

4 Ontario Heart Health Program: Taking Action for Healthy Living (OHHP: TAFHL)

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Heart Health Resource Centre
Centre de ressources - Coeur en santé

ONTARIO PUBLIC HEALTH ASSOCIATION
L'ASSOCIATION POUR LA SANTÉ PUBLIQUE DE L'ONTARIO

History of Heart Health in Ontario

There is a 14-year history of community and provincial commitment to heart health promotion in Ontario. This section provides an overview of the

- Heart Health Action Program – 1990 to 1996,
- Canadian Heart Health Initiative: Ontario Project – 1994 to 1998,
- Ontario Heart Health Program – 1998 to 2003 and
- Ontario Heart Health Program: Taking Action for Healthy Living – 2004 to 2007.

The content of this section is from a presentation by Dr. Barb Riley (Ontario Heart Health Network Conference, November 17th and 18th, 2003, Ottawa).¹

Heart Health Action Program (HHAP) – 1990 to 1996

HHAP was the demonstration phase in Ontario. It provided information about heart health in Ontario, especially with respect to community partnerships, local programming and provincial supports for community projects.

HHAP built on the learnings from pioneering projects in the United States and Europe (Stanford, Minnesota, North Karelia projects). The first to take a community-based approach to cardiovascular disease (CVD) prevention, these pioneering projects demonstrated that

- population-wide changes in CVD risk factors are possible; and
- programs will come and go – the essence of sustainable change is community organization.

Ontario (and the rest of Canada, through the Canadian Heart Health Initiative) acted on these findings by integrating heart health into the existing community health system.

Two things facilitated the initiation of HHAP:

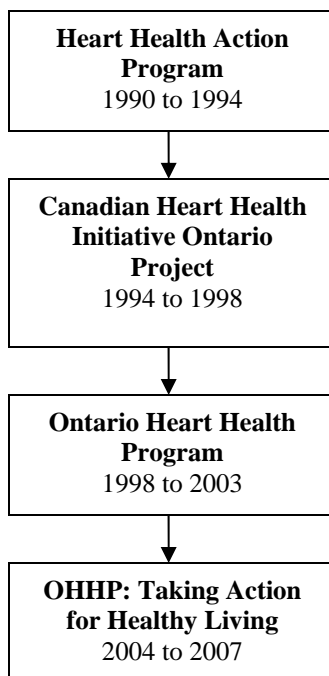
- the formation of a Health Promotion Branch (in 1986) mandated to be a catalyst for community-based health promotion; and
- a new set of guidelines for public health (released in 1989) that introduced healthy lifestyles programs including the three major modifiable risk factors for HHAP (tobacco use, poor diet and physical inactivity).

One main product of the demonstration phase evaluation was a model for promoting heart health in Ontario. Lessons were summarized into:

- elements of community projects (e.g., mandate, human and financial resources and interventions) and
- elements of services to support community projects (e.g., training workshops, consultation and funding).

Canadian Heart Health Initiative: Ontario Project (CHHIOP) – 1994 to 1998

CHHIOP was a research phase for province-wide dissemination of heart health promotion. CHHIOP brought provincial stakeholders together with local stakeholders to jointly design and complete the project. CHHIOP helped determine where to focus



energies for province-wide dissemination of heart health. For example, the research emphasized the importance of focusing on strengthening capacity (i.e., resources and skills) for heart health including public health leadership, community partnerships and provincial resources to support local action. The research also told us that community-based programming was gradually increasing throughout the 1990s, but was at a low level in most communities. This knowledge set the stage for OHHP.

Ontario Heart Health Program (OHHP) – 1998 to 2003

OHHP was the first, and remains the only, provincial heart health program in Canada. Its design incorporates lessons from HHAP, from CHHIOP and from additional analyses of the pioneering programs from the 1980s. The main intent of OHHP was to provide a stimulus to develop a sustainable, province-wide infrastructure for the primary prevention of cardiovascular disease. Evidence from the first three years showed some promising trends in capacity for heart health promotion and in multi-risk-factor programming. It was clear that OHHP was contributing to these trends. The need to do much more for population impact, including a much higher ‘dose’ of programming was also clear. The evaluation identified many supportive elements and areas for improvement, which were lessons to build into the design of OHHP-Phase II (OHHP: Taking Action on Healthy Living).

The elements of OHHP found to be particularly supportive of progress included

- local funding,
- community partnerships (especially with non-traditional partners),
- a Heart Health co-ordinator,
- the availability of resources and programs,
- networking opportunities and
- training and consultation supports.

Riley et. al., (2002²) recommended six areas for improvement to OHHP:

- Revise the provincial goal and objectives to reflect realistic outcomes.
- Develop an identity and strategic focus for the program that reflects co-ordinated and integrated planning and allows for flexibility with local and provincial ‘branding’.
- Revise local reporting to ensure it meets the needs of local and provincial decision makers, meets the needs of reporting for public health chronic disease prevention programs and includes mechanisms for timely feedback.
- Develop mechanisms to safeguard the Heart Health co-ordinator position.
- Support local efforts to negotiate agency roles including harmonizing OHHP activities with health unit programs.
- Develop a funding model that increases lead time for funding approvals.

Recommendations for the next phase of OHHP were also provided by the Ontario Heart Health Network's Continuation Working Group (2002³).

The recommendations were

1. The formation of a Chronic Disease Prevention Steering Committee to provide an equitable balance between the voices of community coalitions and provincial bodies.
2. The central technical support (e.g., training and consultation) provided by OHPRS be maintained as an essential service to communities.
3. That OHPRS co-ordinate central program development (including the possibility of media campaigns) and disseminate prevention programs.
4. The use of a provincial brand for all centrally developed programs.
5. The development and use of a central activity reporting form that can be completed on-line to provide information about program activities to local communities and the Ministry of Health and Long-Term Care. This form would replace the current system.
6. MOHLTC development of a chronic disease health promotion strategy for Ontario to encompass the prevention components for CVD, stroke, diabetes and cancer, while integrating physical activity, tobacco and nutrition strategies.
7. The continuation of community coalitions as the base from which to plan and implement primary prevention of chronic disease initiatives.
8. Health departments provide stewardship to community coalitions working in chronic disease prevention and health promotion.
9. The development of a problem-solving process to clarify the human resources requirements after 2003. This would include information about the co-ordinator role, administration / secretarial needs for the coalition and the support needs of local NGOs and other partners.
10. The continuing development of regional networks to provide peer mentoring to community coalitions.
11. Continuing the joint planning process developed in OHHP using a two-year planning cycle.
12. Designing a constructive evaluation process for local disease prevention programs.
13. Clarification of the roles and responsibilities of the major partners working at the local level.
14. Long-term, stable funding from MOHLTC to community coalitions engaged in health promotion. Stable funding enables a continuous and seamless transition to chronic disease prevention.
15. Continuation of the current level of in-kind contribution requirements.
16. That MOHLTC explore alternative funding models for the local co-ordinator as determined through a consultation process.
17. The availability of small funding grants to local communities engaged in innovative health promotion or disease prevention initiatives that target a specific disease (e.g., stroke) and may have the potential for provincial distribution.

OHHP: Taking Action for Healthy Living – 2004 to 2007

Commitment to this phase reflects the long-term, systemic process necessary for a substantial impact on population behaviours and health-promoting environments. A key opportunity during this phase includes strengthening the alignment with directions in chronic disease prevention; for example, taking a healthy living approach that addresses several chronic diseases. Additional opportunities use programs most likely to have an impact (i.e., those that are designated as ‘better’, ‘best’ or ‘recommended’ practices) and to strike a useful balance between provincial direction and consistency (e.g., common messages and provincial programs) and local priorities and flexibility.

More guidance for future directions – Phase II and beyond – will be the focus of the final evaluation report for OHHP, Phase I (available from MOHLTC by the end of 2004).

References

- ¹Riley, B. (2003). *A 30-minute Tour of Heart Health Promotion in Ontario: Context for OHHP-Phase II*. Ontario Heart Health Network Conference, November 17th and 18th 2003, Ottawa.
- ²Riley, B., d’Avernas, J. & Edwards, N. (2002). *The OHHP: Evidence-based Recommendations for Continuation and Modification*. Available at www.hhrc.net/ref_2.pdf.
- ³Continuation Working Group (2002). *Continuation Plan for 2003 and Beyond*. Ontario Heart Health Network. Available at www.hhrc.net/about/cwgreport.pdf.

Rationale for the Ontario Heart Health Program: Taking Action for Healthy Living

The goal of the Ontario Heart Health Program: Taking Action for Healthy Living (OHHP: TAFHL) is to prevent cardiovascular disease (CVD) and other chronic diseases such as Type-2 diabetes, stroke and some forms of cancer.

OHHP: TAFHL achieves this goal through collaborative partnerships between Ministry of Health and Long-Term Care representatives, provincial organizations, Boards of Health/host agencies, other local community organizations and volunteers, by implementing programs with a primary emphasis on physical activity, healthy eating and smoke-free living at the community level.

As discussed in the previous section (Section 3: Chronic Disease Prevention), the link between OHHP risk factors and the prevention of many chronic diseases is recognized by the national Advisory Committee on Population Health (ACPH).

“There is a sound rationale for an integrated approach with an emphasis on addressing underlying causal factors. In our efforts to address chronic disease, we need to continue effective disease-specific activities. However, there are key conditions which support work to advance integrated chronic disease prevention at this time, namely: a strong foundation of experience; a growing evidence base; and emerging opportunities within jurisdictions and NGOs.” (ACPH, 2002¹)

OHHP – TAFHL builds on the four main elements of the integrated approach proposed by the Advisory

Committee on Population Health (ACPH):

1. Address the common set of risk factors.
2. Recognize and address the relationship between lifestyle choices and social conditions.
3. Consolidate prevention efforts within life settings.
4. Engage partners within and across the systems that impact health.

“The potential benefits of integrated approaches include a reduction of the burden of disease and a contribution to the sustainability of health systems through increased efficiency and effectiveness of prevention efforts.” (ACPH, 2002¹)

Two aspects of OHHP: TAFHL require special mention:

- the partnership aspect; and
- addressing the relationship between health behaviours and conditions of living, notably isolation, low income situations and other social conditions.

The Partnership

OHHP: TAFHL is a vehicle for collaborative, primary prevention efforts in Ontario communities. It provides resources for increasing the number and depth of joint and shared activities among community partners. OHHP: TAFHL is also a vehicle for innovation. Building on OHHP, Phase I, and other heart health programs around the globe, OHHP: TAFHL is intended to help us learn about health promotion in the dynamic and diverse Ontario environment. Some opportunities for innovation in this next phase include

- working with non-traditional

- partners;
- addressing a multiple set of chronic disease outcomes by addressing a trio of common risk factors;
- evaluating innovative approaches to population health issues;
- public health “stewardship” as opposed to leadership or ownership;
- balancing provincial direction and consistency with local priorities and flexibility; and
- local-provincial partnerships and working committees.

Relationship between health behaviours and conditions of living

OHHP: TAFHL is based on several key Guiding Principles (outlined in detail in the Submission Package, Phase II, included as an attachment in this section). One of the Guiding Principles meriting a deeper explanation is grounded in “inclusivity and accessibility”. Different approaches are needed to promote inclusion and accessibility across broad populations including mixes of policies and programs that address health disparity. These approaches include precise targeting to the most vulnerable population as well as sensitivity to the interdependence between individual behaviour, socio-economic status and community/institutional resources.

Within the context of OHHP, community partnerships (CPs) are encouraged to direct their risk-factor-based programming to those segments of their population that have been determined to be priorities, which may include those with less access to the basic determinants of health.

This strategy is illustrated in the following quote:

“Some programs, by their very success, widen the health status gap due to differences in the population. In one smoking cessation program it was found that the prevalence of smoking decreased mainly in adults with high education, increasing social differences. The increasing socio-economic status difference in cardiovascular mortality during the 1980’s was accompanied by a growing social difference in the prevalence of smoking.” (Lyons & Langille, 2000²)

Listed below are those determinants of health suggested by Health Canada as basic to population health:

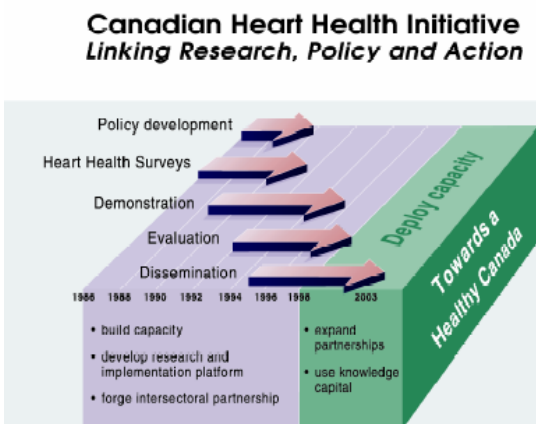
- income and social status;
- social supports networks;
- education;
- employment and working conditions;
- physical and social environments;
- biology and genetic endowment;
- personal health practices and coping skills;
- healthy child development; and
- health services.

History also plays an important role in understanding the rationale for the second phase of OHHP. In 1986, Health Canada, in partnership with the provinces and the Heart and Stroke Foundation (HSFO), began the Canadian Heart Health Initiative (CHHI), a federal/provincial strategy, to tackle the major cause of death, health care costs and disability in Canada.

The long-term health goals of CHHI, patterned after a handful of large-scale intervention programs in the United States and Europe, were to

- improve the heart health of Canadians,
- reduce premature cardiovascular morbidity and mortality,
- reduce the prevalence of preventable or controllable risk factors for CVD (smoking, high blood pressure, elevated blood cholesterol, diabetes, obesity and sedentary lifestyle),
- improve lifestyle behaviours associated with heart health and
- improve working conditions and social and physical environments supportive of citizens in making heart-healthy behavioural choices. (Health Canada³)

Short-term health goals were to increase public knowledge and awareness of the causes and consequences of CVD as well as to increase the knowledge and awareness of individuals at risk of CVD. In addition to long term-health outcomes and behaviours (5 to 20 years), the provincial heart health programs aimed to influence the way communities support changes and influence governments and other organizations in developing healthy public policy. Thus, in addition to health goals, the programs set health systems goals as the basis for accountability in the short term. The five phases of CHHI are outlined in the diagram to the left.



As part of CHHI, Health Canada, through the National Health Research and Development Program, provided matching funds to all provinces to implement community-based

cardiovascular disease (CVD) prevention programs. This is the “Demonstration Phase” in the CHHI diagram. The purpose of the demonstration programs was to demonstrate the efficacy of evidence-based public health approaches in preventing and reducing CVD in the Canadian population and build capacity in the public health system for planning and implementing effective provincial and community heart health interventions (Health Canada³).

Although Ontario's demonstration phase was funded provincially, it was implemented at the same time as, and contributed to, the CHHI Demonstration Phase. Five Ontario communities were selected, based on the submission of community proposals. Each undertook programming, tailored to their community, that met the provincial program goals of being able to

- enable communities to build their capacities for heart health promotion,
- build an understanding of models of community organization and
- document key interventions and findings to disseminate to other communities in Ontario.

Main lessons learned from the HHAP phase that influenced the direction of OHHP: TAFHL include the following:

- The coalition approach taken represented a new way of working for public health and other community agencies. Therefore, community organization and building capacity for planning and implementing comprehensive,

community-based programs was a major focus.

- Programs developed elsewhere must be adapted to fit the local context. Even those designated as “recommended practice” cannot simply be transferred from one jurisdiction to another.

The model developed as a result of HHAP served as a sound basis for heart health promotion in Ontario. The model included several components: elements of community projects (e.g., mandate, structures, culture, research and evaluation and intervention design) and elements of services to support community projects (e.g. training, consultation, funding, information and educational resources). This preliminary model provided a starting point for dissemination of heart health promotion province-wide (OHHP, Phase I).

Lastly, in terms of the history that has influenced OHHP, is the Canadian Heart Health Initiative: Ontario Project (CHHIOP). CHHIOP was undertaken to better understand the capacity of the public health system and community agencies to undertake heart health promotion and the factors influencing local heart health promotion efforts. This research phase reinforced the need to strengthen capacity for local (heart) health promotion and to make effective programs available for local adaptation and use. More details on CHHIOP and its results can be found at www.hhrc.net/supports/ref_1.pdf.

References

¹ Advisory Committee on Population Health (2002). *Advancing Integrated Prevention Strategies in Canada: An Approach to Reducing the Burden of Chronic Diseases*.

²Lyons, R., & Langille, L. (2000). *Healthy Lifestyle: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health*. Health Canada, Population and Public Health Branch, p. 35.

³Health Canada. www.health.gc.ca/pphb-dgspsp/ccdpc-cpcmc/cindi/pdf/chhi-eval_e.pdf

⁴*Heart Health Action Program Final Evaluation Report*, December 1995.

All information for the Rationale section is from Heart Health Resource Centre (2003). *OHHP: TAFHL, Reference Material for OHHP, Phase II, Submission, December 2003*.

Summary of the Ontario Heart Health Program: Taking Action for Healthy Living

In 2003, the Health Promotion and Wellness (HP&W), Public Health Branch (PHB), MOHLTC announced funding for the Ontario Heart Health Program: Taking Action for Healthy Living (OHHP: TAFHL) from April 2004 to December 2007.

This phase builds on the successes and challenges from the previous phase captured by

- the Continuation Working Group Report,
- the Preliminary Findings of the OHHP evaluation and
- the efforts of three Continuation Working Group task groups:
 - Human Resources,
 - Reporting and Evaluation and
 - Governance.

OHHP: TAFHL Goal

The goal of OHHP: TAFHL is to prevent CVD and other chronic diseases such as Type-2 diabetes, stroke and some forms of cancer.

The OHHP: TAFHL goal responds to the substantial burden of CVD and other chronic diseases on Ontario residents and communities. The goal makes explicit the intent to impact, over the long term, on several chronic diseases. In order to do this, OHHP: TAFHL supports communities in addressing a common set of modifiable risk factors for major chronic diseases.

OHHP: TAFHL achieves this goal through collaborative partnerships between HP&W, PHB, MOHLTC, provincial organizations, Boards of Health and other local community organizations and volunteers by implementing programs with a primary emphasis on physical activity,

healthy eating and smoke-free living at the community level. HP&W, PHB, MOHLTC funds OHHP: TAFHL to support communities to take an integrated approach to implementing programs proven effective in addressing the modifiable risk factors for CVD and other chronic diseases. An integrated approach to chronic disease prevention (CDP) in its entirety is almost limitless. Focus is needed to make best use of community resources in a manageable way. To assist with this focus, the Chronic Disease Prevention Alliance of Canada (CDPAC) is focusing on three diseases (heart disease and stroke, cancer and type-2 diabetes) and three risk factors (physical inactivity, unhealthy eating and exposure to tobacco smoke) common to these. OHHP: TAFHL is consistent with this approach, while recognizing that it does not address all possible factors influencing all chronic diseases.

This section includes the Funding Application Package and all support materials distributed to support local communities in the development of their submission.

Section 8 (Ontario Heart Health Program (OHHP) Co-ordinator Tips and Tools) contains more specific suggestions to support the implementation of the OHHP: TAFHL.

Attachments

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Téléphone: (416) 314-5493
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October 17, 2003

Memorandum To: Medical Officers of Health

From: Myrna Gough
Manager, Provincial and Community Programs

Subject: OHHP, Phase II Submission Package

I am pleased to provide you with the Submission Package for the next phase of the Ontario Heart Health Program (OHHP, Phase II). This package includes a section on submission requirements, some background information, as well as revisions to the original 'Heart Health Application Guidelines'.

We have valued your partnership in the program over the last five years. In particular, we would like to acknowledge the contributions of Board of Health staff in the development of the revised guidelines. This involvement has helped to ensure that the program will address local needs.

OHHP, Phase II began April 1, 2003. This first year has been considered a transition year for the program, enabling a Planning Committee to work towards implementing Phase II, which will officially commence on April 1, 2004, ending December 31, 2007.

One of the major highlights of OHHP, Phase II concerns the overall goal of the program, which has been broadened to more accurately reflect the expanded role that Community Partnerships are now playing at the community level in addressing other chronic diseases, such as cancer, stroke and diabetes. However, other essential elements of the Phase I program have not changed. These include the funding allocation to each community, the requirement that communities match funding 2:1, and the requirement for a full-time Program Coordinator.

