and Expenditure Reports via theODH's GMIS system indicates acceptance of OGAPP. Clicking the "Submit" or "Approve" button signifies your authorization of the submission as an agency official and constitutes your electronic acknowledgment and acceptance of OGAPP rules and regulations.

III APPENDICES

A. Continuation Solicitation ReimbursementType Form.
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Appendix A

CONTINUATION SOLICITATION
REIMBURSEMENT TYPE FORM

Ohio Department of Health
Bureau of Health Improvement and
Wellness

ODH Program Title:
[Creating Healthy Communities
CC24]

Reimbursement Type (check one) Monthly ☐ **OR** Quarterly ☐
(Please note that no changes to the reimbursement type can be made after the project number is created in GMIS. No waivers/appeals will be accepted.)

Please print:
Current Project Number _____

Applicant Agency/Organization _____

Applicant Agency Address _____

_____

Agency Contact Person Name and Title _____

Telephone Number _____

E-mail Address _____

_____ _____
Agency Head (Print Name) Agency Head (Signature)

Please note that the agency head listed above must match the agency head listed in GMIS. Unless a new agency, NOIAF's will not be accepted if name doesn't match what is listed in GMIS.

Due to ODH by Wednesday, June 28, 2023.
Please email completed form to Maria Kapenda (maria.kapenda@odh.ohio.gov).

Appendix B

ODH Evidence of Health Equity
Strategies Checklist

This checklist should be used to support planning, implementation, and evaluation of equitable strategies to reduce disparities and overcome social determinants of health. This checklist is a guide to establish a baseline criterion that all projects funded by ODH to support alignment with established priorities to achieve optimal health for all Ohioans.

Health Disparities, Health Inequities, Social Determinants of Health & Health Equity

Racial and ethnic minorities, those living in rural communities, people with disabilities, the LGBTQ community and Ohio's economically disadvantaged residents do not have the same opportunities as other groups to achieve and sustain optimal health. Health disparities occur when these groups experience more disease, death, or disability beyond what would normally be expected based on their relative size of the population. Health disparities are often characterized by such measures as disproportionate incidence, prevalence and/or mortality rates of diseases or health conditions. Health is largely determined by where people live, learn, work, play, and age. Health disparities are unnatural and occur because of low socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these factors. Those most impacted by health disparities also tend to have less access to resources like healthy food, safe housing, quality education, safe neighborhoods and freedom from racism, and other forms of discrimination. These are referred to as **social determinants of health (SDOH)**. SDOH are a root cause of health disparities. The systematic nature of health disparities is considered unjust and is referred to as **health inequities**. The ability of everyone to have the same opportunity to achieve the best health possible is referred to as **health equity**. Programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to advancing health equity.

The ODH is committed to the elimination of health disparities and achieving health equity for all Ohioans. The items below are requirements for all applicants to ensure health equity is embedded within all components of the application (e.g., Goals, Program Narrative, and Objectives.)

1) Identify specific groups who experience a disproportionate burden of disease, health condition or health outcome targeted by this solicitation. See Ohio's State Health Assessment Ohio's health data. https://odh.ohio.gov/wps/portal/gov/odh/explore-data-and-stats/interactive-applications/2019-online-state-health-assessment

2) Identify geographic reference points (i.e., census tracts, census block groups or zip codes) to specify where program activities are focused.

Consider using the Ohio Health Improvement Zones Dashboard to determine or refine your priority service areas. The dashboard was created to support and aid efforts to reach Ohioans living in communities that may experience barriers to health. The dashboard quantifies specific factors that affect the resilience of individuals and communities to achieve optimal health and overcome a disaster like COVID-19.

By understanding where these populations are located and what factors contribute to their levels of risk and

overall health outcomes, subrecipients can collectively and holistically develop strategies to improve health in the communities that need it most. Interactive maps, census tract information and more can be found on the Ohio Health Improvement Zones Dashboard, here: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/health-equity/health-improvement-zones.

3) Use direct or indirect feedback from the prioritized population, community, group, or community agency to identify specific social and environmental conditions (social determinants of health) associated with health disparities and health inequities.

4) Identify measurable health equity targets that demonstrate reducing disparities and improving health equity are critical goals to be achieved through program activities. This information must also be supported by data. For guidance on methodology to establish equity targets, review 2030 Target Setting Methodologies for Objectives in Healthy People 2030.

5) Outline specific evaluation strategies to measure the impact of program activities on decreasing and/or eliminating health disparities and health inequities.

The following are best practices toward eliminating disparities and achieving health equity and are not required, but highly encouraged.

1) Link proposed activities to health equity strategies identified in local, state, or national planning documents. These documents include, but are not limited to strategies, goals, and objectives outlined in Healthy People 2030, the State Health Improvement Plan (SHIP), and local Community Health Assessments.
   - State Health Improvement Plan – https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship.
   - Healthy People 2030 – https://health.gov/healthypeople.

2) Develop staffing plans where board members, leadership and program staff reflect the race, ethnicity, background, and/or culture of the population being served.

3) Identify up- and downstream approaches to address social determinants of health and reduce disparities. Upstream factors like food, housing, and income insecurity that focus on addressing social determinants of health decrease barriers and improve supports that provide opportunity for people to achieve their full health potential. Downstream approaches focus on providing equitable access to care and services to reduce the negative impact of social determinants on health outcomes.

4) Establish non-traditional partnerships among different sectors of the community (e.g., faith-based organizations, local industries, businesses, universities, healthcare) that can provide valuable insight, new perspective, and more effective ways to achieve program goals. Non-traditional partners create opportunity to collaborate across sectors and may serve as a new source of support for the program.

Appendix C

Program Overview

The Creating Healthy Communities (CHC) program is specifically designed to improve population health while addressing health equity in populations experiencing health disparities. Applicants will be required to work on policy, systems, and environmental (PSE) change strategies that address healthy eating and active living in the three priority communities selected in 2020. Healthy People 2030 and Ohio's State Health Improvement Plan serve as guidance for program outcomes:

Healthy People 2030 (HP 2030)

HP 2030 provides 10-year, measurable public health objectives, with a mission *to promote, strengthen, and evaluate the nation's efforts to improve the health and well-being of all people*. HP 2030's vision is *A society in which all people can achieve their full potential for health and well-being across the lifespan.*
The table below lists all HP 2030 objectives relevant to CHC:

Objective	Objective #
Reduce the proportion of adults with obesity	NWS-03
Reduce the proportion of children and adolescents with obesity	NWS-04
Reduce household food insecurity and hunger	NWS-01
Increase fruit consumption by people aged 2 years and over	NWS-06
Increase vegetable consumption by people aged 2 years and older	NWS-07
Increase whole grain consumption by people aged 2 years and over	NWS-09
Reduce consumption of added sugars by people aged 2 years and over	NWS-10
Reduce consumption of saturated fat by people aged 2 years and over	NWS-11
Reduce consumption of sodium by people aged 2 years and over	NWS-12
Increase the proportion of adults who do enough aerobic and muscle-strengthening activity	PA-05
Increase the proportion of adolescents who do enough aerobic and muscle-strengthening activity	PA-08
Increase the proportion of adults who walk or bike to get places	PA-10
Increase the proportion of adolescents who walk or bike to get places	PA-11

Ohio's State Health Improvement Plan (SHIP)

With the long-term goal of ensuring all Ohioans achieve their full health potential, the SHIP takes a comprehensive approach to achieving equity and addressing the many factors that shape our health, including housing, poverty, education, and trauma. The State Health Improvement Plan (SHIP) is a tool to strengthen state and local efforts to improve health, well-being, and economic vitality in Ohio. The table below provides reference pages for further information on SHIP indicators relevant to CHC's mission and vision.

SHIP INDICATOR	Page #	Demographic breakdown available (Y/N)
HB.3 Youth Fruit Consumption	36	N
HB.4 Youth Vegetable Consumption	36	N
HB.5 Child physical activity	39	N
HB.6 Adult physical activity	39	Y
CD.1 Coronary Heart Disease	67	Y
CD.2 Premature Death- Heart Disease	67	Y
CD.3 Hypertension	68	Y
CD.4 Diabetes	68	Y

Policy, Systems and Environmental Change

Policy, systems, and environmental change make healthier choices a real, feasible option for every community member. This is done by looking at the laws, rules, and environment that impact behaviors.

Policy change includes the passing of laws, ordinances, resolutions, mandates, regulations, or rules. Government bodies (federal, state, local level), school districts and schools, park districts, healthcare organizations, worksites and other community institutions all make policy changes.

Systems change involves changes made to the rules within an organization. Systems change and policy change often work together.

Environmental change is a change made to the physical environment, such as installing bike signage or bike racks to help create a bicycle-friendly community.

Identifying assets and needs in communities in relation to healthy eating and active living (HEAL) policies and practices is an important step in informing selection and implementation of future HEAL strategies. This can also help build relationships with community partners, and foster conversation with community partners to identify strategies of mutual benefit.

Resources

- What Is PSE Change?
- Rural Health Info Hub: PSE Change
- SNAP-Ed: What is PSE Change?
- Illinois Prevention Research Center: Policy, Systems, and Environmental Change

Appendix D

Scope of Work

1. **Community Coalition.**
    - Facilitate and/or participate in a diverse and inclusive coalition(s) of residents and organizations representing the three priority communities to collaborate toward completion of workplan activities.
    - CHC Coordinators are not required to lead a coalition, but should be involved in various community groups and have relationships with residents and/or people who represent the CHC priority communities.
    - CHC Coordinators should work with community residents and organizations in a way that works best for each community.
    - If an existing CHC coalition is working well, this group may continue to meet and function as usual.
2. Create a **Work Plan** that addresses the following:
    - Each of the three priority communities is represented by either a new strategy that can be completed in nine months, or one or more sustainability strategies. See appendix K for list of strategies.
        - It is not recommended to start brand new strategies that would span multiple years. Focusing on completing and sustaining past work is encouraged.
        - Work with your program consultant to ensure the proposed workplan meets requirements for shortened grant year.
    - Incorporate community engagement in each strategy. See appendix F for suggestions.
    - Complete at least one SPAN Active Living strategy and at least one Food Service Guidelines strategy (which includes a completed FSG post assessment) *per grant cycle*.
        - Check with your program consultant to ensure SPAN requirements have been met.
3. Year End Requirements.
    - Submit an annual Success Story. Topic to be determined by the end of Q2.
    - Complete annual data summary: Link to Instructions (CHC Hub) .
    - Complete leveraged funding form: Link to Form (CHC Hub).