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- 2 -

With this Submission Package, we invite you to submit your plans for the next four years of the program. The deadline for submission is 4:00 pm on January 15, 2004. We encourage all OHHP Coordinators to seek support from the Heart Health Resource Centre in the development of their plans. If you have a problem receiving this document and/or its attachments, please contact Carol Gold, Program Coordinator, at (416) 314-5503.

Thank you for your ongoing commitment to the Ontario Heart Health Program. We value the contributions that you have all made individually and collectively to make the program a success, and we look forward to your participation during the next four years.

Original signed by

**ONTARIO HEART HEALTH PROGRAM:
Taking Action for Healthy Living**

SUBMISSION PACKAGE

PHASE II (April 2004 – December 2007)

OCTOBER, 2003

Health Promotion & Wellness, Public Health Branch,
Ontario Ministry of Health and Long-term Care



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APPENDICES

- I. Checklist to Support Development of Submissions
- II. Summary of Best Practice Scans

ATTACHMENTS

- A. Four-year Logic Model Template
- B. Sample Four-year Logic Model
- C. OHHP Budget Form
- D. Submission Form

OHHP: Taking Action for Healthy Living

Submission Package

1.0 Purpose of the Submission Package

Boards of Health, in collaboration with their OHHP Community Partnership, will prepare Submissions concerning funding for implementing the second phase of the Ontario Heart Health Program called the *Ontario Heart Health Program: Taking Action for Healthy Living*. The Submission Package is intended to assist Boards of Health in preparing written Submissions.

2.0 Submission Requirements

2.1 Timing

The Submission is to be received by MOHLTC no later than 4:00 pm on January 15, 2004.

2.2 Inclusions

The complete submission will include a Submission Form signed by the Medical Officer of Health or equivalent, along with the following supportive documentation:

- a) A list of the Community Partners.
- b) A letter from the Chair (or designate) of the Community Partnership supporting the submission and confirming the Partnership's commitment to provide in-kind support to the Program.
- c) Terms of Reference for the Community Partnership. These should also address policies for management of materials, revenue generation, and volunteer management and liability. A description of the current organizational structure is also required.
- d) Confirmation of the one full-time equivalent (1.0 FTE) OHHP Coordinator position, a description of the responsibilities, and if possible, the name of the person assigned to the position.
- e) Plans:
 1. A Four-year Strategic Plan for April 2004 - December 2007 to include:
 - A Logic Model Summary (using the template provided in Attachment A).
 - A Narrative to include:
 - I. A description of the local process used to develop the Strategic Plan.
 - II. An outline of the rationale for the decisions made regarding the strategic direction (as outlined in the Logic Model), including any

additions or changes to the *OHHP: Taking Action for Healthy Living* objectives.

- III. A description of how the next phase being proposed builds on the activities, accomplishments and challenges of the OHHP, Phase I.
 - IV. The provision of any other information that would be useful to those reviewing the plan.
2. A 21-month Operational Plan for April 1, 2004 – December 31, 2005. This plan will include a description of the following: proposed programs, (organized by strategies included in the Logic Model) related activities for each program, monitoring and evaluation activities, channels, target groups, approach, community partners and lead agency, outputs and outcome. A revised version of the program record template will be made available at a later date.
- f) A 21-month budget (April 1, 2004 – December 31, 2005), using the OHHP Budget form (Appendix C).
 - g) Identification of the training and support needs of the Community Partnership for the 21-month period, including timing, format and indication of which provider the Community Partnership would prefer to access for the services.

In addition to the above, Appendix I contains a checklist that is intended to help Community Partnerships in the process of developing submissions.

2.3 Copies

Submit three unbound copies of the Submission and one electronic copy (via email).

2.4 Format

Ensure all pages are numbered, using 8.5" x 11" sized paper with 1" margins and 12-pitch font. Use Microsoft Office applications if possible.

2.5 Send to:

OHHP: Taking Action for Healthy Living Submissions
Health Promotion & Wellness, Public Health Branch, MOHLTC
5700 Yonge Street, 4th Floor
Toronto, ON M2M 4K5.

2.6 Contact Information

Please submit in writing to your MOHLTC Program Coordinator any questions regarding completion of your Submission to:

Carol Gold

T: 416-314-5503

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Huguette Jacobson

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3.0 Goal and Strategic Direction for *OHHP: Taking Action for Healthy Living*

The goal of the *OHHP: Taking Action for Healthy Living* is to prevent cardiovascular disease (CVD) and other chronic diseases, such as Type-II diabetes, stroke and some forms of cancer. This goal responds to the substantial burden of CVD and other chronic diseases on Ontario residents and communities, and makes explicit the intent to make an impact, over the long-term, on the elimination of several chronic diseases. To this end, the *OHHP: Taking Action for Healthy Living* supports communities, in collaboration with a wide range of partners, in implementing programs at the community level that have a primary emphasis on physical inactivity, unhealthy eating and use of and exposure to tobacco. Submissions should reflect this same goal.

Outlined below are the elements that comprise the long-term strategic direction of the OHHP. A Logic Model template is attached to assist Community Partnerships in developing their four-year strategic direction. Additional information on the required plans can be found in Section 5.0.

3.1 Guiding Principles

The *OHHP: Taking Action for Healthy Living*

- is a partnership between the Ministry of Health and Long-Term Care, the Board of Health and a variety of community partners.
- focuses on the primary prevention of cardiovascular and other chronic diseases.
- addresses the three primary risk factors for major chronic diseases — physical inactivity, unhealthy eating and tobacco use and exposure — with an emphasis on multi-risk factor programming.
- targets priority audiences within local populations, and, therefore, accesses appropriate channels suited to those priority audiences.
- is a community-centered population health program.

- places emphasis on building and strengthening partnerships within and between communities, as well as between local and provincial partners.
- supports joint programming where two or more local community partners are engaged in the delivery of any particular program.
- nurtures community leadership capacity for health promotion.
- builds on local assets and well-grounded provincial strategies and initiatives.
- promotes long-term health by supporting healthy behaviours, healthy social and physical environments and healthy public policies.
- uses a comprehensive planning framework.
- embraces diverse communities by promoting accessible and equitable activities that diminish health disparities.
- uses clear and appropriate language to reach diverse audiences.
- works toward sustainable programs and strategies in the community.
- values the use of evidence-based, “recommended practice” and innovative strategies in order to achieve population health outcomes.

Submissions will reflect these same principles, although additional local values may be added.

3.2 Objectives

The *OHHP: Taking Action for Healthy Living* aims to contribute to changes in populations, environments, health promotion programming and organizational capacity. Desired changes in each of these areas are described in the *OHHP: Taking Action for Healthy Living* objectives. Objectives specify the direction of change but not the amount of change. This is because similar changes are not expected province-wide, since local assets and needs will guide community partnerships in their selection of objectives and their emphasis on different objectives. Community partnerships can set the desired amount of change for their community if information is available to measure change over time.

As shown in the sample strategic plan logic model (Attachment B), population objectives are the long-term objectives. Community partnerships are asked to select at least one population objective for each of the three primary risk factors: tobacco, unhealthy eating and physical inactivity. Community partnerships will set environmental, programming and organizational capacity objectives that will allow them to contribute most effectively to the population objectives they choose to address during the time period of the OHHP.

3.2.1 Population Objectives

Population objectives refer to changes in behaviours and other risk factors that contribute to cardiovascular and other chronic diseases. The *OHHP: Taking Action for*

Healthy Living will contribute to¹ provincial objectives that were established for the chronic disease prevention program within the Mandatory Health Programs and Services Guidelines for Local Boards of Health, as well as to Cancer 2020 (Cancer Care Ontario). For the OHHP, population objectives are directional only. They specify an audience (e.g., teens), the direction of change (e.g., increase or decrease) and changes in health behaviours and other risk factors (e.g., body mass index).

OHHP: Taking Action for Healthy Living will contribute to:

- Decreasing the percentage of teens who are current cigarette smokers.
- Decreasing the percentage of adults who are current cigarette smokers (ages 18 and older).
- Increasing the percentage of daily smokers who will make at least one attempt to quit smoking per year.
- Increasing the percentage of Ontarians who consume five or more servings of vegetables and fruits daily.
- Increasing the percentage of Ontarians who participate in moderate to vigorous activity on most days of the week.
- Decreasing the percentage of Ontarians who are obese, as measured by a body-mass index greater to or over 30.

3.2.2 Environmental Objectives

Environmental objectives refer to changes in social and physical environments that contribute to population objectives. Community partnerships are asked to specify environmental objectives that will contribute to their population objectives. To the extent possible, community partnerships are encouraged to include the time period for change and the amount of change anticipated (if baseline information is available).

For example, if the community partnership identifies the need to increase physical activity as a priority, environmental objectives may include changes, such as:

- Increasing the number of community walking trails to 15 by December 2004.
- Increasing physical activity to 30 minutes in all elementary and secondary schools by June 2006.

If healthy eating is a priority, environmental objectives may include:

- Increasing the percentage of school and workplace cafeterias that offer healthy food choices by December 2006.
- Increasing the percentage of restaurants that provide point-of-purchase information for healthy food choices by December 2007.

¹ *OHHP: Taking Action for Healthy Living* is one of a number of health promotion initiatives that will work towards achieving these objectives over the long-term.

If smoke-free living is a priority, environmental objectives may include²:

- Decreasing the percentage of residents who will be exposed to second-hand smoke in the home and in private vehicles.
- Increasing the percentage of public places (including bars, restaurants and gaming facilities) that will be smoke-free.

3.2.3 Programming Objectives

Programming objectives refer to the implementation of joint programs by community partnerships. An example would be to host three workshops for food-service personnel.

Programming objectives also include estimates of audience participation (i.e. reach). An example would be to certify food-service personnel from 15% of restaurants.

Community partnerships are asked to apply the following guidelines in order to set programming objectives:

- Give emphasis to environmental and policy change programs.
- Choose a mix of programs that will increase the overall impact of each program individually (i.e. create synergy).
- Select programs that build on each other over time (i.e. sequencing). For example, for a particular audience, a community partnership may focus on awareness programs first, followed by skill building opportunities and environmental/policy programs.
- Choose programs that have been identified, or are strong candidates for being identified, as "recommended" practices.³

3.2.4 Organizational Capacity Objectives

Organizational capacity objectives refer to changes in practices or beliefs of the community partnership. *OHHP: Taking Action for Healthy Living* aims to strengthen knowledge and skills of community partnerships in four areas: health promotion assessment and planning, evaluation, sustainability and transferability⁴.

OHHP: Taking Action for Healthy Living also aims to develop leadership and ownership for health promotion among community partnerships. Examples of indicators include:

- OHHP community partnerships include members from health and non-health sectors.

² Similar to the population objectives, the two smoke-free living environmental objectives are common to the Mandatory Health Programs and Services Guidelines and the Cancer 2020 report (see Population Objectives).

³ Recommended refers to those practices identified as "better" "best" "recommended" or "promising" in different reviews and by different players. All programs classified in any of these groups are encouraged for use by Ontario communities.

⁴ These four areas of capacity are consistent with those measured in the 2002 OHPRS Capacity Survey.

- Member organizations of community partnerships participate in joint programs.
- Community partnerships are supported by in-kind contributions from member organizations.

Community partnerships are asked to include organizational capacity objectives in their plans that will assist in meeting programming, environmental and population objectives. Capacity objectives will relate to the knowledge, skills and leadership capacities of communities.

3.3 Other Strategic Direction Elements

As outlined in the Logic Model template (Attachment A), Submissions will identify the populations on which the local programming efforts will be focussed over the four years; they will also delineate the primary strategies to be undertaken, and will include a list of the programs to be started within each strategy during the first 21 months of the OHHP. Community Partnerships may refer to the Sample Logic Model (Attachment B) for guidance on how they may complete the Logic Model Summary.

4.0 Conditions of Funding

4.1 Funding for Local OHHP Projects

Funding available to community partnerships for *OHHP: Taking Action for Healthy Living* will be identical to the amount received for OHHP, Phase I and will be flowed to the Board of Health. The amount of funding to each Community Partnership was determined in 1998 via a needs-based resource allocation method of an equity funding formula. The local Board of Health will receive base funding of \$45,000, plus an equity-adjusted capitation allocation. The equity-adjusted capitation allocation takes into account community needs, which are based on health and service cost indices. The health indices used include the prevalence of physical inactivity and unhealthy eating and exposure to tobacco smoke. The service cost indices include geographic dispersion and home language. Funds requested in the budget should reflect funds received during OHHP, Phase I.

The funding period for *OHHP: Taking Action for Healthy Living* is from April 1, 2004 to December 31, 2007. Boards of Health will sign an Agreement, which will include a certificate of insurance for no less than \$5 million, which covers this period of time. Programming will not continue past December 2007, although reporting requirements and other end-of-phase activities may be undertaken until March 31, 2008.

4.2 Community Partnerships

Community partnerships include agencies, organizations and groups and volunteers, which may include the following representatives:

- Staff or volunteers of local non-government organizations' (NGOs) offices, such as the Heart and Stroke Foundation of Ontario, Ontario Lung Association, Canadian Cancer Society, Ontario Division and Canadian Diabetes Association.
- Local FOCUS⁵ Community Projects.
- Healthy community coalitions.
- Local hospital(s), community health centres (CHCs) and other health-care providers.
- Networks focused on tobacco control, active living, youth crime prevention and school nourishment programs.
- School boards, community colleges, universities and other educational institutions.
- Recreation sector.
- Local Businesses.
- Workplaces.
- Government representatives.

Communities have structured their partnerships to reflect local needs. A current Terms of Reference, including an Organizational Chart depicting how the Community Partnership will be structured over the next four years, should be included in the Submission.

The Community Partnership reflected in the Submission should be broad-based and multidisciplinary. Each Submission should include a letter of support from the Chair or designate of the Community Partnership, confirming the Partnership's commitment to provide in-kind support to the Program.

4.3 Allocation and Use of Funds

Funds awarded by the MOHLTC may only be used for non-staff program costs. Budget items considered to be non-staff program costs, and, therefore, **eligible for support** within the *OHHP: Taking Action for Healthy Living* funds, include:

- Partnership development.
- Direct programming for local programs jointly shared between at least two community partners.
- Transportation and communication.
- Professional development and training.
- Rental/leasing of equipment.
- Contracted services including time-limited professional and administrative services.⁶

⁵ Health Promotion & Wellness, Public Health Branch, MOHLTC, funds 22 FOCUS Community Projects across Ontario. Their mandate is the prevention of alcohol and other drug misuse and abuse. The FOCUS Resource Centre supports their work just as the HHRC supports the OHHP.

The following will **not be considered eligible** for project funding:

- Staff salaries and benefits.
- Rent for office space.
- Capital expenditures (e.g., assets, such as computers, etc.).
- Infrastructure development (e.g., tennis courts, renovation and/or maintenance of facilities, such as gymnasiums, etc.).
- Programs/projects aimed at the direct treatment or rehabilitation of CVD or other chronic diseases.
- Projects with a primary research component.
- Administrative fees, such as those to cover part or all of the work of the Board of Health in managing project funds or staff.
- Replacing funds already allocated to existing community programs.

OHHP: Taking Action for Healthy Living funds must be used to support risk factor based programs.

- Funds are to be used to expand existing recommended practice and/or provincial programs, or to develop new ones where programs don't already exist. Documents that profile relevant recommended practices can be found in Appendix II, and a list of provincial programs from which to choose can be found in Section 4.5.5.
- Expenditures related to program development work should be approved in advance through the MOHLTC Program Coordinator. If common needs for new programs and resources are identified in multiple communities, projects are encouraged to pool resources and work collaboratively on innovative programs.
- Funds may be used to develop program materials (e.g., manuals and displays). The Community Partnership will establish, in their Terms of Reference, how these materials will be managed and sustained both during and after the funding period.

Should a Community Partnership wish to support a “community contribution program” (formerly called a “community grants program”), whereby community organizations put forth proposals and, based on selection criteria, are provided with funds

- a maximum of 10.0 % of the Community Partnership total budget can be used for all such programs within a fiscal year.
- the OHHP, Phase II Guiding Principles, monitoring and reporting requirements will apply to the “community contribution program”. Projects that are funded through it must be included in the Community Partnerships’ plans and reports (see Section 3.1 on Guiding Principles for details).

Only those programs that are jointly shared between at least two community partners will be allocated a portion of the local *OHHP: Taking Action for Healthy Living* funds and will be included in the local plans and reports.

⁶ Professional/administration service fees may not be used to cover ongoing expenses for salaries and benefits of the OHHP Coordinator or other staff allocated to the project. Your MOHLTC Program Coordinator can clarify specific use of funds.

Should a Community Partnership decide to pursue revenue generation from other sources (e.g., grants, sales and donations), the following criteria will apply:

- Community Partnerships must report any income generated beyond OHHP funding on financial reports. Since this revenue is not factored into the total funding formula, the MOHLTC will not make deductions to the amount flowed to the Board of Health.
- Revenue generated from items, such as manuals, T-shirts, etc., will be on a cost-recovery basis.
- Such revenue should be used to support ongoing programming costs and sustainability of the program. It does not need to be managed by the Board of Health.
- The Community Partnership will delineate their policies on revenue generation in their Terms of Reference.

Interest earned from provincial funds must be reported and returned to the Ministry of Finance.

4.4 In-kind Contributions

Items not included in the budget **that are considered eligible** as in-kind contributions to the project could include:

- Salaries and benefits of Board of Health and Community Partners' staff associated with the project (i.e. OHHP Coordinator and other staff allocated to the project).
- Volunteer time.
- Administrative costs for financial services, such as the preparation of financial reports by the Board of Health.
- Direct programming costs.
- Transportation and communication.
- Professional development and training.
- Rental/leasing of equipment.
- Services (including time-limited professional services).
- Support for evaluation services.
- Cash donations.
- Grants.

Items that will **not be considered eligible** as in-kind contributions include:

- Funding for tobacco legislation.
- Rent for office space.
- Heating, electricity, water, telephone service charges, repairs and maintenance.
- Assets (e.g., computers, photocopier, fax machines, furniture and fixtures).

Each Community Partnership will, at a minimum, match twofold the provincial *OHHP: Taking Action for Healthy Living* funding through in-kind contributions:

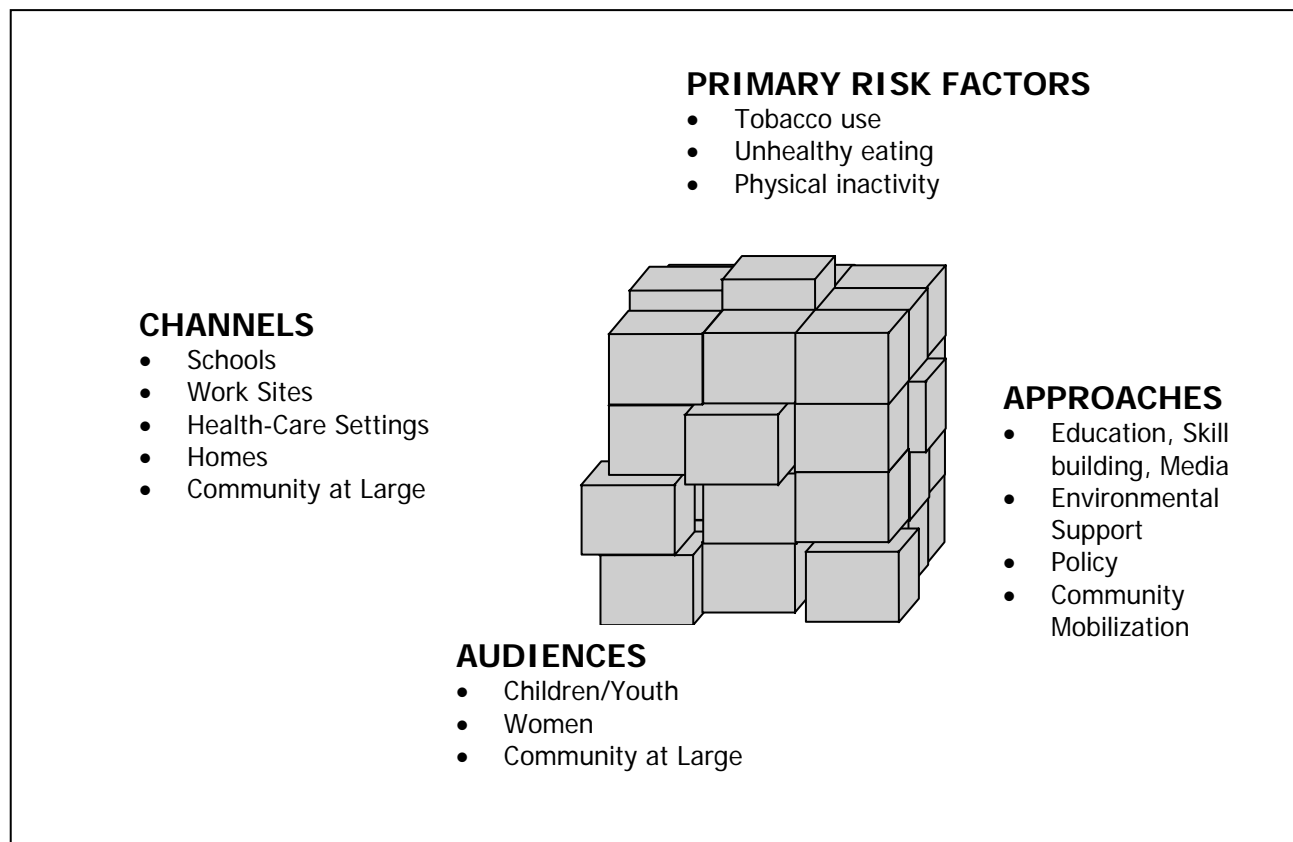
- Community Partnerships will match provincial funds on a 1:1 ratio. This may include staff and volunteer hours, services, supplies, program materials, transportation and communication and donations.
- Boards of Health will, at a minimum, match provincial funds 1:1 by dedicating one full-time equivalent staff person to the OHHP Coordinator position.