State Physical Activity and Nutrition (SPAN) Strategies

CHC state staff supports grant objectives within the CDC SPAN grant. A list of priority strategies and resources are provided in the table below.

SPAN Strategy	**Resources**
Complete Streets	FAQ Factsheet National Complete Streets Coalition
Active Transportation Planning	FAQ Fact Sheet ODOT Active Transportation Academy
Land Use interventions	Land Use and Health Best Practices Report Land Use and Health Implementation Guide Zoning 101 Fact Sheet
Food Service Guidelines	Good Food Here Toolkits and branded materials Healthy Eating Research Nutrition Guidelines for the Charitable Food System

Appendix E

Priority Communities

All grantees are required to complete strategies in **three** priority communities. A priority community is defined as a specific group of people, often living in a defined geographical area (Ohio Health Improvement Zones, city or county jurisdiction, villages, townships, zip codes, census tracts, or school districts), who share a common culture, values, and norms and are arranged in a social structure according to relationships the community has developed over time. Impact is maximized when people have healthy choices available where they live, work, learn, and play. Selection of priority communities should consider the following variables:

1. Presence of health inequities (resources listed below).
    - Ohio Health Improvement Zones.
    - Social Determinants of Health Dashboard.
    - CDC Health Equity Webpage.
    - County Health Rankings.
    - Feeding America- Food Insecurity Data.
    - CDC Social Vulnerability Index.
    - Health Equity Tracker.
2. Readiness of the priority community to advance change.
    - Community resident trust/buy in.
3. Organizational partners have resources/ability to contribute.
4. Total reach (i.e., how many people will be impacted by the change).
    a. City- and county-wide policy adoption is encouraged.
5. Adequate infrastructure for change.

All grantees are approved to use their entire jurisdiction as one of the three required priority communities. Priority communities must remain the same for the entire grant cycle.

Appendix F

Community Engagement

From https://centerforwellnessandnutrition.org/community-engagement-toolkit/

Community engagement was given a working definition by the Centers for Disease Control and Prevention (CDC) when its first edition of Principles was published. The organization agreed that community engagement was: "…the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices (CDC, 1997, p 9 – published in CDC, Principles of Community Engagement Second Edition, 2011, p. 3)".

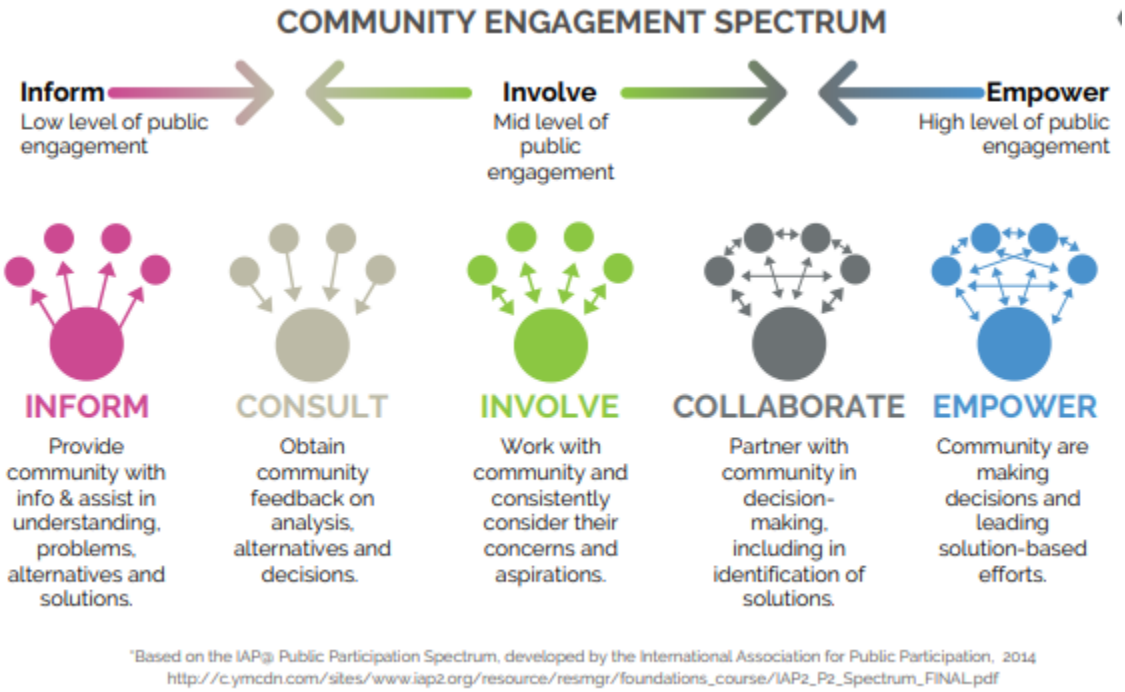
Community engagement is about ensuring that those most impacted by challenges and inequity have an equal voice in designing and implementing solutions. The active participation of residents and their families, partners, and trusted leaders is an integral part of community engagement practices to achieve better results. A shift in power where community residents own the solutions will lead to a better impact, sustainability, and ongoing civic engagement.

Community Engagement Spectrum

Community engagement is driven by the residents. A community with unified residents is a powerful vehicle. It inspires changes that will improve the health of its residents. Residents who have similar interests or situations can address issues that affect their neighborhood's well-being.

Health and well-being are generated where people live, work, learn, and play. Health inequities are the result of poverty, racism, and widespread oppression. In community engagement, public health departments and other agencies work collaboratively on community-driven projects. These grassroots approaches are meant to let residents tackle community issues using their own united voice and actions.

When an agency works with residents, it increases the likelihood of their buy-in and ongoing efforts. Drawing on local knowledge from a diverse group is smart. The group forms solutions that are practical, effective, and rooted in the realities of the community. Being in control places community residents in a position to feel empowered as they build leadership, local capacity, and trust. Inclusion and involvement in decision making supports empowering community members to improve the conditions of their community.



*Based on the IAP2® Public Participation Spectrum, developed by the International Association for Public Participation, 2014
http://c.ymcdn.com/sites/www.iap2.org/resource/resmgr/foundations_course/IAP2_P2_Spectrum_FINAL.pdf

Disability Inclusion

The Creating Healthy Communities program recognizes the importance of working with individuals with disabilities, whether physical, intellectual, or other. CHC works with the Ohio Disability and Health Program to provide additional technical assistance and resources on disability inclusion work related to CHC. Within CHC Community Coalitions, it is highly recommended for people with disabilities to be present and provide input on CHC projects.

Community Engagement Resources

- Toole Design's Community Engagement Template (found in CHC Hub Library).
- Center for Wellness and Nutrition's Community Engagement Toolkit.
- Changelab Solutions Planner's Playbook.
- Safe Routes Partnership Community Engagement Guide.
- Working Toward Food Security Through Community Engagement.
- Race Forward/Racial Equity Tools on Community Engagement.
- Community Commons-Engaging People with Lived Experience Toolkit.
- Nemours-Lived Experience: The Practice of Engagement in Policy.

Appendix G

Training and Technical Assistance (TA)

The purpose of training and TA is to build the capacity of CHC grantee staff and partners (as appropriate and as funding allows) to ensure they have the foundational skills and resources they need to successfully implement CHC strategies. ODH's approach to training and TA will support both strategy-specific and foundational skills to advance PSE changes to improve access to and affordability of healthy food, to increase opportunities for physical activity, and to reduce rates of chronic disease.

Each subgrantee will be assigned an ODH program consultant. Program consultants will conduct quarterly conference calls, at least one in-person site visit, and provide verbal and written feedback on quarterly program and expenditure reports. Sub-grantees are encouraged to call or email their program consultant at any time for programmatic or budgetary questions.

Training and TA will be delivered by ODH in the following ways:

- Statewide in-person or virtual full day meetings.
- Webinars, conference calls, etc.
- Printed and digital materials and other resources (e.g., toolkits, policy templates, etc.).
- CHC Engagement Hub (internal program website with library of resources and discussion forum).

  Grantees are required to:
    - Attend trainings, which include the following:
        - Two CHC All-Project Meetings (virtual or in person).
        - Up to one Additional training (to be determined by ODH).
    - Participate in monthly all-project conference calls.
        - Participation in monthly conference calls requires access to MS Teams.
    - Remain in regular contact with their program consultant in between quarterly reporting.
    - Participate in the CHC Engagement Hub.

Toole Design

CHC contracts with Toole Design to provide additional technical assistance and training on Active Living and Active Transportation Strategies. A compiled list of resources created by Toole Design can be accessed in the CHC Engagement Hub. When submitting a TA request to Toole Design, please email ActiveLivingHelp@tooledesign.com and cc your program consultant. Examples of individual county TA include: General consultation on active living work; Workshop development and facilitation (in person or virtual); Workplan review; Plan/Policy Reviews.

Appendix H

SECTION 6: COMMUNICATION

Communication is critical to building support with the community residents and connecting with organizational partners.

The CDC funding statement must be placed on all original educational materials developed by CHC subgrantees (copied below from the Ownership Copyright section and funding statement on pages 9-10 of the competitive RFP).

> "This publication (journal article, etc.) was supported by the Grant or Cooperative Agreement Number, NB01OT009211-01-00 funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services."

The funding statement is not required on materials such as meeting agendas, flyers, signage, etc.

Grantees must utilize local health department resources to ensure that program information (both print and electronic) is accessible to all individuals, including people with disabilities.

Grantees should familiarize themselves with the CDC's Health Equity Guiding Principles for Inclusive Communication and incorporate key principles and preferred terms into regular communication.

It is suggested that grantees:

- Communicate with ODH prior to the creation of original education or promotional materials.
- Align communication pieces funded by CHC such as advertisements, signage, printed materials, and websites, with the CHC logo and brand. This includes logos, graphics, PowerPoint templates, colors, and fonts.
- Represent the CHC program throughout the state. When programs are identified in the public such as through media articles it is encouraged to state, "The Creating Healthy Communities Program at the (health department name)".
- Create and/or maintain a webpage and/or social media page for the local CHC program.

Appendix I

Guidelines for Completing the Work Plan

Guidelines for how to complete the various parts of the work plan are described below. Specific examples of each component can be found in the sample work plan in **Appendix J**.

Strategy

Select a strategy from Appendix K and/or identify strategies that will need completed from previous year(s).