Members of the community partnership are encouraged to make commitments to sustain components of the local OHHP. The long-term success and continuation of local *OHHP: Taking Action for Healthy Living* projects depends on provincial and local community partners developing processes for working together to address sustainability.

4.5 Project Design and Delivery

OHHP: Taking Action for Healthy Living programming is grounded in a four-dimensional matrix, known as "The Cube", that has been consistently used during the Demonstration Phase and Phase I of the OHHP. It is depicted below in Figure 1.0. What follows are brief descriptions of the required elements of the local mix of comprehensive programming. These, in combination with the Guiding Principles (in Section 3.1 above), will assist communities in planning their programs. Community plans are not expected to reflect implementation across all components of the cube, but rather, the identification of those that address the relevant prioritized needs and assets of the community with respect to the three primary risk factors. This could relate to specific risk factors, populations, channels or approaches.

Figure 1.0: The *OHHP: Taking Action for Healthy Living* Comprehensive Program Planning Cube



4.5.1 Program Standards

With respect to the first programming objective (in Section 3.2.3 above), consistency of messaging between communities of the *OHHP: Taking Action for Healthy Living* is important. Following are brief descriptions of the required elements of the local mix of comprehensive programming. These, in combination with the Guiding Principles (in Section 3.1 above), will assist communities in planning their programs. The following program standards have been identified to assist with consistency of messaging between communities of the *OHHP: Taking Action for Healthy Living*:

- Nutrition and healthy eating: *Canada's Guidelines for Healthy Eating*.
- Physical activity: *Canada's Physical Activity Guide to Healthy Active Living*.
- Healthy Weights: *Canadian Guidelines for Body Weight Classification in Adults* (Health Canada, 2003)⁷.

⁷ BMI is not a direct measure of body fat, but it is the most widely investigated and most useful indicator, to date, of health risk associated with under and overweight. Canadian Guidelines for Body Weight Classification in Adults, 2003.

- Smoke-free living: to have zero exposure to tobacco smoke, to not smoke, and to live, work and play in smoke-free environments.

These standards will be integrated into local communication and programming activities that are funded in whole or part with *OHHP: Taking Action for Healthy Living* funds.

4.5.2 Cardiovascular Disease/Chronic Disease Prevention

Community partnerships are expected to mobilize around the three primary modifiable risk factors for heart and other chronic diseases: physical inactivity, unhealthy eating and tobacco use and exposure. Healthy lifestyle approaches can be directed toward changing individual behaviour, changing some aspect of the community or changing the relationship between the individual and the community.⁸

4.5.3 Risk Factors

In addition to the modifiable risk factors listed above, Community Partnerships may choose to also promote common messages addressing other risk factors in partnership with other organizations/coalitions working with these risk factors. These risk factors could include stress and unhealthy coping, alcohol and other drugs, high blood pressure and/or oral health.

Examples:

- A project may not provide financial support to an Alcoholics Anonymous (AA) meeting, but may conduct a healthy eating activity with an AA group as part of a broader program within an identified strategy.
- Although unmanaged stress is not one of the primary risk factors for OHHP, it is often a barrier to healthy eating, to being active and to being tobacco-free. Requests for health information and programming about stress can be used, along with other heart health messages, to reach audiences. A recent review found strong and consistent evidence of an independent causal association between depression, social isolation and lack of quality social support and the causes and prognoses of heart health.⁹

4.5.4 Audiences

Community partnerships will target selected audiences depending on local needs and assets. Audiences may include children, youth, adults (men and/or women), seniors, family/parents, general community, aboriginal/ethnic/faith/cultural groups, community

⁸ Lyons R & L. Langille. *Healthy Lifestyle: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health*. Health Canada, Population and Public Health Branch, 2000, p. 29.

⁹ Bunker S.J.; Colquhoun D.M.; Esler M.D. et al. "Stress" and coronary heart disease: psychosocial risk factors. National Heart Foundation of Australia position statement update. *Medical Journal of Australia* 2003, 178 (6): 272-276. http://www.mja.com.au/public/issues/178_06_170303/bun10421_fm.html

volunteers/partners, healthcare professionals, individuals living in poverty, politicians and recreation/fitness professionals. It is doubtful that a community partnership will be able to reach all audiences or even everyone within a specific audience. Therefore, emphasis will be placed on realistic targets for that community, with respect to reach and participation over the four years of the funding; these targets could build on work done in OHHP, Phase I.

In selecting the community focus, community partnerships will direct their risk factor based programming to those segments of their population that have been determined to be priorities, which may include those with less access to the basic determinants of health.

4.5.5 Provincial Resources and Programs

Applicants are strongly encouraged to use provincial resources and programs. Some examples include:

Nutrition:

- Eat Smart! (Nutrition Resource Centre).
- Community Food Advisor Program (Nutrition Resource Centre).
- Food Steps (Nutrition Resource Centre).
- Healthy Eating Manual (Nutrition Resource Centre).
- Seniors Nutrition Toolkit (Nutrition Resource Centre).

Physical Activity:

- Walk This Way! A Guide to Stick to It (Physical Activity Resource Centre).
- SummerActive (Health Canada).
- Active Schools Program (Ontario Physical and Health Education Association).
- Active Ontario Program (Ministry of Tourism and Recreation).

Tobacco Control:

- Smokers Helpline (Canadian Cancer Society, Ontario Division).
- Clinical Tobacco Interventions (Ontario Medical Association).

Program funds will not be used to duplicate existing programs.

4.6 Human Resources Contribution

It has been determined that having adequate human resources is critical to the success of the OHHP. The expectations for participants are listed below. The skills required to perform the specific functions of the OHHP Coordinator position, as well as the Job Description, are to be determined locally.

4.6.1 Board of Health

- The Board of Health is expected to provide, as an in-kind contribution, (including salary and benefits) one person at a 1.0 FTE level as the designated local OHHP Coordinator. Boards of Health are encouraged to support the ongoing processes of the program.
- As a partner, the Board of Health will be involved in the programming decisions of the community partnership, including the allocation of resources. It is expected the Board of Health will provide financial status reports to the community partnership on a periodic basis, as well as regular program and financial statements to the ministry.
- The Board of Health will provide the financial services required for the OHHP, such as maintenance of budget records, production of financial reports and submission of financial policies and procedures, according to generally accepted accounting practices. Financial services will be included in reports of in-kind contributions.

4.6.2 OHHP Coordinator

The OHHP Coordinator will be one full-time position within the Board of Health. The position will be governed by the Board of Health's internal policies and procedures. As OHHP funds awarded by the Ministry may only be used for non-staff program costs, all expenses for salary and benefits for the OHHP Coordinator will be considered as in-kind contributions from the Board of Health. Section 4.4 of the Submission provides further details regarding in-kind contributions.

4.6.3 Community Partners

Community partners will be involved in the planning and implementation of the strategies, programs and activities. This involvement of partners is to be considered contributions-in-kind from the community as part of the required 1:1 matching of provincial funds.

Examples of partners' participation could include:

- Dietitians and recreational professionals.
- Communication specialists in hospitals.
- School-board curriculum staff.
- Voluntary organizations.

Individual volunteers will be subject to the organizational policies and procedures of the organization that they represent. Volunteer management and liability will be addressed by each Community Partnership within their Terms of Reference.

5.0 Planning and Reporting Requirements

There are two types of plans required within *OHHP: Taking Action for Healthy Living*:

- One Four-year Strategic plan.
- Two Two-year Operational plans.

5.1 Four-year Strategic Plan

This plan is required only once, at the beginning of the four-year phase commencing April 2004.

The following components should be included in the four-year strategic plan:

- Vision statement.
- Mission statement.
- The *OHHP: Taking Action for Healthy Living* Guiding Principles, as well as any additional statements developed locally to complement the overall ones.
- Intended population(s) or audience(s) towards whom the project efforts are directed.
- Basic strategies, sometimes called areas of emphasis, priorities for action or program components.
- General list of programs and activities to illustrate each strategy.
- Evaluation strategy, as well as links to the programs to be evaluated and the activities to be undertaken as aspects of the methodology.

Based on the *OHHP: Taking Action for Healthy Living* objectives listed within Section 3.2, a Logic Model¹⁰ format reflecting the strategic direction of local community partnerships will be required by January 15, 2004 as part of the Submission. A Sample Logic Model (Attachment B) is provided for reference and to help guide the planning process, as well as a blank Logic Model template (Attachment A).

An accompanying short narrative of no more than five pages should

- describe the local process used to develop the Strategic Plan.
- provide the rationale for the decisions made regarding the strategic direction, including any additions or changes to the *OHHP: Taking Action for Healthy Living* objectives.
- describe how the next phase being proposed builds on the activities, accomplishments and challenges of OHHP, Phase I.
- provide any other information that would be useful to those reviewing the plan.

5.2 Two-year Operational Plan

¹⁰ The Health Communication Unit has workbooks and other support services available on this topic. www.thcu.ca

Two operational plans will be required for the *OHHP: Taking Action for Healthy Living*.

- The first plan will address the period of April 1, 2004 to December 31, 2005. This 21-month plan is required to move the project from the current fiscal year cycle ending March 31, 2004 into the calendar year planning cycle, making it consistent with Board of Health funding cycles.
- A second plan will be required to cover the period of January 1, 2006 – December 31, 2007.
- Plans will be revisited annually, and any deletions or changes will be proposed to the MOHLTC.

The Operational Plan format will be:

- made available to OHHP Coordinators in the Fall of 2003.
- made up of similar categories to the OHHP, Phase I plan, but laid out in a more easily completed format.
- more compatible with the existing Program Record format.

Within each Operational Plan,

- programs should be grouped and presented by Strategy, as identified in the Strategic Plan.
- programs selected should be congruent with the *OHHP: Taking Action for Healthy Living* Guiding Principles (see Section 3.1) and OHHP Design and Delivery elements in Section 4.5.
- only those programs which have OHHP Program funds attached to them (and, therefore, involve two or more community partners) should be included in the plans and reports.
- local planning must be conducted with sustainability and long-term direction of strategies and programs in mind as part of effective public health practice and community involvement work. Community partnerships are encouraged to consult the HHRC Sustainability Manual, especially the sustainability factors, for ideas on how to incorporate this concept into their planning.
- formative, process and outcome evaluation aspects of a particular program will be included, as they were in OHHP, Phase I. This would include such things as pre-testing of new materials, assessing participant satisfaction and debriefing with organizers, as well as tracking and monitoring the immediate outputs.
- some local evaluation may be planned (e.g., a community needs assessment) that is not program-specific. This is the kind of information that should be included in Evaluation Strategy section of the Operational Plan. More details on the Evaluation Strategy may be found in Section 5.4.

5.3 Reporting Requirements

- a) **Program Records**
 - Recorded in different formats to accommodate those with differing technological capacities.
 - Submitted annually with each subsequent report updating the previous record for all repeated programs.

- b) **In-Kind Contribution Reports**
 - Submitted every six months.
 - Will include contributions from community partners and from the Board of Health.

- c) **Financial Reports**
 - Submitted every six months.
 - Format similar to OHHP, Phase I form, complete with instructions for how to complete, as per other forms.

- d) **Narrative Reports**
 - Submitted annually.
 - Should emphasize strategic directions of the local project, partnership development, joint activity of partners, and major lessons learned.

5.4 Evaluation Requirements

5.4.1 Local Evaluation

Community partnerships will:

- identify and conduct an evaluation of at least one local program within the four-year timeframe of the *OHHP - Taking Action for Healthy Living*. The selection of the program to be evaluated will be based on criteria to be developed collaboratively by the Ministry's OHHP Provincial Evaluation and local and provincial partners.
- allocate up to 10% of their funding to local evaluation. Where feasible, community partnerships have the option to obtain part or all of their evaluation services through in-kind support. This could include professional services for evaluation, time-limited data entry, analysis of program data, reporting services, and contributing to RRFSS¹¹ data collection, analyses and reporting. If more than 10.0% of funding is required for evaluation, community partnerships may consider using additional in-kind contributions for this purpose.
- include evaluation as a strategy within their strategic and operational plans.

¹¹ Rapid Risk Factor Surveillance System, <http://www.cehip.org/rrfss/rrfss.htm>
For information contact the Ontario Coordinator: Lynne Russell, tel. 905-570-9952 ext 238, lrussell@cwHPin.ca

- participate in an annual process to identify and share lessons learned from the *OHHP - Taking Action for Healthy Living* (e.g., forum and facilitated discussions).

Community Partnerships are encouraged to:

- Access evaluation consultation and support from the OHPRS, e.g., the Health Communication Unit with respect to general evaluation knowledge and skills.
- Explore opportunities to link with existing research and evaluation services (e.g., RRFSS; Public Health Research, Education and Development Program).

5.4.2 Provincial Evaluation

The MOHLTC will be conducting a provincial evaluation of *OHHP - Taking Action for Healthy Living*. Projects will contribute information to the provincial evaluation by submitting the required planning and reporting forms to the evaluation, as well as by participating in relevant evaluation programs of the OHPRS (e.g., a survey of capacity planned for every two to three years).

Appendix I: Checklist to Support Development of the Submissions

Submissions will:

- ❑ reflect the *OHHP: Taking Action for Healthy Living* goal.
- ❑ reflect the *OHHP: Taking Action for Healthy Living* Guiding Principles.
- ❑ reflect a broad-based and multidisciplinary community partnership.
- ❑ be submitted by the Board of Health in collaboration with their community partnership.
- ❑ contain a letter from the Chair or designate of the community partnership supporting the Submission and confirming its commitment to provide in-kind support to the program.
- ❑ confirm the one 1.0 FTE OHHP Coordinator, a description of the responsibilities attached to the position, and if possible, the name of the person assigned to the position.
- ❑ use the Logic Model format to summarize their four-year strategic direction.
- ❑ identify the populations on which the local programming efforts will be focussed over the four-year term, the primary strategies to be undertaken and a list of the programs to be undertaken within each strategy during the first 21-month period.
- ❑ include a completed budget form.

The strategic plans will:

- ❑ include at least one population objective for each of three primary risk factors over the four-year term.
- ❑ reflect environmental, programming and organizational capacity objectives set by the Community Partnership that will allow it to contribute most effectively to the population objectives it will address over the four-year term.
- ❑ reflect each project's intent to increase the number of joint and shared programs within a Community Partnership.

Appendix II: Summary of Best Practice Scans

TITLE	SOURCE
Recommended Practices Toolkit (Tobacco)	Program Training and Consultation Centre http://www.ptcc.on.ca
Guidelines for Comprehensive Programs to Promote Healthy Eating and Physical Activity	US State and Territorial Nutrition and Physical Activity Work Group http://www.astphnd.org/programs/00Nupawqfm.pdf
International Best Practices in Heart Health, Part I & II	Heart Health Resource Centre http://www.hhrc.net
Preventing Substance Abuse Problems Among Young People: A Compendium of Best Practices	Health Canada 613.954.5995 ISBN 0-662-30636-8
Promising Practices in Chronic Disease Prevention and Control: A Public Health Framework for Action	CDC Department of Health and Human Services http://www.cdc.gov/nccdphp
Review of Nutrition Interventions for Cancer Prevention	Cancer Care Ontario http://www.cancercare.on.ca/prevention_diet.htm
The Guide to Community Preventive Services	CDC http://www.thecommunityguide.org
What Works in Nutrition Promotion	Nutrition Resource Centre http://www.nutritionrc.ca
Worldwide Efforts to Improve Heart Health: A Follow-up to the Catalonia Declaration – Selected Program Descriptions	CDC http://www.cdc.gov/nccdphp/needhome.htm

**ONTARIO HEART HEALTH PROGRAM:
Taking Action for Healthy Living**

**GUIDELINES
FOR THE
COMPLETION OF THE
OPERATIONAL PLAN**

PHASE II (April 2004 – December 2007)

December, 2003

Health Promotion & Wellness, Public Health Branch,
Ontario Ministry of Health and Long-term Care



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ATTACHMENTS

A: Criteria For Recommended & Promising Practices

“OHHP – *Taking Action for Healthy Living*” Guidelines for Completing the Operational Plan

A: Overview

OHHP Community Partnership (CP's) are required to submit a Four-year Strategic Plan and a Two-year Operational Plan in their submission for funding. On page 21, section 5.1 of the Submission Package, detailed outlines have been provided, along with a sample logic model and template, to support the development of the strategic plan.

The following Guidelines are to be used in conjunction with the *OHHP-Taking Action for Healthy Living* Program Plan template to complete the Operational Plans. This document complements other documents already available on the HHRC web site, including:

- The "OHHP – *Taking Action for Healthy Living*" Submission Package
- Reference Material for "OHHP – *Taking Action for Healthy Living*"
- OHHP "Question & Answer" documents created by MOHLTC
- HHRC Orientation Materials.

The Operational Plan will accompany the Strategic Plan, specifically the Logic Model. Information that is already in the Logic Model is not required in the program plan. In the development of each program plan, CP's should ensure there is congruency with the information already contained in their Logic Model.

In submitting the plans to the MOHLTC, CPs agree that the Four-year Strategic Plan and both Two-year Operational Plans will be shared with the HHRC and the provincial evaluator.

B: Revision and Approval Process & Timeline (Specific to the Initial Operational Plan)

(i) Review

- Health Promotion and Wellness will review all plans and submissions.
- Review criteria will be specific to the OHHP Phase II submission package and Guidelines for Completing the Operational Plan.
- Review criteria will be made available in the near future.
- Ministry feedback on submissions will be provided to OHHP Coordinators by February 20, 2004. At this time, each project, in addition to receiving feedback on their plans, will also be asked to provide any additional information and/or revisions that may be required to complete the OHHP Phase II submission package.
- Additional documentation and/or revisions must be submitted to the ministry by March 15, 2004.

(ii) Approval & Payment

The approval and payment process follows:

- The ministry will send letters of approval to each host agency, containing the agreement (contract) and request for a certificate of insurance, in April, 2004.
- A signed copy of the agreement and the certificate of insurance must be returned to the ministry within two weeks of receiving the letter.
- The ministry will begin making bi-weekly payments to agencies after the signed agreement and the certificate of insurance have been received.

C: General Guidelines

(i) Purpose of the Operational Plans

Information to be recorded in the Operational Plan was determined based on the four purposes served by these plans:

1. **Local programming:** The Operational Plan allows CP's to set and maintain their direction, and to gain a longer term view of programs, including planning for sustainability.
2. **Program support:** The Heart Health Resource Centre (HHRC) uses Operational Plans to provide relevant and timely support to Community Partnerships. The HHRC support includes sharing Operational Plans (or a summary of these) to facilitate peer networking and learning across the CP's. The ministry will review and approve the plans as a support to program development as well as for accountability purposes.
3. **Administration:** The Operational Plan provides a key component of the contract between Community Partnerships and the Ministry of Health and Long-Term Care (MOHLTC); they demonstrate how the terms of the *OHHP – Taking Action for Healthy Living* are translated into specific programs.
4. **Evaluation:** The Operational Plan is used to identify evaluation priorities, including programs for possible in-depth evaluation.