Healthy People 2030 Objective

Select one or more Healthy People 2030 Objectives that align with your selected strategy listed in Appendix C.

Target Outcome

Work with community coalition to determine a realistic outcome once the strategy is complete. These targets should address the behavior change (when applicable) that occurs as a result of the intervention. For strategies in which behavior change is not an appropriate measure of success, such as a policy change, the outcome can address the immediate goal of the policy. These strategies include: Complete Streets, Active Transportation Planning, Land Use, Shared Use, Food Service Guidelines, and Food Access Policy/Planning. The outcome should be measurable through data collection and the method of collection should be identified. Examples are provided below.

- Behavior Change Example:
    - *Surveys and observations will show a 10% increase in park utilizations as a result of improved playground equipment.*

- Policy Change Examples:
    - *Adopted/Revised Complete Streets Policy will meet xx% criteria from National Complete Streets Coalition Rubric.*
    - *Adopted/Revised Active Transportation Plan supports infrastructure and non-infrastructure improvements in the jurisdiction of XX as evidenced by surveys, community feedback, list of prioritized projects, and potential leveraged funding.*
    - *Assessment tools in the Good Food Here Toolkit will indicate that 50% of products offered in (venue) meet food services guidelines.*

Process Objectives

For each strategy, write the intermediate steps or specific, measurable actions that need to be completed in a specific timeframe. Process objectives explain what is to be done and when it is going to be completed. There should be a **minimum of seven** process objectives to accomplish each strategy. An example of seven process objectives 'buckets' may include:

1. Assessment.
2. Community Engagement.
3. Planning/Fundraising.
4. Second Round of Community Engagement.
5. Implementation (include activities that will contribute to sustainability).
6. Promotion.
7. Evaluation.

Related Activities

List steps to accomplish each process objective. Related activities should be unique to each strategy and priority community. **The related activity should not repeat the process objective.**

*Note: Process objectives are mini-goals or milestones and should have three to six related activities. If a process objective has only one or two related activities, then more detail is needed, or the process objective may be a related activity for a different, larger goal.

Agency or Person Responsible

Identify the person(s) and/or agency (ies) responsible for each process objective.

Specific Dates

List specific beginning and ending dates throughout the year for planning and measuring progress. process objectives and related activities should be properly tailored to each strategy. *Having process objectives that span a full year is discouraged.*

Evaluation Measure(s)

Evaluation can help identify needed changes, find out how well objectives are being met, determine the effects of the program, and identify ways to improve the program. In the work plan, include a brief description of the evaluation measures for each process objective. After the measures are developed, gather, and record the data.

Progress

Each quarter, provide in narrative or bullet form, the progress to date for each process objective. This section should be left blank for the initial application. Guidance for completing progress notes can be found in the CHC Engagement Hub

Sustainability Efforts

At the end of your workplan, there is space to report on ongoing efforts related to past CHC work that does not meet the criteria for a full strategy in your workplan, but continued time and effort, as well as additional CHC funds are needed to ensure the strategy is sustainable long-term. **This section is required for 2024. If you are unsure of what strategies to include in this section, please reach out to your program consultant.**

Sustainability Efforts (scored as part of your application, all fields required)

Strategy/Priority Community/Year Started	Activities	Relevant Partners	Evaluation Measure
1.			
Potential Reach (if applicable/not already reported): Quarter 1: Step 1: Identify Measurement Category (Choose an item.) Quarter 1: Step 2: Plan how you will measure (include GEOID if applicable): Quarter 3: Step 3: Record Potential Reach: _____ (copy to data summary in CHC Hub)			
Q1:			
Q2:			
Q3:			

Appendix J

2024 CREATING HEALTHY COMMUNITIES WORK PLAN

Agency:_____ Grant #:_____ County Served: _____

Priority Community: Apple City

Strategy #1: New/Repaired Parks and Playgrounds.

Healthy People 2030 Objective(s):

- Reduce the proportion of adults with obesity – NWS-03.
- Reduce the proportion of children and adolescents with obesity – NWS-04.
- Increase the proportion of adolescents who do enough aerobic and muscle-strengthening activity – PA-08.
- Increase the proportion of adults who do enough aerobic and muscle-strengthening activity — PA-05.

Target Outcome: Surveys and observations will show a 10% increase in park utilization as a result of the improved park and playground equipment.

Potential Reach:

Quarter 1: Step 1: Identify Measurement Category **Category 2: Strategies intended to potentially reach people living in a specific geographic area**
Quarter 1: Step 2: Plan how you will measure (include GEOID if applicable):
Quarter 3: Step 3: Record Potential Reach: _____ (copy to data summary in CHC Hub).

Q3 only, brief summary of annual progress, including if target outcome has been met:

Process Objectives	Related Activities	Agency or Person Responsible	Specific Dates for Each Activity		Evaluation Measures
			Start	End	

1. Conduct a pre-assessment of Honeycrisp Park.	• Meet with community members and local partners to form a park planning group. • Conduct CHII assessment. • Review results of CHII assessment with ODH's Inclusion/Disability Specialist, and Honeycrisp Park planning group. • Develop evaluation questions to collect qualitative data from community members. • Gather park usage data prior to improvements.	• CHC Staff. • Apple City Parks and Recreation. • McIntosh Elementary Schools. • ODH's Inclusion/Disability Specialist.	01/01/24	02/29/24	• CHII Results. • Evaluation Questions. • Meeting(s) Summary.
Q1:					
Q2:					
Q3:					
2. Develop park design with community residents and partners.	• Reference ODH community engagement resources. • Coordinate with planning group to draft a community engagement plan. • Obtain community input on desired park enhancements through mid to high level of public engagement (involve, collaborate, and empower). • Generate list of community priorities identified from engagement activities/events. • Ensure that inclusive enhancements are included in park layout/equipment. • Consult ODH's Inclusion/Disability Specialist as needed. • Draft a layout of the park.	• CHC Staff. • Honeycrisp Park Planning Group. • Apple City Parks and Recreation. • McIntosh Elementary Schools. • ODH's Inclusion/Disability Specialist.	02/01/24	03/31/24	• Engagement Plan. • Copy of engagement strategies. • List of Community Priorities. • Drafted layout.
Q1:					
Q2:					
Q3:					

3. Finalize Honeycrisp Park design.	• Hold community input meeting with planning group. • Coordinate with potential playground vendor(s) to revise draft layout based on input from community and planning group. • Consult ODH's Inclusion/Disability Specialist as needed. • Finalize design.	• CHC Staff. • Honeycrisp Park Planning Group. • Apple City Parks and Recreation. • McIntosh Elementary Schools. • ODH's Inclusion/Disability Specialist. • Playground vendor(s).	04/01/24	04/30/24	• Finalized Layout.
Q1:					
Q2:					
Q3:					
4. Purchase materials and identify additional funding resources.	• Solicit playground vendors, obtain quotes. • Choose playground vendor, sign contract. • Analyze the cost of suggested enhancements and reassess budget. • Research grant opportunities, leveraged funds, and share with partners.	• CHC Staff. • Honeycrisp Park Planning Group. • Apple City Parks and Recreation. • McIntosh Elementary Schools. • Selected playground vendor.	05/01/24	05/31/24	• Vendor Quotes. • Copy of Contract.
Q1:					
Q2:					
Q3:					
5. Prepare for build week.	• Determine build week date(s) and schedule. • Recruit resident volunteers for build week. • Coordinate additional supplies needed for the build week. • Conduct site preparations to ensure utility checks are complete.	• CHC Staff. • Honeycrisp Park Planning Group. • Apple City Parks and Recreation. • McIntosh Elementary Schools. • Selected playground vendor.	05/01/24	07/31/24	• Volunteer Registration. • Materials List.
Q1:					
Q2:					
Q3:					

6. Install park/playground equipment.	• Coordinate installation with community residents and key partners. • Ensure installer conducts equipment checks to verify park/playground equipment is safe before opening. • Document installation process with photographs.	• CHC Staff. • Honeycrisp Park Planning Group. • Apple City Parks and Recreation. • McIntosh Elementary Schools. • Selected playground vendor.	06/01/24	07/31/24	• List of playground enhancements. • Photographs.
Q1:					
Q2:					
Q3:					
7. Promote refurbished Honeycrisp Park.	• Develop marketing materials to announce playground enhancements. • Draft media release and distribute to media outlets. • Promote the playground using strategies outlined in the engagement plan. • Document opening events with photographs. • Hold opening event.	• CHC Staff. • Honeycrisp Park Planning Group. • Apple City Parks and Recreation. • McIntosh Elementary Schools.	07/01/24	8/31/24	• Copies of marketing materials. • Media release. • Photographs of the opening event. • Media coverage.
Q1:					
Q2:					
Q3:					
8. Evaluate park usage.	• Gather qualitative data from community members using evaluation questions developed during pre-improvement evaluation. • Observe park usage post-improvements. • Compare pre-improvement evaluation data with post-improvement data. • Summarize results.	• CHC Staff. • Honeycrisp Park Planning Group. • Apple City Parks and Recreation. • McIntosh Elementary Schools. • Selected playground vendor.	9/01/24	9/30/24	• Evaluation Results.
Q1:					
Q2:					
Q3:					

Appendix K

Strategies

The list of pre-approved strategies in the table below is derived from Healthy People 2030 and the State Health Improvement Plan (SHIP). Many strategies have additional information on the CHC website or CHC Hub at the links provided:

Active Living	**Healthy Eating**
• New/Repaired Parks and Playgrounds. • Worksite Active Commute Support. • Bike Infrastructure. • Pedestrian Infrastructure. • Public Transit Improvements. • Multi-Use Trails. • Safe Routes to School. • Complete Streets Policy. • Active Transportation Planning. • Land Use Policy. • Shared Use Policy.	• Farmers' Markets. • Healthy Food Retail. • Food Bank/Pantries. • Community Gardens. • Farm-to-Institution. • Community Supported Agriculture (CSA). • Safe Routes to Healthy Food. • Produce Prescriptions. • Food Service Guidelines. • Food Access Policy & Planning.
Innovative/Promising Practice: CHC Grantees may propose one strategy per year that is not listed above. Strategy must align with a HP2030 Goal and/or the State Health Improvement Plan. For ideas, visit County Health Rankings, What Works for Health and/or the CDC's Community Guide. Work with your program consultant to receive approval prior to submitting your application.	