(ii) Submission Requirements

The first Operational Plan addresses the period of **April 1, 2004 to December 31, 2005 (DUE: January 15, 2004)**. This 21-month plan is required to move the project from the current fiscal year cycle ending March 31, 2004 into the calendar year planning cycle, making it consistent with Board of Health funding cycles. A second operational plan is required for the period of **January 1, 2006 to December 31, 2007 (DUE: October 15, 2005)**.

Submit your Operational Plan to your Program Coordinator at Health Promotion and Wellness, Public Health Branch, MOHLTC with the other required elements as outlined in the Submission Package.

Direct any questions about your Application, including the Operational Plan, to your Program Coordinator:

Huguette Jacobson T: 416-314-5482 F: 416-314-5497 E: huguette.jacobson@moh.gov.on.ca	Carol Gold T: 416-314-5503 F: 416-314-5497 E: carol.gold@moh.gov.on.ca
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Community Partnerships are encouraged to revisit their Operational Plan annually, and any deletions or changes to programs from what was projected in their initial will need to be proposed to the MOHLTC for approval. Revisions to the first two-year Operational Plan and/or budget should be submitted to the ministry by Nov. 30, 2004 and revisions to the second Two-Year Operational Plan will be due on November 30, 2006. This update should include notification of any programs locally approved under a Community Contribution Program in the last year. If no changes are required, CP's only need to confirm that there are no changes.

All program plans submitted should be congruent with the *OHHP: Taking Action for Healthy Living* Guiding Principles and OHHP Design and Delivery elements, detailed in the Submission Package (Sections 3.1 and 4.5, respectively). More details on a “program” are offered below.

In your Operational Plan, only include programs that have OHHP funds attached to them and have two or more partners directly participating in each program.

Include one Program Plan for each program that the Community Partnership will plan, implement and/or evaluate during the period for the Operational Plan to which OHHP funds are being directed.

Each program included in your Logic Model should have a separate Program Plan. All programs included in your Operational Plan should also appear on the Logic Model. It is at the level of “program” where the Logic Model interfaces with the Operational Plan.

All OHHP funds should be reflected in your Operational Plan.

(iii) What To Include as a “Program”

A program is a well-organized series of activities designed to facilitate change in a well-defined target group. In more practical terms, the information recorded on page 1 of the Program Plan (e.g., program focus, channel, audience, etc.) should be meaningful for the full set of activities that are part of the program. Examples of programs include:

- Workplace Wellness
- School Mobilization
- Smoke-free Homes
- Healthy Living Events
- Local Evaluation
- Community Mobilization

Special circumstances:

Community Contribution Program: As these will be selected after the Operational Plans are submitted, complete one Program Plan for the full program (i.e., Community Contribution Program). OHHP provincial funds allocated to this program should not exceed 10% of your provincial funds. Community Partnerships should include specific information on each approved CCP program in their updates, e.g., November 30, 2004 and November 30, 2006.

- **Professional Development:** Include professional development opportunities as a program (likely under the strategy that refers to Partnership/Coalition Management) that will use OHHP funds.
- **Resources used for community mobilization, capacity building, etc:** Although not really a “program”, typically, Community Partnerships allocate funds to meetings, travel, and other partnership “administrative” costs. Complete a Program Plan for “Community Mobilization” (or equivalent) to reflect these activities and costs.
- **Innovative Program Development:** As outlined in the OHHP Guiding Principles, on p. 8 of the Submission Package, the OHHP “values the use of evidence-based, “recommended practice” and innovative strategies in order to achieve population health outcomes. Most, if not all, of the programs selected by your Community Partnership should be “recommended programs”. Appendix II of the Submission Package contains a summary of the scans of these programs that

are available through the HHRC. However, should your CP identify a gap that cannot be filled with an adaptation of an existing “recommended practice”, there is support for innovation. In this case, complete a Program Plan for the innovation but also attach the required additional elements as rationale. These elements can be found at the end of the Program Plan form. Attachment A to this document provides the list of program attributes that have been used, in slightly different forms, across the OHPRS to determine “recommended practices”.

D: Specific Guidelines

Each of the following headings refers to the corresponding section of the Program Plan form. All sections are to be completed for every program.

LOCAL PROJECT AND HOST ORGANIZATION: Record the name of the local OHHP project and the organization that is legally accountable for the project.

JURISDICTION COVERED: Several local projects have more than one Community Partnership, each covering a specific geographic area within the full project area. Indicate if the Program Plan is for the full local project area (i.e., full health unit area) or part of it. Specify the partial jurisdiction.

CONTACT PERSON AND PHONE NUMBER: Record the name of the OHHP Coordinator who will be the contact person for the full Operational Plan.

NAME OF PROGRAM: Record the name of the program, as it appears on the Logic Model.

LANGUAGE: Check all the languages in which program delivery or program materials are available. Select bilingual if it is both English and French. If available in other languages, specify all of the individual languages.

STRATEGY: Record the name of the strategy within which the program is located in your Logic Model.

PROGRAM DESCRIPTION: Please provide a 2-3 sentence description of the program. Provide more information than what is in the name of the program, but not all the details of the specific activities (which are listed in your Logic Model and therefore not repeated here). Details of programming objectives (e.g., amount of activity and estimated reach), since those are also detailed in your Logic Model are also not required here. To gauge the scope of the description to include, picture someone reading the Program Plan that knows nothing else about your project, other than the Logic Model.

Some examples of a Program Description:

“This Communication Campaign will run for six months, kicking off in February (Heart Month), and culminating with a July event at our local waterfront. It will include a mix of broadcast media, community events, and small group presentations, all geared to young moms with the emphasis being on working through the social networks to which they belong.”

“This Walking Program will occur in urban neighbourhoods. Women from the local area will be recruited, trained and supported as walking group leaders. Walk This Way! materials will be distributed to participants. In some communities, walking routes will need to be mapped before the clubs can be started.

“This Active Commuting program builds on previous work done in our community in developing walking trails. We now turn our attention to active commuting lanes on selected streets. This will require policy within our municipality so links have already been established with our urban planners. This planning

period will be focused on gathering evidence and examples of how this has worked in other communities, supporting a Feasibility Study, including surveying the public regarding their support for this approach, and the recruitment of partners to work on this policy initiative.”

OHHP POPULATION OBJECTIVES: Population objectives refer to changes in behaviours and other risk factors that contribute to cardiovascular and other chronic diseases. Record the appropriate code(s) from the list of population objectives below.

Code	Population Objective
Tob-teens	Decreasing the percentage of teens who are current cigarette smokers
Tob-adults	Decreasing the percentage of adults who are current cigarette smokers (ages 18 and older).
Tob-quit	Increasing the percentage of daily smokers who will make at least one attempt to quit smoking per year.
Nutr	Increasing the percentage of Ontarians who consume five or more servings of vegetables and fruits daily.
Phys act	Increasing the percentage of Ontarians who participate in moderate to vigorous activity on most days of the week.
BMI	Decreasing the percentage of Ontarians who are obese, as measured by a body mass index greater to or over 30.

Note: It is only under special circumstances that a Community Partnership will add or modify a population objective. Therefore, the “Other” category would likely NOT be used.

PROGRAM FOCUS: Select which of the three risk factors apply to the program during this planning period. Please check each behaviour that will be addressed separately. Please note that there is no “multiple risk factor” option. Use “Non-specific” for programs that focus on such things as organizational development, capacity building, partnership development etc. **Each program should have at least one box checked** as these are the primary mandate areas of the OHHP.

INTEGRATION WITH OTHER ISSUES: Many OHHP programs will relate to additional topics beyond the three risk factors identified. Identifying how the risk factor-based programs integrate with other areas will help evaluators understand and share the inter-connectedness of community programs as well as flag for peer CP’s where sharing of approaches might be appropriate. In addition, the various resource centres within OHPRS and other community programs, such as FOCUS coalitions, will be interested in where possible integration opportunities exist with the OHHP. Should a program connect with any of the areas listed, check all that apply. The list on the Program Plan form is intentionally a broad mix of topics that span other risk factors and diseases in order to capture a wide range of integration opportunities. There is no expectation that ANY of these other topics will apply to a particular program.

To assist in specifying the possibilities under Chronic Diseases, please select from the following list or offer another alternative:

- Asthma
- Stroke
- Diabetes
- Cancer

To assist in understanding what will fall within the category of Social Determinants of Health, consider the list outlined by Health Canada. It is not necessary to specify a particular determinant on the form.

- Income & social status
- Social supports networks
- Education
- Employment & working conditions
- Physical & social environments
- Biology & genetic endowment
- Personal health practices & coping skills
- Healthy child development
- Health services.

CHANNEL: Indicate the one primary channel for this program and as many other channels for the program that apply within this planning period. The primary channel is the one to which your Community Partnership plans to give most emphasis (i.e., planning and/or implementation) during the planning period. "Other" channels are those you plan to give some emphasis to during the planning period, but less emphasis than the primary channel.

Use the following definitions of channels:

CHANNEL	DESCRIPTION
Media	Includes websites, newsletters, newspapers, radio, television, billboards, telephone lines, etc.
Day Cares/Nursery Schools	For children under school age in your community (JK or SK)
Schools: elementary, secondary, post secondary	Includes cafeteria and vending machines
Day Camps	Includes summer, YMCA camps, PD day programs for children
Recreation facilities	Includes public and private recreation facilities
Worksites	Includes cafeteria and vending machines
Health Care Settings	Includes hospitals, community health centres, clinics, pharmacies, health units, physician and dentist offices, long-term care
Restaurants	Includes fast foods, cafeterias not in schools or workplaces
Grocery Stores	Includes convenience stores
Community at large	Includes library, community groups, community centres, churches/faith, local events, shopping malls, community kitchens, food banks, drop-in centers
Not Applicable	Includes planning, evaluation, capacity building and other activities not specific to a particular delivery channel (e.g., strategic planning events, community surveys, etc.)

AUDIENCE: Indicate one primary audience and as many "other" audiences as apply to this program. If there are no "other" audiences, select "not applicable". The primary audience is the one to which the CP will give the most emphasis during the planning period. Other audiences will be given some emphasis, but less than the primary audience during the planning period. **Please note:** Your population objectives typically indicate the ultimate beneficiary (sometimes called "end-user") for your program. The one or more audiences you record on your Program Plan are not necessarily the ultimate beneficiary. Often, Community Partnerships target intermediaries who will in turn deliver a program in a community setting. Record the audiences that your CP will directly target during the planning period.

Use the following definitions to guide your selection:

AUDIENCE:	DESCRIPTION
Children	< 13 years
Youth	13 to 18 years; Grade 9 to 12
Adults – all	19 to 64 years Includes teachers, administrators and other adults reached in the school setting; employees in the workplace setting (as end users not intermediaries)
Adults – female (to be consistent with PP)	19 to 64 years
Adults – male	19 to 64 years
Seniors	65+
Family / parents	
General community	
Diverse populations	Specify which population the program will be geared towards. This might include Aboriginal, ethnic, faith, cultural groups, people living with disabilities, among others. Be as specific as possible.
Community volunteers/ partners	Includes Steering Group, Community Partnership, working groups
Health care professionals	This would include allied health professionals such as kinesiologists, physiotherapists, public health nurses etc.
Education professionals	These professionals work within school settings (from pre-school to post-secondary).
Sport / Recreation/ fitness professionals	Coaches, recreation staff, personal trainers, fitness instructors etc.
Individuals living in low income situations	Could include families, women, people living in geared-to-income housing, etc.
Politicians / other gatekeepers / opinion leaders	Includes other gatekeepers and opinion leaders

APPROACH: Indicate one primary approach and as many “other” approaches as apply to this program. If there are no “other” approaches, select “not applicable”. The primary approach is the one to which you will give the most emphasis during the planning period. Other approaches will be given some emphasis during this 21-month period, but less than the primary approach.

Use the following definitions of approaches:

APPROACH	<i>DESCRIPTION</i>
Awareness	<i>Awareness</i> refers to health communication aimed at increasing knowledge and/or changing attitudes about the topic being addressed (e.g. physical activity, chronic disease prevention, heart health) in the specific intended population. It includes a mix over time of media (both broadcast or mass media such as TV, radio and newspaper, and narrowcast such as pamphlets and posters), community events such as contests, fairs, and displays, and interpersonal opportunities such as presentations, briefings and symposia.
Education	<i>Education</i> refers to providing information and the opportunity to develop skills to effect knowledge, attitude and behaviour change. It includes activities for end-users such as low-fat cooking courses, tobacco use prevention computer games, self-help groups, clubs. Also includes activities for intermediaries (those who deliver programs) such as train-the-trainer workshops and peer learning opportunities.
Environmental	<i>Environmental Support</i> refers to creating social and/or physical environments that support

APPROACH	<i>DESCRIPTION</i>
Support (social and physical)	healthy behaviours (e.g., walking trails, bicycle racks at worksites, healthy food choices in restaurants/ vending machines, point of purchase information, inventories of heart health programs and services). This category does not include policy supports.
Policy development	<i>Policy</i> refers to changing formal or informal rules of governing bodies to support healthy behaviours (e.g., nonsmoking bylaws, bylaws for mandatory bicycle lanes, workplace policies). Policy development refers to efforts to introduce a new policy (e.g., advocacy for change, drafting terms of a policy).
Policy implementation	Policy implementation refers to efforts to assist with policy implementation (e.g., signage, enforcement).
Community Mobilization	<i>Community Mobilization</i> involves generating interest in, and commitment to, health-related matters within a community and facilitating community involvement in planning and carrying out initiatives/activities. Includes activities such as partnership building, coalition planning, training, volunteer recruitment and recognition.

MAIN PROGRESS PLANNED FOR THIS PLANNING PERIOD: “Main progress” refers to various phases of a program that will occur during this period. Not all phases will apply to each program. Indicate all that your CP aims to complete, in full or in part, during the planning period. Please indicate if the phase will be undertaken in year one and/or year two.

Use the following definitions:

MAIN AREA OF PROGRESS (PHASE)	<i>DESCRIPTION</i>
Planning	The two or more partners are in place. Objectives have been established and Program Plan completed. No implementation has yet begun.
Development / adaptation of program materials	The direction of the program has been determined and detailed plans established to the degree that now materials to support the program are being developed and focus tested prior to any implementation.
Pilot testing	The program is made selectively available to a sub-set of the intended population for the eventual program. Detailed feedback is sought through a formative evaluation in order to make any necessary improvements to the program prior to widespread implementation.
Program Implementation	Plans are complete, materials have been developed and the program has been pilot tested (if applicable). The program is now being fully implemented with the intended population.
Evaluation	This refers NOT to formative evaluation during program development but to summative, outcome or impact evaluation that is being done following program implementation.
Supports for sustainability	Efforts are underway to determine or set in place situations that will enhance the likelihood that the program will be sustained following the investment of OHHP funds. The list presented on the Program Plan could be supplemented with the suggestions within the HHRC Sustainability Manual.

OHHP PROVINCIAL FUNDS: Record the total OHHP funds your CP has allocated for this program for the full planning period. You may also add details here regarding the split in the funds between the 2 years or the breakdown of how the funds will be spent, although you are not required to do so.

LIST OTHER FUNDING SOURCES: Should the program have funding other than the ministry OHHP funds and the contributions-in-kind from partners, these should be reported here. For instance, a program might receive funds from a national diabetes project, a Trillium project and/or a private sector source. Although the source is all that is required, it would be helpful to know the amount of funding attached to this program if possible.

COMMUNITY PARTNERS: Record the name of at least the two partners, and more if applicable, that are involved in this program through their contribution of in-kind resources. You may also record the name of a committee, and attach (as a separate page) partners who are members of the committee. Include organizational names of those involved rather than the names of individual committee members.

STATUS OF PROGRAM: Indicate the one option that best describes the status of the program. As per the Submission Package, most, if not all of your programs should be “recommended practices” that have already been tried and tested elsewhere so an aspect of this part of the plan seeks to identify the degree to which recommended programs are used.

- If the program has already been taking place in your community through the OHHP or otherwise, check the box titled "An existing program in your community". Then identify if it is a “recommended program” by checking off a box on the far right. CP’s are reminded that Phase I required that existing “recommended practices” were to be selected during this phase as well. The list of documents summarizing many recommended programs is in Appendix II of the Submission Package and is also posted to the HHRC Web site.
- If you are planning a program in your community that came from another location, check the box titled "A new program in your community, developed elsewhere". Identify if this is a “recommended program” by checking the appropriate box, and identify the source of the program.
- If the program is to be newly developed (i.e. an innovative approach or one for which no existing evidence of effect can be found), provide, on a separate attachment, a detailed rationale as to why this program should be approved. Include in the rationale:
 - Budget, including a breakdown for major expenses
 - Gap or need addressed
 - Theory and/or evidence base for the program
 - Potential for provincial implementation.

Ministry support will be given to programs that:

- address a widespread need across many Ontario communities, for which there is no existing “recommended practice”;
- are supported by theory and/or evidence;
- have potential for provincial implementation; and
- can be developed at a reasonable cost.

CP’s should ensure that they have the financial resources to adequately develop new programs (innovations and to evaluate their effectiveness. It is recommended that CPs nominate an innovative program for in-depth evaluation.

Review of new program requests by the Ministry will result in one of the following decisions:

- Proposal to develop a new program is approved and the CP can proceed with development.
- Proposal to develop a new program is approved, and two or more CP’s are invited to work together for program development and pilot testing (if a similar innovation was proposed by two or more CP’s).
- Proposal to develop a new program is not approved based on an insufficient or weak rationale.

Decisions about possible province-wide availability and implementation would be decided after the results of the developmental and pilot work are complete in the community.

USE OF PROVINCIAL RESOURCES AND PROGRAMS: The extent of use of provincial programs is of interest to the ministry, as it funds most of the programs, to the OHPRS resource centers who often

support the implementation of the program, and to the various CP's who can share and compare how these resources are used differently in various communities.

There is no expectation that any CP would implement all of the provincial programs listed. Leave this section blank if no provincial programs or resources are being used with this program. If the program will utilize materials from a provincial program (listed on the form), check all those that apply. If other provincial materials are being used, specify these under "other".

POSSIBLE PROGRAM FOR IN-DEPTH EVALUATION: Each Community Partnership, with support from the OHHP provincial evaluators and OHPRS resource centers (e.g., The Health Communication Unit), is required to "identify and conduct an evaluation of at least one local program within the four-year timeframe of the *OHHP - Taking Action for Healthy Living*" (Submission Package p. 24). An "in-depth evaluation" will typically involve both process and outcome components. Programs selected for in-depth evaluation will be a joint decision between the Community Partnerships, the provincial evaluators, and those overseeing the provincial evaluation. The Operational Plan is the place for Community Partnerships to identify programs for possible in-depth evaluation. A program should be nominated if it meets most or all of the following criteria:

- The program has a large investment of OHHP funds.
- The program has not been evaluated in another jurisdiction and has no previous in-depth evaluation by your Community Partnership.
- The program will not be in a pilot phase; rather, it will be fully implemented within the four years of this phase of the OHHP.
- Implementation of the program will be extensive enough to expect changes as per the program objectives established for it.
- The program shows promise in meeting the criteria for "recommended practices" (see Attachment A of these guidelines for details).

Each Community Partnership can nominate more than one program but at least one program MUST be identified within the overall Operational Plan. However, you are asked to be selective and only nominate those that meet most or all of the above criteria. For CP's that have multiple local coalitions or sub-partnerships, only one program need be identified across the overall project's Operational Plan. More can be identified according to the criteria above.

It is recommended that any program proposed for development as an innovative approach be identified as one for which an in-depth evaluation is included.

ATTACHMENT A:

Criteria For Recommended & Promising Practices

Within Ontario, no single set of criteria is used to assess programs for possible dissemination (i.e., use in many communities). However, some common criteria can be identified¹², and are described below. These common criteria can be used by OHHP community partnerships as a guide to help maximize the likelihood that their programs will be judged as “recommended” or “promising”. Support will be available through the HHRC and OHHP Evaluation Services to apply these criteria to specific programs, and to design evaluations that will best inform a review process.