A complete list of references is included at the end of the appendix. Evidence-based sources include the following:

- County Health Rankings and Roadmaps, What Works for Health.
- CDC Community Guide.
- CDC A Practitioner's Guide for Advancing Health Equity.
- Institute of Medicine (IOM) Accelerating Progress in Obesity Prevention.
- NACCHO Mobilizing for Action through Planning and Partnerships (MAPP) Resource Guide for Disability Inclusion.

Please reference the glossary for more information on each strategy.

Appendix L

Glossary of Terms

Active Transportation	Refers to any form of transportation that involves increased physical activity levels –notably walking, biking, or taking transit.
Active Commute Support	Active Commute Support creates PSE changes that encourage people to replace car trips with alternative modes that increase physical activity. Employers can incentivize walking, biking, or taking transit to increase their employees' physical activity. Examples of commute support include: changing rooms or lockers with showers, bicycle parking, bicycle racks/shelters in safe, convenient, and accessible locations.
Bike and Pedestrian Infrastructure	Ensures that a network of infrastructure is in place to make bicycling or walking viable modes of travel. It also means ensuring that the infrastructure is safe and comfortable to use. This approach can promote health by providing added opportunity for physical activity from transportation. This strategy is related to, and supportive of, Safe Routes to School, Complete Streets, and bicycling and walking programs. Elements of bicycle and pedestrian infrastructure may include: bicycle lanes; bicycle parking and storage facilities; curb extensions; intersection treatments for bicycles – bicycle boxes, stop bars, lead signal indicators; landscaping; paved shoulders; pedestrian and bicyclist-scale lighting; pedestrian overpass or underpass; separation/buffers; shared-lane markings ("sharrows"); sidewalks; signage, especially high-visibility signage; signalized pedestrian crossings and mid-block crossings; trails or shared-use paths. https://www.transportation.gov/mission/health/Expand-and-Improve-Bicycle-and-Pedestrian-Infrastructure
Active Transportation Plan	Active transportation plans (ATPs) are documents that provide a roadmap for improved walking and bicycling conditions. The planning process includes steps for gathering input and building community support, and lays the groundwork for funding and implementing a wide variety of projects, programs, and policies. Active transportation planning can take place at the regional, county, city, village, or neighborhood level. Plans may also address access to transit through active travel modes.
Built Environment	Human-made (versus natural) resources and infrastructure designed to support human activity, such as buildings, roads, parks, restaurants, grocery stores and other amenities.
Coalition	A formal alliance of organizations or an organized group of people in a community that come together to work for a common goal. Coalitions 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 issues, or other similar common bonds.
Community Engagement	The process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices

Community Supported Agriculture (CSA)	A system that connects the producer and consumers within the food system more closely by allowing the consumer to subscribe to the harvest of a certain farm or group of farms. Consumers pay in advance for a weekly/bi-weekly share of the harvest through the growing season. CSA subscriptions can be set up to accept SNAP as a form of payment.
Complete Streets	Complete Streets are streets designed and built for all travelers. When streets are designed for all modes, they are safer, more comfortable, and more convenient for people of all ages and abilities to walk, bicycle, take public transit, or drive a motor vehicle. A Complete Streets policy establishes the foundation for ensuring that all streets in a community serve all users, either through new construction or redesign of existing streets.
Dietary Guidelines for Americans	The Dietary Guidelines for Americans, 2020-2025 provides advice on what to eat and drink to meet nutrient needs, promote health, and help prevent chronic disease. This edition of the Dietary Guidelines is the first to provide guidance for healthy dietary patterns by life stage, from birth through older adulthood, including women who are pregnant or lactating.
Disability	A disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html
Farm to Institution	One approach to align food service operations with health and sustainability guidelines. Programs and policies that support sourcing local and regional foods for schools, hospitals, faith-based organizations, worksites, and other public service venues that can benefit institutional customers and their families, farmers, the local community, and the economy.
Farmers' Market	A farmers' market is a public and recurring assembly of farmers or their representatives selling the food that they produced directly to consumers. Markets can be set up to accept SNAP, WIC Farmers' Market Nutrition Program Vouchers, and Senior Vouchers as forms of payment, as well as, offer nutrition incentives (Produce Perks) where SNAP shoppers can receive a $1 – for – $1, up to $20 per day match to spend on fruits and vegetables. https://produceperks.org/
Food Access Policy and Planning	Transforms the local food systems by working on the following: identifying and filling gaps in local food system infrastructure, campaigning for public-policy change, and strategizing to cultivate a policy landscape that cultivates sustainable, equitable local food systems. (i.e., Columbus & Franklin County Local Food Action Plan.)
Food Bank/Pantry	A food pantry is an individual site that distributes food directly to those in need who reside in a specified area. A food pantry is a member agency of, and obtains food from, a food bank. CHC promotes the Client Choice Pantry model, which allows clients to select their food from the pantry's food stock instead of receiving a pre-packed or standard bag of groceries.
Food Service Guidelines	Improving food and beverage offerings in the following venues: food banks/food pantries, vending machines, catered meetings, cafés, cafeterias, snack carts, and micro markets in community and worksite settings including libraries, parks and recreation facilities, higher education campuses, hospitals, and city and county buildings through adoption of food and beverage guidelines policies. Ohio Food and Beverage Guidelines are based on American Heart Association Standards.