Effectiveness Criteria: Effectiveness criteria assess whether the program did or did not work. Both results of reported evaluations of the program and the quality of study designs are considered. Strongest evidence is provided by positive results (e.g., change in behaviours or environments) using a good impact or outcome study design. Weaker evidence is provided by positive results using a process evaluation only.

Plausibility Criteria: Plausibility criteria assess whether a program will *likely* be effective based on its attributes. The assessment of plausibility therefore does not necessarily reflect what happened but the potential of the program (i.e., “could the program...” rather than “did the program...”). Plausibility criteria include several attributes, for example:

Evaluation Attributes

Formative evaluation/pilot testing: Formative methods (e.g., consultation, focus groups) have been used to assess relevance, comprehension, and acceptability of activities, materials, methods, etc.

Process evaluation: Feedback has been gathered and integrated on program implementation, site response, participant response, practitioner response and competency.

Content Attributes

Appropriate theoretical foundations are applied (e.g., behaviour change principles)

Process Attributes

Collaborative approach: Local individuals, groups and intended audiences are involved in planning and implementation.

Visibility: Program could be widely promoted in the community or setting, or those engaged in the program are visible.

Sustainability: Currently active, or evidence of sustainability; not dependent on special resources.

Community leader support: Has the potential to elicit involvement/ support/ buy-in of formal and/or opinion leaders (channel-specific leaders).

¹² In the past 5-10 years, substantial work has been done to develop and test a process to identify and review programs for their possible widespread application. Heart health promotion has been a leader in this field, with three international scans for ‘best practices’. These scans, as well as a project to identify ‘best practices’ for diabetes prevention, and a project to identify ‘better practices’ in tobacco control, were used to develop the list of common criteria described above.

Outreach (community buy-in): Engages individuals from the community with the objective of consulting, animating, or sensitizing the community to the issue.

Mobilizes community resources: Identifies and uses resources within the community.

Competing programs: Fills a unique need within the community that is not provided by other programs or services.

Community needs/wants: Responds to articulated community needs.

Other Attributes

Time sensitivity: Refers to whether the evidence is current, and whether it can still be considered reliable.

Replicability: Refers to whether the program can be repeated in the same and/or new locations (e.g., has implementation guidelines).

Generalizability: Refers to whether the program appears to be limited in its effectiveness to particular populations or situations.

Cost benefit: Refers to whether the potential impact is worth the estimated costs.

Evaluability: Refers to whether the program can be evaluated to determine its effect

Programs are generally judged as recommended or promising on the basis of the above criteria (or equivalent). Practicality criteria are then applied by community practitioners or decision-makers to determine: a) the readiness of the community to address the perceived need of the program being considered; and b) the availability of the necessary technical, financial, and personnel resources to implement the program.

OHHP Phase II - Taking Action for Healthy Living
Questions and Answers
Health Promotion & Wellness, Public Health Branch
Ministry of Health & Long-Term Care
November 6, 2003

Funding

1. Q: Are we submitting one budget for 21 months? How will we be paid?
A: *Yes. Funds will be flowed biweekly during the 21-month period.*

2. Q: The OHHP - Phase II was approved for five years, to end on March 31, 2008. Due to the recent change from a fiscal year to a calendar year, the program now technically ends on December 31, 2007. Coordinators have been directed to submit plans until December 31, 2007. Are they going to receive funding for the entire five-year period?
A: *Yes. Funds will be flowed to March 31, 2008. Further direction will be provided regarding programming from Jan 1, 2008 to March 31, 2008.*

3. Q: While our first plan is for a 21-month period, do we need to allocate and spend our annual budget in each of the fiscal years? Or can we carry unused funds from one year over into the next year?
A: *It is possible to carry unused funds over from Year 1 to Year 2. At the end of the 21-month period (Year 2) all unused funds must be returned to the Ministry of Finance.*

4. Q: In the Submission Package it states that "Funds requested in the budget should reflect funds received during OHHP, Phase I". What does that mean?
A: *Your annual allocation remains the same. Your 21-month budget should reflect one year and nine months of funding.*

Fundraising

5. Q: Can we use the proceeds from local fundraising done outside of the heart health funding envelope to support activities that do not address heart health primary prevention?
A: *It is up to each Community Partnership to decide how to use the proceeds from these kinds of fundraising initiatives. However, heart health provincial funds and/or the proceeds from fundraising that is carried out under the heart health program should not be used for initiatives that are not eligible under the Ontario Heart Health Program.*

6. Q: How should Community Partnerships report money that they raise through

fundraising?

A: *The funds should be reported as "Revenues from the Project" on the Interim/Final Financial Report Form.*

Planning and Evaluation

7. Q: Do the operational plans replace the activity plans that were submitted in Phase I?

A: *Yes. We are aiming to have the OHHP - Taking Action for Healthy Living template and accompanying guidelines available at the OHHP conference on Nov. 17 - 18.*

8. Q: Are we going to be able to submit our plans and reports online?

A: *We are aiming to have online planning and reporting tools available. However, we do not know at this time if this will be feasible for the January 15, 2004 deadline.*

9. Q: Our Community Partnership is comprised of several working groups. Is each working group required to do programming on each of the three risk factors?

A: *You are required to provide us with a coordinated plan that synthesizes the work of all of your working groups. Your strategic plan and your 21-month operational plan (e.g. the combined work of the various groups) must demonstrate that your Community Partnership is addressing the three risk factors on a continued basis over the four years.*

10. Q: Within our Community Partnership each working group creates their own plans. What is the best way to synthesize the separate plans into one coordinated plan?

A: *The various working groups' strategies may be operationalized across the overall local partnership through using the logic model format. The row for "intended population" should be used to identify specific populations/geographic populations being addressed within each strategy.*

11. Q: Are Community Partnerships limited to using the population objectives listed in the Submission Package, or are they able to identify their own population objectives, provided they have at least one for each of the three risk factors?

A: *In order to maintain consistency across the provincial program we strongly recommend that Community Partnerships choose from the designated set of population objectives. Should a partnership wish to propose changes or additions to those in the submission package, they should provide a detailed rationale and should support it with local evidence.*

12. Q: Within each operational plan, the first bullet states that "programs should be

grouped and presented by strategy, as identified in the strategic plan". Does this mean that we are not required to group activities according to "channel", as we have done in previous years?

A: *This is correct. Group your programs by strategy as you would have previously done by channel. Within the operational plan format there is provision to show what channel(s) the program addresses.*

13. Q: The submission package states that eligible programs include "direct programming for local programs jointly shared between at least two community partners". Could a Community Partnership provide multiple coalitions with budgets, a large percentage of which will be provided to community partners to implement activities and events through an application and approval process at monthly meetings?

A: *Programs that are to receive financial support through OHHP funding must be presented in the 21-month operational plan. The application and approval process within the multiple coalitions needs to happen before the January 15, 2004 submission date. Each program plan outlined in the 21 month operational plan will need to identify at least 2 community partners who will provide in-kind contributions throughout the program. The exception to this is the 10% of the total budget that is for the "Community Contribution Program". The specifics of these programs may be determined by Community Partnerships after April 1, 2004. Further information will be included in the guidelines that accompany the OHHP Taking Action for Healthy Living Program Plan template.*

14. Q: When should Community Partnerships approach the Ministry to gain approval for new or revised programs?

A: *Community Partnerships may submit plans for new or revised programs within their operational plans, as long as they are within the financial scope of the projects. They must provide a sound rationale demonstrating the existence of a gap; the proposed impact of the programs; how they will be evaluated; and how they would be positioned as provincial programs after being piloted in one or more communities.*

When new and revised programs are planned that require resources in addition to the allocation provided to the local partnership, a full proposal would need to be submitted, in collaboration with the appropriate resource centre. Further information will be included in the guidelines that accompany the OHHP - Taking Action for Healthy Living Program Plan template.

15. Q: For the Terms of Reference, is it possible to include a generic statement on "the need to address policies for management of materials, revenue generation, and volunteer management and liability", but to have the policies themselves as attachments to the Terms of Reference?

- A: *Yes. However, if you do this, you must include copies of the policies with your submission.*
16. Q: Given the time and the funds required, to what extent are Community Partnerships required to set and measure changes in their overall behavioural and awareness objectives within the target audiences?
- A: *There are no expectations for local projects to measure changes in behavioural objectives. However, some of the in-depth evaluations will most likely include examining some changes over time.*
17. Q: The submission package indicates that Community Partnerships will identify and conduct an evaluation of at least one local program within the four-year timeframe of the program. Does the ministry have evaluation criteria and a process in place that can be followed?
- A: *Whenever possible Community Partnerships should indicate the programs on which they would like to conduct an in-depth evaluation within their January 15, 2004 submission. Final selections will be negotiated jointly by the OHHP evaluator and the local projects. A preliminary list of evaluation criteria will be included in the guidelines that accompany the OHHP - Taking Action for Healthy Living Program Plan template. This list may be refined through partnership at the provincial and local levels.*
18. Q: Is it mandatory that we spend 10% of our funding on local evaluation? Or is that just the maximum allowed?
- A: *You are permitted to spend **up to 10%** of your funding on local evaluation. You may spend less. You may also consider using additional in-kind contributions for this purpose.*
19. Q: What is meant by "management of materials"? Does this refer to the products produced by the Community Partnership (e.g., brochures, promotional items, posters, etc.)?
- A: *Yes.*
20. Q: On page 21 of the Submission Package it states that, "Individual volunteers will be subject to the organizational policies and procedures of the organization that they represent". Does this mean that Community Partnerships are not able to independently recruit volunteers?
- A: *No. Community Partnerships may recruit, screen and manage volunteers. Volunteer management and liability will be addressed by each Community Partnership within their Terms of Reference.*

**OHHP - Taking Action for Healthy Living
Questions and Answers
Health Promotion & Wellness, Public Health Branch
Ministry of Health & Long-Term Care
November 26, 2003**

1.0 Program Administration

1.1 Approval, Timelines, and Funding

Q: For the first “2-year” Operational Plan (that is 21 months), what’s the actual time period that we should be planning for?

A: *Plan for the 21 months: “year 1” is the first 9 months from April 1, 2004 through December 31, 2004 and “year 2” is the last 12 months from January, 2005 through December, 2005.*

Q: What is the funding allocation for “years” 1 and 2?

A: *The funding allocation corresponds exactly to the program period, i.e., 9 months in 2004 and 12 months in 2005. Funds will continue to flow on a biweekly basis.*

Q: Will there be an opportunity to forward our submission after January 15, 2004?

A: *No. All submissions are due on January 15, 2004.*

Q: Do we have to wait for approval from the ministry before implementing our programs?

A: *Yes. You must be in receipt of a letter of approval for your proposal from the MOHLTC before implementing your program. The Approval and Payment process is outlined on pages 3-4 of the Guidelines for the Completion of the Operational Plan (Guidelines).*

Q: Our agency may not be able to return the signed agreement and the certificate of insurance to the ministry within the timeframe specified in the letter of approval. Will we be able to proceed to implement the program?

A: *Yes, you may proceed. However, the ministry will not release funds until we receive and approve the necessary documents, i.e., the signed agreement and the certificate of insurance. At that time, funds will be paid retroactive to April 1, 2004.*

Q: Does the OHHP Coordinator need to be one FTE?

A: *Yes. This is based on strong evidence from the demonstration phase that this is the absolute minimum staff support required to undertake comprehensive, community-based programming of this nature. As well, in developing the Submission Package for OHHP, Phase II, all members of the planning committees involved in this discussion*

were in strong and united agreement that one person full time is required to fill the OHHP coordinator position. Applications in Phase I that did not meet this requirement were approved with the understanding that they would work towards fulfilling this requirement.

1.2 Revisions

Q: We support a Community Contribution Program (CCP). Do we have to inform the ministry of the programs that are selected within this program?

A: *Yes. In the update required by November 15, 2004, a Program Plan for each of the selected programs within the CCP should be included. If there are no other changes to your plan, this may be all that is provided to the ministry at that time.*

Q: Will there be any chance to change the plans submitted for January 15, 2004?

A: *Yes. There will be two opportunities. Based on feedback from the ministry (to be provided by Feb. 20, 2004), changes may be made before March 20, 2004. Revisions to program plans for Year 2 should be submitted to the ministry by November 15, 2004.*

1.3 Planning and Reporting

Q: How do we report on Year 6?

A: *Use the existing forms and guidelines from Year 5.*

Q: Do we have to estimate in-kind contributions as part of the plan?

A: *No. However, it will be expected that knowledge of the actual in-kind contributions will be necessary for reporting purposes. Although you are not required to indicate these on the Program Plan form, you will need to have negotiated with your partners at the planning stage and identified what the contribution from them is going to be throughout the program.*

2.0 Planning

2.1 Audience

Q: Are local projects permitted to focus on one audience for all programs, addressing the audience through different channels?

A: *Addressing one audience would be permitted, but only for a defined time frame. In addition, you must provide a rationale for doing so. If there is to be only one major focus within the population, it is recommended that a comprehensive approach be taken across risk factors, settings, and approaches.*

Q: On page 10 of the Guidelines under "Audience", there is a reference to 'beneficiaries' and intermediaries'? What is the difference between them? Are intermediaries an acceptable primary audience?

A: *'Beneficiaries' refers to the ultimate end-users of a program, and intermediaries refers to program planners and providers. Intermediaries would be the ultimate beneficiaries of capacity building programs. With many programs, however, they are different. For example, if your Community Partnership was working with school board officials and teachers to include daily physical activity in the curriculum, the ultimate beneficiary would be students, even though your primary audience was intermediaries (principals and teachers). With OHHP programs, intermediaries are very often targeted directly. They are definitely an acceptable primary audience.*

2.2 Partnership

Q: Is it necessary for local projects to include letters from each partner confirming their commitment to the OHHP? In the event that there are multiple partnerships within a local project, is it necessary to include a letter from each of the partnerships?

A: *The Submission Package directs you to submit a letter from the Chair (or designate) of the Community Partnership supporting the submission and confirming the Partnership's commitment to provide in-kind support. Where there are multiple Partnerships, provide letters from each Chair (or designate).*

Q: Can our Community Partnership be one of the partners required for the "two partners per program" requirement?

A: *No. The members of your coalition are the partners, not the partnership as a whole. At least two of these partners must be involved in each program that receives provincial funding. Partners must be organizations, not individual volunteers, and must make substantive contributions to the program. The contribution-in-kind can be any of the things itemized in the Submission Package on page 15.*

Q: Can the OHHP Coordinator be one of the two partners required for each program.

A: *The OHHP Coordinator, as an individual, is not a partner. However, the employer of the OHHP Coordinator (in most cases, the Board of Health) is a partner agency. Therefore, the other partner would need to be other than the Board of Health / sponsoring agency. To further clarify, no program can be solely the responsibility of the OHHP Coordinator. At least one other partner is required to contribute something.*

Q: The Submission Package states that we must have at least two partners per program. We are considering starting a new program next year, for example, "5 to 10 A Day". We have not previously had this program thus we do not currently have partners for it. Can we have the objective of recruiting partners as part of the plan?

A: *Yes, as long as there are at least two partners committed to the program at the time of submission.*

Q: Are provincial partners and/or resource centres eligible to be counted as a partner to meet the requirement that there be two or more partners contributing in-kind support to local initiatives?

A: *No. While you may seek support from provincial partners and/or resource centres, it is a requirement that the two or more partners contributing in-kind support are local partners.*

Q: Our community partnership is involved in programs that do not use OHHP provincial funds. Do we need to include these in our Operational Plan?

A: *No. Your Operational Plans should include programs that meet the two criteria described in the Guidelines; namely, programs that involve two or more community partners (one of which may be the health unit), and programs that use some OHHP provincial funds. Other programs that fit the OHHP mandate and are carried out by two or more OHHP partners should not be included in your Operational Plan. Accordingly, you will not be asked to report on these programs on the OHHP program reporting form. However, a narrative component to the OHHP annual reporting will provide an opportunity to describe related partnership programs that contribute to synergy and other ways to maximize impact in your communities. You may gather kind-contributions for those programs on which you report in the above-mentioned narrative component.*

2.3 Objectives

Q: What are organizational capacity objectives?

A: *A definition and description of these is on Page 11 in the Submission Package. Organizational capacity objectives refer to changes in practices or beliefs of the Community Partnership. Within this broad definition, two main areas are identified in the Submission Package: 1) knowledge and skills of community partnerships; and 2) leadership and ownership for health promotion among community partnerships. Community partnerships are encouraged to set organizational capacity objectives in these areas, focusing on the most appropriate local needs. Further help is provided in the OHHP Reference Material (will be available soon), where specific types of skills are listed related to health promotion assessment and planning, implementation, evaluation, sustainability, and transferability.*

2.4 Narrative

Q: The submission package states that the narrative is to include: "an outline of the

rationale for the decisions made regarding the strategic direction as outlined in the Logic Model". Is a rationale for every component in the program Logic Model (i.e. vision, mission, objectives, activities, programs, population and strategies) required?

A: *Yes, please provide a brief rationale of 1 or 2 sentences for each element of the Logic Model. The rationale might be generated from such things as local data, history within the project, current health status and local capacity. Within each program, you should deal collectively with the list of activities and not on an individual basis.*

3.0 Evaluation

Q: Can you give some direction as how to we might allocate funds for evaluation purposes for the first 21 months, when we are only nominating programs for consideration and are not likely to know the specifics of methodologies, frameworks, etc.?

A: *A general guideline (described on page 24 of the Submission Package) is to allocate 10% of your overall program budget (which includes OHHP provincial funds and in-kind contributions) to evaluation. This 10% guideline can also apply to individual programs that you nominate for in-depth evaluation. That is, for the one or more programs you nominate for in-depth evaluation, allocate 10% of your program budget (estimated in-kind and OHHP provincial funds) for an evaluation.*

4.0 Program Plan Template

Q: Is the Program Plan template final?

A: *No. The final version will be forwarded by December 2, 2003.*

Q: In a program like Workplace Wellness, there are potentially many approaches to be taken with the various activities planned. How many "approaches" can be checked off on the Program Plan?

A: *One approach can be checked under the "primary" column and as many as apply under the "other" column. Select the primary approach based on the one to which you will allocate the greatest percentage of resources (funds, material, time) over the 21 month period.*

Q: In the section of the Program Plan titled "Community Partners", there may be different partners involved in specific activities under a single program heading. Should we differentiate partners according to the activities they're involved with, or just include them all in one list?

A: *The requirement is that you list all partners involved in each program. If there are several activities under one program, and therefore several partners, you may put them all into one list.*

- Q:** Within the section on the Program Plan titled "Status of Program":
- a) For the question "Is this a "recommended program?" - if under one program there are a number of activities, not all of which are 'recommended practices', should we specify only the activities we feel qualify as such?
 - b) Where we are asked to differentiate between existing and new programs, but we may have programs that have activities that differ in terms of whether they're existing or new, how do we address this?
- A:**
- a) *"Recommended practices" are at the program and not the activity level. The activity level is where the Partnership would make decisions about how they see the program best delivered in their community. For example, with the Eat Smart Cafeteria Program, the program would be the recommended practice, and the local activities, e.g., promotional campaign, menu choices, etc., would help to implement changes at the local level to implement the goal of the program.*
 - b) *Identification of whether a program is an existing or a new one should always take place at the program level and not at the activity level.*

5.0 Logic Model Template

- Q:** Are we permitted to use programs other than Excel to create the Logic Model, as long as the same categories are used?
- A:** *The Logic Model is being converted into Word. We encourage you to use this version if you are having trouble with Excel. Please keep in mind that if you convert it into other programs, (e.g., Visio), ministry staff and consultants will not be able to access it.*
- Q:** On the Logic Model beside the 'Programs' line, we have 6 boxes, each explaining the different programs we will be doing e.g., Comprehensive School Health, Community Development, Workplace Wellness, etc. On the line for 'Activities' we placed all the activities that will be included under each program, e.g., for Community Development the activities will be Families In Training, Eat Smart, Summer Active, etc. Do I fill out just one Program Plan sheet (template) for Community Development? When I write the program description and list the activities, do I have to fill out a Program Plan sheet (template) for each activity, e.g., Eat Smart, Families In Training, Summer Active?
- A:** *"Community Development" is the strategy and "Eat Smart" (for example) is the program. Therefore you need to complete a Program Plan sheet for Eat Smart. The activities of Eat Smart (e.g., training, promotion, dining guide, tent cards, and recruitment of restaurants) fall within the Activity lines of both the Logic Model and the Program Plan.*
- Q:** Can you clarify the purpose of the Logic Model in terms of being a four-year plan? It seems that there is an expectation that we provide more detail about the activities and programming objectives which relate to the next 21 months on the Logic Model, rather than in the Operational Plan. I thought the Logic Model was intended to be more of an overview of the next four years.

A: *The Logic Model is intended to provide an overview of the overall program: to identify the strategies and populations that will be the focus over the next four years, and to illustrate how these link to the longer-term objectives and the goal of the local and the provincial program. However, it was decided that all activities for each program be included in the Logic Model and therefore taken out of the Program Plan, to avoid duplication.*

To further clarify, there is an overlap between the Logic Model and the Operational Plan, which occurs at the program level. For example, for each program listed in the Logic Model, you need to complete a Program Plan form. Given that the 21-month Operational Plan (Year 1) will be submitted concurrently with the four-year plan (the Logic Model), detail about the activities within each program for the first 21 months should be provided within the latter. To eliminate duplication, these details are not required on the Program Plan form. For the second Operational Plan (Years 3 &4), the Programs, Activities, and Programming Objectives components of the Logic Model will need to be updated.

**OHHP - Taking Action for Healthy Living
Questions and Answers
Health Promotion & Wellness, Public Health Branch
Ministry of Health & Long-Term Care
December 5, 2003**

1.0 Program Administration

Q: If we do not use all of Year 6 funding, can we carry it over year 7?

A: *No. Any funds not spent by year-end must be returned to the Ministry of Finance. In addition, please note the following: Public Health Branch now requires Health Departments to project whether 100% of annual heart health funding allocations will be used. If not, projected surplus will be recovered in-year, rather than at year-end, as was previously done. However, this will not change your allocation for the following year.*

We recommend that OHHP coordinators work closely with the financial officers within their health units to ensure that the projections they report to the ministry are in line with the needs of your Community Partnerships.

Q: Will health units receive anything in writing about this new requirement?

A: *No. This has already been implemented. Therefore, please contact your financial officers as soon as possible.*

Q: We have just learned that the cost of our community telephone survey taking place in January and February 2004 will be \$3,000 more than planned because PHRED is contracting out this kind of work. Could we pay the \$3,000 with next year's (i.e., 2004) budget?

A: *This is not allowed. OHHP funds that will be spent after April 2004 are linked to programs taking place from April 1, 2004 to December 31, 2005 that will be included in your operational plan.*

Q: What are the timelines for approval of proposals?

A: *Please refer to pages 3 & 4 of the Guidelines for the Completion of the Operational Plan.*

Q: How do we maintain momentum between submitting the proposal and waiting for approval?

A: *The letter of approval is the official notice to the host organization that your plan has been approved.*

- Q:** What should be included in the letter of support from the Chair (from page 5, item b, in the Submission Package)?
- A:** *The letter should show involvement on the part of the Community Partnership in the planning process, including its participation in the development of the submission; its commitment to the program; and demonstration of in-kind support to the program, with the minimum required 1:1 matching of provincial funds. Attached to the Qs and As is a sample letter of support.*
- Q:** Does every subcommittee and working committee within a local project need to submit a letter of support?
- A:** *The requirement is that one letter be submitted on behalf of the Community Partnerships (CP). The Community Partnership may have all partner agencies sign the letter, if desired. If there are multiple coalitions, the CP is still only required to submit one letter on behalf of all the coalitions, but may submit letters from each Chair.*
- Q:** Do we need to provide letters of support for individual activities such as Food Access?
- A:** *The letter is required on behalf of the whole CP, but it is not needed for individual programs or activities.*
- Q:** What should we do in the event that the individual with sign-off authority cannot sign by the submission date of January 15, 2004?
- A:** ***You must** submit your proposal for January 15, indicating that it is draft. Forward the final submission as soon as possible after that.*
- Q:** What are the dates for making changes to the plans?
- A:** As outlined in the Guidelines for the Completion of the Operation Plan (pages 5 and 6), you will have the opportunity to revise your first Operational Plan and submit it to the ministry for November 30, 2004.
- Q:** How do you define a “substantive contribution”?
- A:** *In stating that partners must demonstrate a "substantive contribution" to the program, we mean that they must contribute time or dollars. For example, a partner that only participated on a committee once or twice a year, contributing a few hours in total to the program, should not be considered to have made a substantive contribution.*
- Q:** Within certain Community Partnerships, it is volunteers rather than agencies that drive specific programs. This is usually due to geographic or other circumstances and the volunteers always have a history of involvement with the partnership. In these cases, would individual volunteers qualify as partners?

A: *Yes, as long as they had a history with the CP. In addition, when several volunteers are represented as a collective within a program they are considered to be a partner.*

Q: Can two people constitute a partner/organization?

A: *In some cases, two people might be considered to be a collective of individuals, which would be qualify as a partner. For example, a group of individuals who have a history of working together may be considered to be a partner or an organization. We are prepared to be flexible in terms of how we approach this, recognizing that one size does not fit all across the thirty-seven local projects.*

2.0 Planning

Q: We are considering focusing on adults for the next four years. This decision is largely based on the rationale that it is more effective to provide a stronger "dosage" of health promotion programming to a narrower audience. We have negotiated with other agencies within the community to ensure that they are targeting other audiences. Is this permitted?

A: *You will need to provide a solid rationale for this in the narrative component of your four-year strategic plan showing how this approach meets the needs of the community and how it coincides with the direction of the OHHP.*

Q: Our CP has piloted and run a successful weekly smoking cessation support group in one area. We want to extend the program to another area next year. We would partner with an addiction group who would facilitate the group and OHHP funds would be used for advertising and supplies. Could we use OHHP funds as well for a receptionist (student) for the group at a cost of \$1,500 for 12 month? We would invest on sustainability options for this administrative position.

A: *This is possible given that: a) it is a small "time-limited contracted administrative service" filled by a student, not a health unit staff; b) there is a strong contribution from a partner and c) the expenditures are likely to be sustained in the following year.*

Q: If we don't have partners in place for programs at the time of submission, can the program be included in the overall plan?

A: *As indicated in question 4 of the November 26 Qs&As, partners need to be committed to the program at time of submission. If you don't have partners in place for specific programs you should work toward getting them on board and add those programs to your revised plan by November 30, 2004.*

Q: Our CP might want to participate in other programs (e.g. stroke strategy, Canada on the Move) at a later date? How can we take advantage of programs and new partnership opportunities?

- A:** *Should your CP desire to take advantage of other opportunities at a later date and you need an approval before the revision date of November 30, 2004, please provide your Program Coordinator with the following information: a) a rationale for pursuing this program b) the value added to your OHHP Operational Plan; c) how this program meets the OHHP guidelines. You will also need to indicate how the reallocation of funds to this new program impact on other program(s) of your CP and budget.*
- Q:** Will we be permitted to change our plans and/or take on a new partner(s)?
- A:** *Yes. If you become aware of opportunities to add a new partner(s) to your program you may do so. However, keep in mind that you will need to revise your plan for November 30, 2004.*
- Q:** What should we do with respect to programs where the health unit is the only partner such as Eat Smart!, Community Food Advisory Programs (CFA), and some workplace programs? These are programs that we don't want to lose.
- A:** *A program does not qualify unless there are two community partners. Because these are valuable programs, we recommend that you look at how you can build community partnerships into these programs. For more information please contact the Nutrition Resource Centre (NRC). They have developed a chart, which outlines how local projects have integrated local partners into these programs.*
- Q:** Do workplace programs that demonstrate components of partnership participation, e.g., "Workplace Week" programs, qualify for the OHHP?
- A:** *Yes.*
- Q:** In some regions, several OHHP Coordinators collaborate in the implementation of Programs. Would that be considered multiple partners?
- A:** *We recommend bringing in other community partners, not connected with a Board of Health or other host organization.*
- Q:** Do we have to include policy development in our plans?
- A:** *You need to state in your plan that your intent is to address policy development and that you will expand on this as the opportunities arise. You also need to detail the activities related to this program, and how you are working with partners. Keep in mind that policy development doesn't need to be accomplished over 21 months, but can be over the next four years*
- Q:** When will the supporting reference documents be available?
- A:** *The Reference Materials will be distributed by December 8, 2003.*

Q: Can we include programs that would not have the "recommended" status in our plans?

A: *The expectation is that you will strive to use recommended programs, as often as possible.*

3.0 Narrative

Q: How long should the narrative be?

A: *As indicated on page 22 of the Submission Package, the narrative should be a maximum of five pages. The purpose of the narrative is to help the reviewer understand the context for the program. While some programs may not require much explanation, others may require more, e.g., in the case where there is a focus on only one population.*

Keeping the reader in mind, provide a rationale for every component in the Logic Model (i.e. vision, mission, objectives, programs, population and strategies). You may use the narrative to address questions that you anticipate might be raised by the reader. In addition, describe any unique features related to the process of planning.

Q: Do you wish to receive a summary of the rationale for each element in the Logic Model or was it intended to be a more generic overview of the "big picture" elements that influence the change in direction?

A: *We do expect to receive a summary of the rationale for each element in the Logic Model. However, if some elements are the same, you do not need to repeat the information in a new summary, but indicate that it is the same. If information differs from element to element, then specify what these differences are. In terms of evaluation, this information will be important because it will help the evaluator to understand the context for the overall project. It's also useful with respect to determining accountability.*

4.0 Full-time FTE

Q: In the event that a submission puts forward less than one FTE person in the OHHP coordinator position, who has the responsibility to explain the reason for this decision to the ministry?

A: *It is the responsibility of the senior management of the host organization.*

Q: What will be the consequence if a proposal identifies less than one person FTE in the OHHP coordinator position?

A: *The ministry will review these proposals on a case by case basis. It is not possible at this time to identify a consequence.*

Q: Are there any guidelines with respect to the job description for the OHHP Coordinator?

A: *The Reference Material provides a chart that outlines the functions of this position.*

Q: Can we submit our current job descriptions?

A: *You may submit your job description, as long as they include your responsibilities as the OHHP Coordinator.*

Q: Can the coordinator be the Chair of the Community Partnership?

A: *It is not advisable that the OHHP Coordinator also fill the Chair position. When that is the case, we recommend that you replace the Coordinator with a community partners.*

5.0 Evaluation

Q: In the Submission Package it states that "Community Partnerships must allocate up to 10% of their funding to local evaluation." Does that mean that they must allocate up to 10% each year? Must the 10% of funding for evaluation be used each year?

A: *You will have 21 months to spend up to 10% in the first Operational Plan timeline. For example, if your 21 months budget is \$175,000, you may use up to 10 % (\$17,500) either in the first 9 months or in the following 12 months or spread across the 21 months. The same principle will apply for your second Operational Plan of 24 months.*

Q: Should we evaluate one program within each strategy?

A: *You are required to nominate one program overall for in-depth evaluation, but you may nominate more than one program.*

Q: What is the time frame for the evaluation support to be in place?

A: *We are unable to provide a time frame at this time. Currently the HHRC has been providing regional training on evaluation for both this and next year's plans. Negotiation with THCU, HHRC and MOHLTC has begun for additional supports. An Evaluation Team will also offer support.*

Q: Where a program is taking place in more than one community, could it be evaluated across a number of CPs?

A: *Opportunities for collaboration are positive, although not a requirement. This is something that could be looked into further.*

Q: Does the program to be evaluated have to take place within the first 21 months?

A: *The program is to be evaluated over the four years. If you don't identify a program at the outset, you may not have time to undertake the program that warrants a solid evaluation.*

6.0 Program Plan Template

Q: When will the electronic version of the Program Plan template be available?

A: *It will be available the week of December 1 – 5.*

Q: Why does the MOHLTC want a list of other funding sources on the Program Plan form?

A: *This information will help to inform the provincial evaluation. It captures the richness of the linkages and connections outside of the OHHP partners.*

Q: Should programs from various geographical areas appear together in the Program Plan?

A: *They should be grouped together and you would indicate the appropriate "Jurisdiction Covered" on the Program Plan template.*

Q: Do we have to use the template when we are doing our planning?

A: *During the planning process, if you have developed forms that work for your partnership, you may use them. You must submit completed Program Plans using the template.*

Q: In the box titled "Use of Provincial Resources and Programs" it states, "Please check programs will be used in this program". If we intend to simply highlight or promote any of these resources during the program period rather than actually use them, should we check off the relevant boxes? Or do we only check the boxes if we are physically distributing the resources or otherwise building our program around them?

A: *You should not check off any of the boxes unless you will be actively disseminating the resources. Resources must be attached to a program.*

Q: When will coordinators be able to enter information on-line?

A: *We do not know at this time.*

Q: How do we report resources that are used for community mobilization or those that support meeting costs?

A: *You should include a Program Plan for Community Mobilization. All MOHLTC funds must add up to your total OHHP provincial allocation. The kinds of activities and costs captured on the Program Plan template as Community Mobilization can include professional development, capacity building, meeting costs, administrative costs, costs for food.*

7.0 Logic Model

Q: What is the ministry's definition of a) "programs" and b) "strategies"

A: ***a) Programs:** A well-organized series of activities designed to facilitate change in a well-defined target group. This definition is consistent with that used in “What Works in Nutrition Promotion”, Nutrition Resource Centre and “International Scans for Best Practices in Heart Health”, Heart Health Resource Centre.*

***b) Strategy:** A group of programs that are related to the same goal, usually within a setting or a population. Strategies are often based on pressing issues or challenges affecting the achievement of the mission and vision, values and services. They describe a major area of responsibility over a 2-4 year period and usually require collaboration among stakeholders to ensure success, so therefore are usually tied to stakeholder needs and expectations in order to engage them. In the context of the OHHP, a CP might establish a Workplace strategy, or Youth Strategy or a Physical Activity strategy. Often the structure of work groups are based on these strategies.*

Q: What happens if we find out in year two or three that a program will no longer be relevant on the Logic Model?

A: *You will have an opportunity to update your Logic Model when you submit your second Operational Plan.*

Q: What about programs that no longer require funding?

A: *Once a program has become sustainable outside of the OHHP, you should remove it from the Logic Model.*

Q: If a working group has four programs planned under one strategy, does this mean that we need to include activities and programming objectives in the Logic Model for each individual program?

A: *Yes, even though you may have many programs, e.g., 20 or more. Your activities may not fit on one page. You also need to fill out a Program Plan form for each program. When completed, the logic model will provide an overview of what the CP is doing over the four years. Description comes in the plan.*

The HHRC provides support to those who would like some help with their Logic Models, or help in determining what is a strategy, a program and activities.

Q: Where will there be examples of Logic Models?

A: *Several OHHP Coordinators have worked with the HHRC and a number of logic models will soon be ready to either be posted on the HHRC website or can be obtained directly*

from OHHP coordinators. The HHRC will update OHHP Coordinators through the listserv.

8.0 Budget

Q: When we have revenue from a project, what do we do with it and how do we report it?

A: *Please report any revenue from your project on the Financial Report under "Revenue from the Project. Your CP can carry over and reinvest these funds in programs. It will not reduce your allocation. Note: it is a requirement of the submission that you address within your terms of reference how you will handle revenue generation.*

9.0 Community Contribution Program (CCP)

Q: Is it necessary for the CCP to have a particular target or focus for the 21 months?

A: *No.*

Q: How does the CCP differ from other Programs?

A: *Within the CCP you may use up to 10% of your overall budget. The CCP can function as seed funding. Some CPs initiate requests for proposals for small amounts of money. CPs are required to provide the specific information on each program they approve when they revise their Program Plans on November 30, 2004.*

10.0 Training and Support Needs

Q: In the Submission Package we are directed to identify our training support needs (page 6, section G). What should we do if we don't know yet what our needs are?

A: *This information should be provided with your revised plans on November 30, 2004.*

11.0 Volunteer Management Policies

Q: What should we do if we don't have policies regarding volunteer management?

A: *It is a requirement of the submission that you address volunteer management in your Terms of Reference. The HHRC will develop a collection of volunteer management policies to assist CPs in this regard and will post them on its website.*

SAMPLE 'LETTER OF INTENT'

<Date>

<Name of HU>

<Address of HU>

Dear <Name of MOH or other applicant>

On behalf of the <Name of Community Partnership>, I am writing to indicate our support, as partner agencies, to the <Name of HU> in submitting a proposal to the Ministry of Health and Long-Term Care for Phase II of the Ontario Heart Health Program (OHHP). The members of this Partnership have been closely involved in the planning process that has taken place to develop this proposal. We are committed to the success of the <Name of the Project> and we are prepared to support it with in-kind contributions of at least one half of provincial funds.

We wish every success for all of the Community Partnership's endeavours and we are confident that our community will benefit from the OHHP.

Sincerely,

<name of Chair>

<Title (optional)>

Health Care Programs

Programmes des soins de santé

Health Promotion and Wellness
Public Health Branch

5700 Yonge Street, 4th Floor

North York ON M2M 4K5

Telephone: (416) 314-5493

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Promotion de la santé et mieux-être
Direction de la santé publique

5700, rue Yonge, 4ème étage

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DATE: May 7, 2004

MEMO TO: OHHP Coordinators

FROM: Myrna Gough
Carol Gold
Huguette Jacobson

RE: OHHP - Phase II Reporting Guidelines and Templates

We are pleased to forward the reporting guidelines and the templates for OHHP Phase II. These reporting forms and guidelines have undergone an extensive development process that began as part of the Phase II planning process, spearheaded by the Planning, Reporting and Evaluation (PRE) Working Group. The PRE Working Group had many inputs to consider, including the Preliminary Evaluation Report (2002), the report from the Continuation Working Group, and a qualitative study in 2003 on aspects of the OHHP model. Although the PRE group disbanded once the Submission Guidelines for Phase II were completed, a subsequent committee agreed to provide direction and advice on Phase II planning and reporting requirements using PRE's early developmental work. Barb Riley (Phase I evaluator) contributed to this process by developing and completing a 'draft final version' for yet another review process. Both new and 'veteran' Coordinators were involved in this two-stage review process, which included providing written comments and participating in a follow-up conference call. The input from both the committee and the additional reviewers was extremely helpful to Barb in finalizing the documents. We thank everyone kindly for their efforts.

Please review these Guidelines carefully before the OHHP meeting on May 18th. In the development process, we quickly learned that the best way to figure out what is clear and what is confusing is by filling out the forms. Therefore, please fill out a minimum of one Program Report in preparation for the 18th. At the meeting, you will be asked to identify any issues or questions you may have about reporting, and you will have an opportunity to discuss these both individually and in group discussions. Those of you who have had experience with OHHP reporting, please think about any advice or tips that you could offer on how to complete the reports (e.g., lead time for finance department, how and when to collect in-kind data from community partners, how to keep track of program information throughout the year, etc). We will pool your wisdom on the 18th!

.../2

Please note that the guidelines describe the plans to develop an on-line system for reporting (and planning). The attached forms and guidelines represent the core content for the on-line system. They are intended to be used as paper forms until the on-line system is ready. Accordingly, in their current format the forms are not designed for electronic data entry. However, if desired, it is possible to use them electronically.

If you have questions, please do not hesitate to contact either Huguette Jacobson at 416 314-5482 or Carol Gold at 416 314-5503. We are looking forward to the discussion on May 18, 2004. Thanks again for your work and your individual contributions to ensure the success of *OHHP - Taking Action for Healthy Living Partnership*.

ONTARIO HEART HEALTH PROGRAM:
Taking Action for Healthy Living

**GUIDELINES
FOR COMPLETING
REPORTS**

PHASE II
(April 2004 – December 2007)

Health Promotion & Wellness, Public Health Branch,
Ontario Ministry of Health and Long-term Care



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OHHP – *Taking Action for Healthy Living* Guidelines for Completing Reports

April 1, 2004 – December 31, 2007

A: Overview

OHHP Community Partnerships are required to submit four reporting components:

- a. Financial Report
- b. In-kind Contributions Report
- c. Program Reports
- d. Narrative Report

Submission dates are in Section B.

The report components follow directly from your plans, and use the same definitions and terms (with refinements, as needed).