Health Disparities	A difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have progressively experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, disability status, or geographic location. Other characteristics include cognitive, sensory, or physical disability.
Health 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.
Healthy Food Retail	A retail store that sells nutritious food such as fruits and vegetables (fresh, canned, and frozen), whole grains, lean meats, and low-fat dairy. Healthy Food Retail interventions can include assisting a corner or convenience store to sell a variety of healthy food items, establishing a healthy checkout lane in a full-service grocery store, or supporting the opening of a new full service grocery store in a food desert area.
High-Risk Populations	Groups of individuals that experience disparities in the social determinants of health, quality of life, and/or health outcomes. Disparities are related to race, ethnicity, economic status, age, sex, sexual orientation, disability, and geographic location.
Land Use Policy	Land Use policies are used by communities to protect the health and safety of residents while safeguarding the community's economic, social, and environmental well-being. Communities with balanced, self-contained neighborhoods which have a sufficient mix of land uses (such as residential, commercial, industrial, and green space) and incomes to support the housing, employment, shopping, and recreational needs of the community provide increased opportunities for physical activity.
Ordinance	A formally adopted law, rule, or regulation that is enacted by the governing body of a city or county.
Physical Activity Guidelines for Americans	Science-based guidance to help Americans ages six and older improve their health through appropriate physical activity. The 2018 Physical Activity Guidelines for Americans is the current document.
Policy, System and Environmental (PSE) Changes	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.
Population-Based Health	A health promotion approach that aims to address social and structural factors that affect behaviors. Population-based approaches focus on communities, neighborhoods, cities, states, and even entire nations instead of concentrating solely on individual responsibility and behavior. This approach seeks to alter our environment through policy, regulation, changes in practices, or forging new social norms to create a culture of wellness and an environment that supports healthy choices.
Population-Based Interventions	Planned and systematic activities that create change in social systems and environmental conditions at the community level that will influence and support individual behavior change.
Produce Prescriptions	Produce Prescription Programs leverage clinical care systems to improve the health of patients suffering from chronic diet-related disease by increasing access to healthy foods and providing healthy eating and nutrition

	counseling. The program allows practitioners to "prescribe" fruits and vegetables for select patients, redeemable at participating farmers' markets and grocery retail.
Public Transit Improvements	Enhancements to existing transportation systems or development of new systems that can support a healthy lifestyle. Examples may include providing trips to grocery stores in rural areas for people with limited mobility, allowing bicycles to be placed on the front of buses, adding bus stops in areas where fresh food is sold, bike share programs, etc.
Safe Routes to Healthy Foods	Safely connecting people to places to buy and obtain healthy food. https://www.saferoutespartnership.org/healthy-communities/101/safe-routes-healthy-food
Safe Routes to School	Safe Routes to School programs aim to make it safer for students to walk and bike to school and encourage more walking and biking where safety is not a barrier. http://www.saferoutesinfo.org/
Shared Use	Also known as joint-use agreement. A formal agreement between two separate entities, often a school district and a city or county, setting forth the terms and conditions for the shared use of public property. Typically, each party under a Shared Use agreement helps fund the development, operation, and maintenance of the facilities that will be shared. In so doing, no single party is fully liable for the costs and responsibilities.
SMART Objectives	**Specific**–Identifies a specific event or action that will take place or change that will occur. Who is expected to change or benefit?; **Measurable**–Quantifies the number of events or the amount of change to be achieved. What or how much is expected? Measurable objectives use action verbs such as, "establish," "enact," train," "adopt," "commit," "institute," or "organize."; **Achievable**–Realistic given available resources and plans for implementation yet challenging enough to accelerate program efforts. Uses baseline measures to assist in estimating potential success; **Relevant**–Logical and relates to the program's goals. It is sufficiently meaningful and important. Considers the financial and human resources and the cost benefit of the intervention.; **Time**–Specifies a time by which the objective will be achieved. When will the event or change occur?
Social Determinants of Health (SDOH)	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into five domains: economic stability; education access and quality; healthcare access and quality; neighborhood and built environment; social and community context.
Sustainability	Ensuring that an effort or change lasts. Sustainability is often misunderstood as securing further or ongoing funding for a program that otherwise would end. Note that sustainability can be achieved without ongoing funding by changing policies, norms, attitudes, etc. For example, a health day that discourages smoking at a park will likely not effect permanent change, whereas a tobacco-free park policy will create a sustainable change without future investments/resources.

Appendix M

Attachments

2024 CREATING HEALTHY COMMUNITIES WORK PLAN

Agency: _____ Grant #: _____ County Served: _____

Priority Community: _____

Strategy #1:					
Healthy People 2030 Objective(s):					
Target Outcome:					
Potential Reach: Quarter 1: Step 1: Identify Measurement Category Choose an item. Quarter 1: Step 2: Plan how you will measure (include GEOID if applicable): Quarter 3: Step 3: Record Potential Reach: _____ (copy to data summary in CHC Hub)					
Q3 only, brief summary of annual progress, including if target outcome has been met:					
Process Objectives	Related Activities	Agency or Person Responsible	Specific Dates for Each Activity		Evaluation Measures
			Start	End	
1.					

Appendix N

References

Centers for Disease Control and Prevention – Division of Community Health. A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Atlanta, GA: US Department of Health and Human Services; 2013.

County Healthy Rankings and Roadmaps- What Works for Health *https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health*

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