This package contains paper versions of all forms. The expectation is that on-line reporting will be available by January 2005 at the latest, for completion of the first report (for the first nine months of Phase II). Throughout 2004 (while the electronic system is being developed and pilot tested), please record information on the enclosed paper forms.

Local reporting has four main purposes:

1. **Local planning and evaluation:** Common reporting across the OHHP allows all community partnerships to learn about programs undertaken in other communities. Reporting allows community partnerships to evaluate if they have met their programming objectives. It also provides an opportunity to reflect on programs – their selection, planning and implementation – to inform future plans.
2. **Administration:** Program Coordinators at the Ministry of Health and Long-Term Care review reports for accountability; that is, to review use of provincial OHHP funds and compliance with the submission requirements and with approved program plans and budget.
3. **Technical support:** The Heart Health Resource Centre (HHRC) uses reports to inform its plans for training and consultation, and to identify possible programs to review for best practices. The HHRC, along with other provincial partners, also look for opportunities for local-provincial joint action (e.g., for policy change).
4. **Evaluation:** The provincial evaluators use information from local reports to describe implementation of the OHHP, with a focus on the nature and amount of programming that will most likely impact on OHHP population, environmental and organizational capacity objectives.

The main content of the four reports is shown in the table below:

COMPONENT	CONTENT
Financial Report	Expenses in relation to standard budget categories
In-kind Contributions Report	Personnel and non-personnel contributions from the local board of health and other community partners
Program Reports	Description of programs (e.g., strategy, focus, channel, audience, approach, activities) and their implementation during the reporting period
Narrative Report (for the overall project)	Commentary on strategic directions, partnership development, successes, challenges and lessons learned for the overall project (not specific to individual programs)

B. Submission Guidelines

Submit reports to your Program Coordinator at Health Promotion and Wellness, Public Health Branch, Ministry of Health and Long-Term Care.

Typically, 'interim' (6-month) reports are required for financial and in-kind contribution reports (for this 21-month period **only**, 'interim' Program and Narrative reports are also required). 'Final' (year-end) reports are required for all four reporting components. **Year-end reports are cumulative for the full reporting period** (therefore, include information from the interim reports).

The typical 6-month and 12-month time periods for the reports are revised for the initial 21-month planning and reporting period for Phase II (Apr1/04 to Dec31/05). Below are submission dates for all plans and reports for the initial 21-month period. Dates for submitting revised plans and budgets are included to provide local projects with a single reference for all plan and report dates; and to illustrate the link between plans and reports. All reports and payments will also be identified in the Project Profile provided by the MOHLTC to approved programs.

At a later date, a similar table will be provided for the last 24 months of OHHP-Phase II.

For both interim and final reports, please submit:

1 copy of all **Financial and In-kind contribution Reports**

3 copies of all **Program and Narrative Reports**

REPORT	SUBMISSION DATE
Updated Submission for Apr1/04 to Dec31/05 Include updates to: <ul style="list-style-type: none"> - Terms of reference - Training support needs - Program Plans - Logic model - Community Contribution program 	November 15, 2004

REPORT	SUBMISSION DATE
- Budget More detailed instructions for this Updated Submission will be provided by the MOHLTC.	
Interim Reports for Apr1/04 to Dec31/04 <ul style="list-style-type: none"> • Financial Report • In-kind Contributions Report • Program Reports • Narrative Report 	February 15, 2005
Interim Reports for Jan1/05 to Jun30/05 <ul style="list-style-type: none"> • Financial Report • In-kind Contributions Report 	August 15, 2005
Year-end Financial Projection for Oct1/05 to Dec31/05 NOTE: This is a 3-month year-end projection. Further information about the report format will be provided at a later date.	October 15, 2005
Operational Plan and Budget for Jan1/06 to Dec31/07	October 30, 2005
Final Reports for Apr1/04 to Dec31/05 <ul style="list-style-type: none"> • Financial Report • In-kind Contributions Report • Program Reports • Narrative Report NOTE: these reports are cumulative for the 21-month reporting period	February 15, 2006

NOTE: Although no other submissions are required in addition to the above listing, please note that local projects should not make any changes to the budget without the prior written consent of the Ministry. Please refer to Section 5 "Budget" of the Agreement.

Direct any questions about reporting to your Program Coordinator:

Huguette Jacobson Tel: 416-314-5482 Fax: 416-314-5497 E-mail: huguette.jacobson@moh.gov.on.ca	Carol Gold Tel: 416-314-5503 Fax: 416-314-5497 E-mail: carol.gold@moh.gov.on.ca
Mailing address: Health Promotion and Wellness Public Health Branch, Ministry of Health and Long Term Care 5700 Yonge Street, 4 th Floor Toronto, ON M2M 4K5	

In submitting reports to the MOHLTC, community partnerships agree that the reports will be shared with the HHRC and the provincial evaluator.

C: Process to Review and Provide Feedback on Local Reports

- Health Promotion and Wellness will review all reports for compliance with guidelines and use of provincial OHHP funds. Unless further clarifications are required, OHHP Coordinators will receive confirmation of receipt and approval of reports within six weeks of reports being submitted.
- Any follow-up or clarification for administrative purposes will be requested by the Ministry Program Coordinators from the OHHP Coordinators.
- Information will be housed centrally.
- The content, format and responsibility for developing feedback reports will be determined in the first year of the OHHP-Phase II. These reports will be provided to local and provincial stakeholders when the system has been implemented.

D: Guidelines to Complete Report Components

(i) Financial Report

Report all expenses in relation to the standard categories, as defined on the report form. Note that reports are cumulative for the first 21 months and then for calendar years thereafter.

(ii) In-kind Contributions Report

In-kind contributions provide evidence of the local-provincial partnership for the OHHP. The combination of provincial OHHP funding and in-kind contributions provides the most accurate and complete picture of resources invested in the OHHP. This complete picture is essential to inform discussions about resource allocation and other supports at both local and provincial levels.

Local projects are not asked to provide the dollar value for all in-kind contributions. However, dollar values will be estimated centrally and reported back to local and provincial stakeholders when the system has been implemented.

Complete all sections of the in-kind contributions report. All sections are for the current reporting period.

OHHP COORDINATOR: Record the host organization and any changes to the Coordinator position during the reporting period. Complete one row for each new Coordinator. Under position title, record the position title of the OHHP Coordinator (e.g., CDP Coordinator, OHHP Coordinator, Health Promoter, etc). Complete a row for the Coordinator who is in the position at the end of the reporting period. This person will have a start date but no end date. **Note:** The start date may precede the start date of Phase II (Apr1/04) if the Coordinator has not changed since Phase I or the transition year (2003/04).

VOLUNTEERS: Record the total number of volunteers during the reporting period. Volunteers reported may or may not be volunteers of one or more partner organizations (e.g., Heart and Stroke, Cancer Society, Health Unit). Record the total number of hours during the reporting period. This is the sum total of hours for all volunteers reported under 'total number' of volunteers.

HUMAN RESOURCE CONTRIBUTIONS:

Board of Health. Report all positions that spent some time on the OHHP. Report each position separately (Enforcement Officer, Epidemiologist, Public Health Nurse). Include all staff dedicating time to the OHHP, including those offering clerical, administrative, management, financial and program support. Include time spent on organizational aspects of the OHHP, and/or on planning, delivering and evaluating OHHP programs.

Under ‘%FTE or hours for the reporting period’, report the most appropriate unit for time spent for each position during the reporting period. For example, it may be 20% of time for the full reporting period, or it may be 15 hours total, 4 hours per month, etc.

Under “Salary/Wage” report the salary (i.e., annual salary) or wage (e.g., dollars/hour) for each position. Include employee benefits in the salary/ wage figures reported. You do not need to calculate the salary/wage for the time spent during the reporting period.

Other Community Partners. In this table, report time spent by all community partners (other than the board of health). Under “Total Number of Staff”, report the total number of staff from partner organizations that spent time on the OHHP during the reporting period. Report management-level positions separate from non-management positions (e.g., program, clerical, finance, technical, research & evaluation, etc). Include time spent on organizational aspects of the OHHP, and/or on planning, delivering and/or evaluating OHHP programs.

Note: The dollar value of time spent by community partners is not required. It will, however, be calculated centrally and reported to local and provincial stakeholders when the system has been implemented.

NON-PERSONNEL CONTRIBUTIONS:

Complete each row, as appropriate, for board of health and for other community partners. Include non-personnel expenses for organizational aspects of the OHHP and/or for aspects of planning, delivering and/or evaluating OHHP programs. Please note the units suggested for each item. For items requesting dollar values and for which dollar values are not available, use the following guidelines:

TYPE OF EXPENSE	TO ESTIMATE DOLLAR COST
Mileage	35¢ per kilometer
Photocopies	7 ¢ per copy
Telephone or fax line	\$38 per line, per month
A-V Equipment (TV/VCR, projector)	\$50 per day for TV/VCR or projector; \$100 per day for LCD data projector

COMMUNITY PARTNER ORGANIZATIONS:

Report the total number of organizations (including the Board of Health) that contributed personnel or non-personnel resources to the OHHP during the reporting period. Therefore, each organization listed should be reflected in one or both of the sections reporting Human Resource Contributions or Non-Personnel Contributions. Each organization reported should have a separate management structure, though not necessarily be administratively distinct. For example, different departments within local

government (e.g., Parks and Recreation, Housing, Transportation) should be reported as separate partner organizations.

(iii) Program Report

Include a Program Report for each program that was in your Operational Plan for the same reporting period. Explain all variances from plans, including programs for which nothing was done (box is provided on the Program Report). Also include a Program Report for any new programs that were not included in your Operational Plan, but for which OHHP provincial funds were dedicated and in which two or more partners actively participated.

All OHHP provincial funds should be reflected in your Program Reports.

Each of the following headings refers to the corresponding section of the Program Report. All sections are to be completed for every program. Please use your Program Plans as a starting point, so that you can directly transfer some information, and identify what, if anything, has changed since submitting your Plan (which will be reported under Variance from plans).

LOCAL PROJECT AND HOST ORGANIZATION: Record the name of the local OHHP project and the organization that is legally accountable for the project.

JURISDICTION COVERED: Several local projects have more than one Community Partnership, each covering a specific geographic area within the full project area. Indicate if the Program Report is for the full local project area (i.e., full health unit area) or part of it. Specify the partial jurisdiction.

CONTACT PERSON AND PHONE NUMBER: Record the name of the OHHP Coordinator who is the contact person for the full report.

NAME OF PROGRAM: Record the name of the program, as it is currently called in your Operational Plan.

LANGUAGE: Check all the languages in which program delivery or program materials are available. If available in other languages, specify all of the individual languages.

STRATEGY: Record the name of the strategy within which the program is located.

PROGRAM DESCRIPTION: Please provide a 2-3 sentence description of the program. Provide more information than what is in the name of the program, but not all the details of the specific activities. To gauge the scope of the description to include, picture someone reading the Program Report who knows nothing else about your project, but wants to understand the major focus of this particular program.

Some examples of a Program Description:

"This Communication Campaign ran for six months, kicking off in February (Heart Month), and culminating with a July event at our local waterfront. It included a mix of broadcast media, community events, and small group presentations, all geared to young moms with the emphasis being on working through the social networks to which they belong."

"This Walking Program occurred in urban neighbourhoods. Women from the local area were recruited, trained and supported as walking group leaders. Walk This Way! materials were distributed to participants. Walking routes were mapped in 4 communities before the clubs were started."

“This Active Commuting program builds on previous work done in our community in developing walking trails. We carried out several planning steps for a policy initiative to ensure active commuting lanes on selected streets. We initiated discussions with municipal urban planners, gathered evidence and examples of how this worked in other communities, supported a Feasibility Study, including surveying the public regarding their support for this approach, and the recruitment of partners to work on this policy initiative.”

VARIANCE FROM PLANS, AND BRIEF EXPLANATION: Since developing your Operational Plan, many things may have changed with respect to a program. Please itemize main changes and provide a rationale for changes made to your plans, including any changes made in allocation of OHHP provincial funding. If nothing was done on a program (that was in your Operational Plan), include a Program Report and describe the change (e.g., cancelled, deferred) in this section and offer a brief rationale, including how you have reallocated the provincial funds. For any additional programs that were not part of your Operational Plan, include a Program Report and explain why the program was added in this section.

OHHP OUTCOME OBJECTIVES:

Population: Population objectives refer to changes in behaviours and other risk factors that contribute to cardiovascular and other chronic diseases. Check the one or more boxes that correspond to the long-term desired impacts of the program. An “other” option is provided, but should only be used if the objective was approved in your Operational Plan. OHHP programs are intended to address the six population objectives below, either directly or indirectly.

CODE	POPULATION OBJECTIVE
Tob-Teens	Decreasing the percentage of teens who are current cigarette smokers
Tob-Adults	Decreasing the percentage of adults who are current cigarette smokers (ages 18 and older).
Tob-Quit	Increasing the percentage of daily smokers who will make at least one attempt to quit smoking per year.
Nutrition	Increasing the percentage of Ontarians who consume five or more servings of vegetables and fruits daily.
Phys Act	Increasing the percentage of Ontarians who participate in moderate to vigorous activity on most days of the week.
BMI	Decreasing the percentage of Ontarians who are obese, as measured by a body mass index greater to or over 30.
Other	Specify (as approved in your Operational Plan)

Environmental: Environmental objectives are changes in social and physical environments that contribute to population objectives. While there is not a definitive set of OHHP environmental objectives, the codes reflect some main changes that OHHP projects may aim to achieve. Many (but not necessarily all) programs will have environmental objectives, since this is a main focus in OHHP-Phase II. Check all that apply for this program or ‘None’ (for no environmental objective).

CODE	ENVIRONMENTAL OBJECTIVE
Active Transport	Increasing availability or use of walking trails, bicycle paths, or routes that promote active modes of transportation
Daily PA	Increasing time spent on daily physical activity in curriculum

CODE	ENVIRONMENTAL OBJECTIVE
Food choices	Increasing availability of healthy food choices
Signage	Providing point of purchase, or point of decision (e.g., at stairs) information
Providers	Increasing provider knowledge and skills for program delivery
Smoke-free Sp.	Increasing smoke-free spaces
Other	Please specify

Organizational Capacity: Organizational capacity objectives refer to changes in practices or beliefs of the *community partnership* (i.e., not program providers in various community channels). Not all programs will have organizational capacity objectives. Check all that apply for each program or 'None' (for no organizational capacity objectives).

CODE	ORGANIZATIONAL CAPACITY OBJECTIVE
Interest	Increasing interest in the OHHP among possible community partners (i.e., recruiting new partners)
In-kind	Increasing participation and contributions from community partners
Assess & Plan	Increasing knowledge and/or skills within the community partnership related to assessment and planning
Implement	Increasing knowledge and/or skills within the community partnership related to implementing programs (e.g., mobilizing appropriate resources, recruiting participants, etc)
Evaluation	Increasing knowledge and/or skills within the community partnership related to evaluation
Sustain/ transfer	Increasing knowledge and/or skills within the community partnership related to sustaining and transferring programs (Note: programs do not necessarily have to be transferred for this objective to be met)
Other	Please specify

OHHP MANDATE FOCUS: Select one or more of the three risk factors that were addressed during the reporting period. Please note that there is no "multiple risk factor" option. Check each risk factor that is addressed, whether it is addressed separately or in combination with others. Should the program not focus on one or more of the primary mandate areas of the OHHP, check "Non-specific". The program focus may be on such things as organizational development, capacity building, partnership development etc.

INTEGRATION WITH OTHER ISSUES: Many OHHP programs will address more than the three mandate areas of the OHHP. Check the one or more additional issues that are addressed explicitly with the program (i.e., not just if the program is related to it). There is no expectation that ANY of these other topics will apply to a particular program.

To assist in understanding what will fall within the category of Social Determinants of Health, consider the list outlined by Health Canada. It is not necessary to specify a particular determinant on the form.

- Income & social status
- Social supports networks
- Education
- Employment & working conditions
- Physical & social environments
- Biology & genetic endowment
- Personal health practices & coping skills
- Healthy child development
- Health services.

CHANNEL: Indicate the one primary channel for this program and as many other channels for the program that apply within this reporting period. The primary channel is the one to which your Community Partnership gave most emphasis (i.e., for planning and/or implementing a program) during the reporting period. “Other” channels are those you gave some emphasis during the reporting period, but less emphasis than the primary channel.

Use the following definitions of channels:

CHANNEL	DESCRIPTION
Media	Includes websites, newsletters, newspapers, radio, television, billboards, telephone lines, etc.
Day Cares/Nursery Schools	For children under school age in your community (JK or SK)
Schools: elementary, secondary, post secondary	Includes cafeteria and vending machines
Day Camps	Includes summer, YMCA camps, PD day programs for children
Recreation facilities	Includes public and private recreation facilities
Worksites	Includes cafeteria and vending machines
Health Care Settings	Includes hospitals, community health centres, clinics, pharmacies, health units, physician and dentist offices, long-term care
Restaurants	Includes fast foods, cafeterias not in schools or workplaces
Grocery Stores	Includes convenience stores
Community at large	Includes library, community groups, community centres, churches/faith, local events, shopping malls, community kitchens, food banks, drop-in centers
Not Applicable	Includes planning, evaluation, capacity building and other activities not specific to a particular delivery channel (e.g., strategic planning events, community surveys, etc.)

For each channel checked indicate the number of the particular organization (e.g., schools, worksites) that was actively participating in the program during the reporting period. **Note:** Under channel, you are asked to report the number or **organizations** participating (i.e., not individuals). “Actively participating” means that the organization was not merely the passive recipient of a promotion or some written material, but that it was actively using OHHP information or resources, or was collaborating in some other active way (e.g., working with OHHP staff to develop a policy). It may be that different numbers of organizations were reached with different parts of your program. Identify the number of organizations that were actively participating *in some way* (not necessarily the same way). Count each unique organization only once (i.e., do not double count), even if the same organization is involved in two different activities (e.g., health risk assessments, policy development) within this same program.

AUDIENCE: Indicate **one** primary audience and as many “other” audiences as apply to this program. If there are no “other” audiences, select “not applicable”. The primary audience is the one to which the community partnership gave the most emphasis during the reporting period. Other audiences were given some emphasis, but less than the primary audience during the reporting period. **Please note:** Your population objectives typically indicate the ultimate beneficiary (sometimes called “end-user”) for your program. The one or more audiences you record on your Program Report are not necessarily the *ultimate* beneficiary (ies). They are the audiences that you directly reached during the reporting period.

Use the following definitions to guide your selection:

AUDIENCE:	DESCRIPTION
Children	< 13 years
Youth	13 to 18 years; Grade 9 to 12
Adults – all	19 to 64 years. Includes teachers, administrators and other adults reached in the school setting; employees in the workplace setting (as end users not intermediaries)
Adults – female	19 to 64 years
Adults – male	19 to 64 years
Seniors	65+
Family / parents	
General community	
Diverse populations	Specify which population the program will be geared towards. This might include Aboriginal, ethnic, faith, cultural groups, people living with disabilities, among others. Be as specific as possible.
Community volunteers/ partners	Includes Steering Group, Community Partnership, working groups
Health care professionals	This would include allied health professionals such as kinesiologists, physiotherapists, public health nurses etc.
Education professionals	These professionals work within school settings (from pre-school to post-secondary).
Sport / Recreation/ fitness professionals	Coaches, recreation staff, personal trainers, fitness instructors etc.
Individuals living in low income situations	Could include families, women, people living in geared-to-income housing, etc.
Politicians	
Other gatekeepers/opinion leaders	Decision-makers within organizations, or those who are leaders within particular audiences

For each audience checked, indicate the number who was reached with the program. Estimate as close to actual as you can. If the same audience was reached with more than one activity in a program, estimate the reach for the most substantive part of the program (e.g., if an audience was reached with a promotion and then self-help guides, estimated reach would be for the self-help guides).

Count individuals only once (i.e., do not double count individuals, even if they were reached with more than one aspect of the program).

APPROACH: Indicate **one** primary approach and as many “other” approaches as apply to this program. If there are no “other” approaches, select “not applicable”. The primary approach is the one to which you gave the most emphasis during the reporting period. Other approaches were given some emphasis, but less than the primary approach.

Use the following definitions of approaches:

APPROACH	DESCRIPTION
Awareness	<i>Awareness</i> refers to health communication aimed at increasing knowledge and/or changing attitudes about the topic being addressed (e.g. physical activity, chronic disease prevention, heart health) in the specific intended population. It includes a mix over time of media (both broadcast or mass media such as TV, radio and newspaper, and narrowcast such as pamphlets and posters), community events such as contests, fairs, and displays, and interpersonal opportunities such as presentations, briefings and symposia.
Education	<i>Education</i> refers to providing information and the opportunity to develop skills to effect knowledge, attitude and behaviour change. It includes activities for end-users such as low-fat cooking courses, tobacco use prevention computer games, self-help groups, clubs. Also includes activities for intermediaries (those who deliver programs) such as train-the-trainer workshops and peer learning opportunities.
Environmental Support (social and physical)	<i>Environmental Support</i> refers to creating social and/or physical environments that support healthy behaviours (e.g., walking trails, bicycle racks at worksites, healthy food choices in restaurants/ vending machines, point of purchase information, inventories of heart health programs and services). This category does not include policy supports.
Policy development	<i>Policy</i> refers to changing formal or informal rules of governing bodies to support healthy behaviours (e.g., nonsmoking bylaws, bylaws for mandatory bicycle lanes, workplace policies). Policy development refers to efforts to introduce a new policy (e.g., advocacy for change, drafting terms of a policy).
Policy implementation	Policy implementation refers to efforts to assist with policy implementation (e.g., signage, enforcement).
Community Mobilization	<i>Community Mobilization</i> involves generating interest in, and commitment to, health-related matters within a community and facilitating community involvement in planning and carrying out initiatives/activities. Includes activities such as partnership building, coalition planning, training, volunteer recruitment and recognition.

COMMUNITY PARTNERS: Record the name of at least the two partners, and more if applicable, that are directly involved in one or more of the main accomplishments reported for this program during the reporting period. You may also record the name of a committee, and attach (as a separate page) partners who are members of the committee. Include organizational names of those involved rather than the names of individual committee members. As a guideline for which partners are ‘directly involved’ – those are partners who make it possible to plan and/or implement the program.

OHHP PROVINCIAL FUNDS: Record the OHHP funds your community partnership **spent** on (not allocated to) this program during the reporting period.

OTHER FUNDING SOURCES AND AMOUNT: Report any organizations or individuals that provided funds for this program (i.e., cash contributions). For instance, a program might receive funds from a national diabetes project, a Trillium project and/or a private sector source.

PROGRAM MATERIALS: Please check all types of products that were used as part of this program during the reporting period. Keep in mind that more is not necessarily better; it depends on the purpose and scope of the program. “New” program materials are those developed by your community partnership in the reporting period. “Existing” program materials are those a) developed by your community partnership in previous years; and b) developed elsewhere, and used by your local project. Many materials will likely be adapted by your community partnership. If adaptations are cosmetic only (e.g., tag line that is tailored to your community partnership, minor editorial changes), report them as *existing* program materials. If adaptations are made to content, report them as *new* program materials.

EVENTS: Please check all types of events that were carried out as part of this program during the reporting period. More is not necessarily better. The intent is to capture the nature and scope of the program. Report the total number of events held during the reporting period. Report each event *only once*. If an event is part of more than one program, report it for one program only.

The “Number of events” refers to the *total number* of events held. The same event (e.g., workshop) held 3 times would be recorded as 3 events.

MAIN ACCOMPLISHMENTS FOR THIS PERIOD: “Main accomplishments” refers to various phases of a program that occurred during the reporting period. Not all phases will apply to each program. Indicate all that your project completed, in full or in part, during the reporting period.

Use the following definitions:

MAIN AREA (PHASE)	<i>DESCRIPTION</i>
Planning	The two or more partners are in place. Objectives have been established and Program Plan completed. No implementation has yet begun.
Development / adaptation of program materials	The direction of the program has been determined and detailed plans established to the degree that now materials to support the program are being developed and focus tested prior to any implementation.
Pilot testing	The program is made selectively available to a sub-set of the intended population for the eventual program. Detailed feedback is sought through a formative evaluation in order to make any necessary improvements to the program prior to widespread implementation.
Program Implementation	Plans are complete, materials have been developed and the program has been pilot tested (if applicable). The program is now being fully implemented with the intended population.
Evaluation	This refers NOT to formative evaluation during program development but to summative, outcome or impact evaluation that may be done following program implementation.
Supports for sustainability	Efforts are underway to determine or set in place situations that will enhance the likelihood that the program will be sustained following the investment of OHHP funds. The list presented on the Program Plan could be supplemented with the suggestions within the HHRC Sustainability Manual.

USE OF PROVINCIAL RESOURCES AND PROGRAMS: Please check the resources and programs that were used in this reporting period. Use “other” for provincial resources and programs not listed. It is unlikely that *every* program will have one or more of these resources and programs checked. However, it is encouraged that local programs use provincial resources to the extent possible.

OTHER COMMENTS (OPTIONAL): This section is to assist with local planning; for your own project and for other projects that may be interested in doing something similar. Jot down any information (e.g., reflections, lessons, spin-offs, etc) that should be considered in future planning for this or other programs.

(iv) Narrative Report

The narrative report is to be completed by the community partnership. One form is to be submitted on behalf of the community partnership. Initially, the form may be used to gather information from each member of the partnership (or from relatively independent committees/ partnerships in projects with multiple coalitions). This information would then be consolidated onto one form. The overall narrative could reflect different opinions and perspectives apparent throughout the local project. The intent is not necessarily to achieve consensus; it is to reflect the richness of the local projects, including common themes and differences within each project.

HEALTH PROMOTION AND WELLNESS

HEART HEALTH PROGRAM - FINANCIAL REPORT - INTERIM / FINAL

File No:

Project Name:

Host Organization:

Funded Period: April 1, 2004 -
December 31, 2005

Period of Report:

Report Due Date (Note 1):

REVENUES AND EXPENDITURES FOR MOHLTC GRANT

REVENUES	December 31, 2004	June 30, 2005	December 31, 2005	TOTAL	APPROVED BUDGET(Note 2)
MOHLTC FUNDING					
Interest earned from MOHLTC funding (Note 3)					
Revenues from the projects					
Other sources of income(e.g. donations)					
EXPENDITURES (Net of GST)					
Salaries and Wages					
Contract Employees					
Employee Benefits					
Fee for Service					
Transportation and Communication					
Services (including rentals)					
Supplies					
Program & Materials					
Acquisition/Construction of Assets					
Other (Please Specify)					
Goods and Services Tax (GST) (Note 4)					
Total Expenditures					
Under/(Over) Expenditure (Note 5)					

I certify that the above report is an accurate statement of revenues and expenditures attributable to the project/program for the period specified and the supporting documents are available for audit.

Authorized Signature: _____

Title: _____

Date: _____

Please Print Name: _____

NOTES:

1. Report due dates are indicated in your Project Profile.
2. Fill in the approved amount for each category of expenditures as per the 21month approved budget.
3. Interest earned from MOHLTC funding must be returned to MOHLTC.
4. Enter GST amount not eligible for rebate.
5. Subtract your total expenditures only from MOHLTC funding (do not include interest earned, revenues from the project, or other sources of income)

The following is a guide to allocate your specific expenditures to the right category of expenditures on this report.

SALARIES & WAGES	EMPLOYEE BENEFITS	TRANSPORTATION & COMMUNICATION	SERVICES	SUPPLIES	PROGRAM & MATERIALS	ACQUISITION / CONSTRUCTION OF ASSETS
*Project Salaries & Wages *Allowances and Bonuses *Overtime *Contract Employees *Fee for Services	*Canada Pension Plan *Unemployment Insurance *Private Pension Plan *Group Health Insurance *Employee Health Tax *Workers Compensation *Severance Pay *Maternity	Tel. Service Charges *Tel. Equipment Rental Long Distance Charges *Facsimile Line Charges Courier Charges Mailing Cost Vehicle Rental Meal Allowance	Program Advertising *Job Advertising Media Initiatives Translation Legal Services *Repairs & Maintenance Professional Development Office Equipment Rental Professional Fees *Rental/Lease	Office Supplies *Cleaning Supplies Books & Maps *Water *Electricity *Gas for Heating	Publications Project Supplies	*Computers *Photo Copier *Fax Machine *Furniture & Fixtures

* Non-eligible expenditures under the Ontario Heart Health Program

OHHP – *Taking Action for Healthy Living* In-kind Contributions Report

Please complete all sections for the reporting period

OHHP PROJECT NAME:			
CONTACT PERSON:		PHONE NUMBER: ()	
REPORTING PERIOD:			

OHHP Coordinator

Complete one row for each individual who was OHHP Coordinator for part or all of the reporting period.

HOST ORGANIZATION:			
POSITION TITLE (not the name of each Coordinator)	START DATE (month/year)	END DATE (month/year)	

Volunteers

TOTAL NUMBER DURING REPORTING PERIOD:		TOTAL HOURS DURING REPORTING PERIOD:	
---------------------------------------	--	--------------------------------------	--

Human Resource Contributions

BOARD OF HEALTH (add more rows if needed)

POSITION TITLE	% FTE OR HOURS FOR THE REPORTING PERIOD (e.g., total hours, hours per week, hours per month)	SALARY / WAGE (including benefits)

OTHER COMMUNITY PARTNERS

TYPE OF POSITION	TOTAL NUMBER OF STAFF	% FTE OR HOURS FOR THE REPORTING PERIOD (e.g., total hours, hours per week, hours per month)
Management		
Non-Management		

NON-PERSONNEL CONTRIBUTIONS

CATEGORIES OF EXPENSES	BOARD OF HEALTH	OTHER COMMUNITY PARTNERS
Transportation (Dollar cost of travel, including meals)		
Communication (Dollar cost of long distance charges, telephone service charges, mailing costs, courier charges)		
Translation Services (Dollar cost)		
Donated Media Services (Dollar costs of discounted or free coverage by media outlets)		
Other Services (Dollar cost of legal services, office equipment ¹ , professional development)		
Supplies (Dollar cost)		
Program & Materials (Dollar cost of publications, project supplies)		
Meeting Space (Estimated time for the reporting period)		
Other (Specify: _____)		

¹ Only include office equipment specifically dedicated to the OHHP, such as computer and office furniture for the OHHP Coordinator. Report these expenses as one-time costs (i.e., do not report the depreciated value each year).

Community Partner Organizations

TOTAL NUMBER DURING REPORTING PERIOD:	
---------------------------------------	--

Attach a list of all community partner organizations. Include those that made personnel and/or non-personnel contributions during this reporting period.

OHHP PROJECT NAME:			
HOST ORGANIZATION:			
JURISDICTION COVERED:	<input type="checkbox"/> FULL PROJECT AREA	<input type="checkbox"/> PART OF PROJECT AREA: <i>Specify</i>	
CONTACT PERSON:			PHONE NUMBER: ()

OHHP – Taking Action for Healthy Living Program Report (April 1/04 to December 31/05)

Please complete one reporting form for each program.

NAME OF PROGRAM:		LANGUAGE: <i>(Check all that apply)</i>	
STRATEGY:		<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: <i>Specify</i>	
PROGRAM DESCRIPTION: <i>Please give a 2-3 sentence description of this program</i>			
VARIANCE FROM PLANS: <i>Please list and explain briefly</i>			
OHHP OUTCOME OBJECTIVES ADDRESSED WITH THIS PROGRAM: <i>Check all that apply.</i>	POPULATION:	ENVIRONMENTAL:	CAPACITY:
	<input type="checkbox"/> Tob - Teens <input type="checkbox"/> Nutrition <input type="checkbox"/> Tob - Adults <input type="checkbox"/> Phys.Act. <input type="checkbox"/> Tob - Quit <input type="checkbox"/> BMI <input type="checkbox"/> Other _____	<input type="checkbox"/> Active Transport <input type="checkbox"/> Signage <input type="checkbox"/> Providers <input type="checkbox"/> Daily PA <input type="checkbox"/> Smoke-free Sp. <input type="checkbox"/> Food choices <input type="checkbox"/> Other _____ OR <input type="checkbox"/> None	<input type="checkbox"/> Interest <input type="checkbox"/> Implement <input type="checkbox"/> In-kind <input type="checkbox"/> Evaluation <input type="checkbox"/> Assess & Plan Sustain/transfer <input type="checkbox"/> Other _____ OR <input type="checkbox"/> None
OHHP MANDATE FOCUS FOR THIS PERIOD: <i>Check all that apply.</i>		INTEGRATION WITH OTHER ISSUES: <i>Check all that apply.</i>	
<input type="checkbox"/> Nutrition / Healthy Eating <input type="checkbox"/> Physical Activity <input type="checkbox"/> Tobacco OR if none of the previous 3: <input type="checkbox"/> Non-specific		<input type="checkbox"/> Alcohol & Other Drugs <input type="checkbox"/> Cancer <input type="checkbox"/> Healthy Weights <input type="checkbox"/> Diabetes <input type="checkbox"/> Stress Management <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Air Quality <input type="checkbox"/> Stroke <input type="checkbox"/> Injury Prevention <input type="checkbox"/> Other Chronic Diseases: _____ <input type="checkbox"/> Social Determinants of Health OR <input type="checkbox"/> None <input type="checkbox"/> Other: <i>Specify</i> _____	
CHANNEL FOR THIS PERIOD: <i>Choose <u>one</u> "primary" and as many "other" that apply.</i>		AUDIENCE FOR THIS PERIOD. <i>Choose <u>one</u> "primary" and as many "other" that apply.</i>	
PRIMARY	OTHER	PRIMARY	OTHER
# ORGANIZATIONS ACTIVELY PARTICIPATING		ESTIMATED REACH	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Children (<13 years)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Youth (13-18 years)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Adults (19-64 years)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			All
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Male
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Female
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Seniors (65+)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Families/Parents
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			General Community
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Diverse Populations: <i>Specify</i> _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Community Volunteers/Partners
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Professionals
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Health Care
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Education
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Sport, Fitness and/or Recreation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Individuals living in low income situations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Politicians
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Other gatekeepers/Opinion leaders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Other: <i>Specify</i> _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Not applicable

APPROACH FOR THIS PERIOD. Choose one primary and as many "other" that apply.	OHHP PROVINCIAL FUNDING: \$ _____	COMMUNITY PARTNERS: <i>Please list names of partner agencies or committees that were involved in this program. For committees, record all member agencies (in the space provided or on a separate page)</i>
	OTHER FUNDING SOURCES AND AMOUNT:	

NEW	EXISTING	PROGRAM MATERIALS (new and existing) <i>Check all that apply</i>
		PROMOTIONAL
<input type="checkbox"/>	<input type="checkbox"/>	Radio
<input type="checkbox"/>	<input type="checkbox"/>	Television
<input type="checkbox"/>	<input type="checkbox"/>	Newspaper
<input type="checkbox"/>	<input type="checkbox"/>	Other print (e.g., newsletters, brochures, posters, transit ads, etc)
<input type="checkbox"/>	<input type="checkbox"/>	Website
<input type="checkbox"/>	<input type="checkbox"/>	Promotional items (e.g., mugs, bookmarks, etc)
<input type="checkbox"/>	<input type="checkbox"/>	Other, <i>Specify:</i> _____
		INSTRUCTIONAL
<input type="checkbox"/>	<input type="checkbox"/>	Presentation slides/notes
<input type="checkbox"/>	<input type="checkbox"/>	Self-help guides
<input type="checkbox"/>	<input type="checkbox"/>	Games/ activities
<input type="checkbox"/>	<input type="checkbox"/>	Advocacy products (e.g., letters, briefs)
<input type="checkbox"/>	<input type="checkbox"/>	Videos
<input type="checkbox"/>	<input type="checkbox"/>	Implementation/ Training guides/ Manuals
<input type="checkbox"/>	<input type="checkbox"/>	Resource inventories/ directories
<input type="checkbox"/>	<input type="checkbox"/>	Other, <i>Specify:</i> _____
		PLANNING AND EVALUATION
<input type="checkbox"/>	<input type="checkbox"/>	Plans
<input type="checkbox"/>	<input type="checkbox"/>	Surveys/ questionnaires
<input type="checkbox"/>	<input type="checkbox"/>	Proposals
<input type="checkbox"/>	<input type="checkbox"/>	Reports
<input type="checkbox"/>	<input type="checkbox"/>	Other, <i>Specify:</i> _____

EVENTS <i>Check all that apply</i>	NO. OF EVENTS
PROMOTIONAL	
<input type="checkbox"/> Mass participation	_____
<input type="checkbox"/> Recognition events	_____
<input type="checkbox"/> Press conferences	_____
<input type="checkbox"/> Public forums	_____
<input type="checkbox"/> Other, <i>Specify:</i> _____	_____
INSTRUCTIONAL	
<input type="checkbox"/> Presentations/seminars	_____
<input type="checkbox"/> Health fairs/booths	_____
<input type="checkbox"/> Workshops/ training events	_____
<input type="checkbox"/> Formal meetings with policy makers	_____
<input type="checkbox"/> Group programs (incl. Clubs, self-help and instructor-led)	_____
<input type="checkbox"/> Other, <i>Specify:</i> _____	_____
PLANNING AND EVALUATION	
<input type="checkbox"/> Meetings	_____
<input type="checkbox"/> Interviews	_____
<input type="checkbox"/> Focus groups	_____
<input type="checkbox"/> Other, <i>Specify:</i> _____	_____

MAIN ACCOMPLISHMENTS FOR THIS PERIOD <i>Check at least one, and all that apply.</i>
<input type="checkbox"/> Planning <input type="checkbox"/> Development/adaptation of program materials <input type="checkbox"/> Pilot testing <input type="checkbox"/> Program implementation <input type="checkbox"/> Process evaluation <input type="checkbox"/> Outcome evaluation <input type="checkbox"/> SUPPORTS FOR SUSTAINABILITY <i>(Check all that apply)</i> <input type="checkbox"/> Involved new partners <input type="checkbox"/> Rotated leadership <input type="checkbox"/> Obtained other funding <input type="checkbox"/> Provided train the trainer support <input type="checkbox"/> Applied lessons from evaluation <input type="checkbox"/> Phased out some activities <input type="checkbox"/> Established policy or by-law <input type="checkbox"/> Entrenched program/activity in a local agency <input type="checkbox"/> Other: <i>Specify</i> _____

USE OF PROVINCIAL RESOURCES AND PROGRAMS <i>Please check which of the following provincial resources and programs were used in this program. Check all that apply.</i>
NUTRITION <input type="checkbox"/> Eat Smart! <input type="checkbox"/> Community Food Advisor Program <input type="checkbox"/> Food Steps <input type="checkbox"/> Healthy Eating Manual <input type="checkbox"/> Seniors Nutrition Toolkit <input type="checkbox"/> Healthy Measures PHYSICAL ACTIVITY <input type="checkbox"/> Walk This Way! A Guide to Stick to It <input type="checkbox"/> SummerActive <input type="checkbox"/> Active Schools Program <input type="checkbox"/> Community Fitness / Recreation / Sport Toolkits TOBACCO CONTROL <input type="checkbox"/> Smokers Helpline <input type="checkbox"/> Clinical Tobacco Interventions <input type="checkbox"/> Lungs Are For Life <input type="checkbox"/> Quit & Win <input type="checkbox"/> OTHER <input type="checkbox"/> <i>Specify:</i> _____
OR <input type="checkbox"/> None of these provincial resources or programs were used

OTHER COMMENTS (optional): _____

OHHP – *Taking Action for Healthy Living* Narrative Report

OHHP PROJECT NAME:		
CONTACT PERSON:		PHONE NUMBER: ()
REPORTING PERIOD:		

Strategic Directions

Please comment on your overall progress in relation to the OHHP objectives. In what areas is your partnership really making a difference? What changes are you pursuing with most vigor?

Partnership Development

Please comment on the directions and emphasis of your partnership in the area of partnership development. Was your partnership focusing on maintaining the contributions from a core set of partners? Expanding the diversity of partners? Increasing the depth of participation from existing partners? Etc.

Main Successes

What would your partnership describe as exemplary from its efforts in the past year – things that happened that you'd like others to know about? This might include spin-offs of programs and transfer of ownership to individual agencies.

Main Challenges

Inevitably, not everything works out the way you want. What were some things that were disappointing in this past year? Challenges may include organizational and programming aspects of your local project.

Lessons Learned

Experience breeds insight. Please share your insights and advice so that we can accelerate the learning curve about how best to implement community health promotion projects throughout Ontario.