DEPARTMENT OF HEALTH

Local Public Health Implementation Guide: Statewide Health Improvement Partnership

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Local Public Health Implementation Guide: Statewide Health Improvement Partnership

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OSHII SHIP content staff cannot meet with LPH SHIP Grantee's local partners. Only LPH SHIP staff should be meeting with local partners. This guide is to help frame those discussions, and OSHII staff are available to meet with LPH SHIP staff for further help in framing SHIP to LPH SHIP Grantee's local partners.

Introduction: Purpose and Use of the SHIP 6 Implementation Guide

The SHIP 6 Implementation Guide supports local public health (LPH) staff and their partners in implementing effective, equity-driven strategies to improve the health and well-being of Minnesotans. It serves as a practical resource for grantees of the Statewide Health Improvement Partnership (SHIP) as they plan, implement, and evaluate policy, systems, and environmental (PSE) changes across multiple community settings.

Purpose

The primary purpose of the SHIP 6 Implementation Guide is to:

- Provide clear, consistent guidance on SHIP strategies and expectations
- Strengthen alignment with public health principles, including health equity and authentic community engagement
- Promote shared understanding between local and state partners
- Offer evidence-informed tools, examples, and best practices for effective implementation
- Encourage continuous improvement and adaptability to local context

Use of this guide is intended for day-to-day use by:

- LPH SHIP staff, including coordinators, strategists, and evaluators
- Community partners such as schools, health care providers, worksites, and local organizations
- Minnesota Department of Health (MDH) staff who provide technical assistance and grant monitoring.

Users are encouraged to refer to this guide throughout the SHIP planning and implementation cycle. It can support:

- Strategy development and partner onboarding
- Grant writing and budgeting
- Evaluating readiness and measuring progress
- Ensuring alignment with SHIP's core components and values.

SHIP's Strategic Approach

As guided by Minnesota Statute, Section 145.986, SHIP's goal is to address leading preventable causes of illness and death such as poor nutrition, physical inactivity, and commercial tobacco use, through community-level, evidence-informed strategies. SHIP promotes comprehensive, culturally informed approaches that are:

- Based on scientific evidence or community-informed theory
- Focused on PSE change at individual, community, and systems levels
- Implemented across key community settings (schools, worksites, health care, community, and child care)
- Designed to address health disparities and reduce inequities
- Evaluated through measurable outcomes.

Focus Areas and Strategy Types

- To provide structure and align with public health goals, SHIP strategies are organized into four Focus Areas:
  - Healthy Eating
  - Active Living
  - Commercial Tobacco-Free Living
  - Mental Wellbeing
- Each focus area includes strategies categorized as:
  - Proven Effective: Those that are supported by strong evidence and measurable outcomes (e.g., Results First Minnesota).
  - Theory-Based: Strategies informed by promising practices, community wisdom, and emerging research.

Commitment to Equity

Equity is foundational to SHIP's vision. The work is rooted in authentic partnerships, community-led solutions, and structural changes that recognize the impact of systemic and historical injustices. SHIP prioritizes strategies that elevate community voice, address root causes of health inequities, and promote belonging, safety, and resilience for all Minnesotans.

This guide is a 'living' document. As the practice of public health evolves, SHIP will continue to integrate new evidence, lessons learned, and feedback from local partners to ensure its relevance and responsiveness.

SHIP 6 Theory of Change (TOC)

Overall Goal

To advance health equity and reduce chronic disease risks across Minnesota communities by creating sustainable, community-driven, PSE changes that promote healthy eating, active living, commercial tobacco-free living, and mental wellbeing.

Use of Frameworks and Theories in SHIP 6

SHIP 6 aligns its work with nationally recognized public health frameworks to guide strategy development, implementation, and evaluation. This ensures that SHIP's efforts are evidence-informed, equity-driven, and positioned for sustainable impact across Minnesota communities.

Healthy People 2030 Alignment

SHIP 6 uses the Healthy People 2030 framework to prioritize objectives that address preventable chronic diseases, promote mental well-being, and reduce health disparities. Healthy People 2030 emphasizes the social determinants of health (SDOH) and health equity, which are embedded across SHIP's strategies, particularly within the focus areas of healthy eating, active living/transportation, and commercial tobacco-free communities.

Social Ecological Model (SEM)

SHIP 6 applies the Social Ecological Model to design and implement interventions at multiple levels of influence (i.e., individual, interpersonal, organizational, community, and societal.) This layered approach recognizes that improving health requires action not just at the individual level but across organizations, communities, and systems.

Overall Theory of Change:

If SHIP 6 invests in relationship-centered, equity-focused, and community-driven strategies that address the social determinants of health through PSE change, then local public health agencies and community partners will build sustainable capacity to reduce chronic disease risk factors, improve mental wellbeing, and achieve long-term health equity.

SHIP 6 Causal Theories of Change for Settings

In SHIP 6, causal theories of change explain how PSE changes within each setting contribute to improved health outcomes. Four focus areas form the foundation: Healthy Eating, Active Living, Commercial Tobacco-Free Living, Mental Wellbeing.

These areas are integrated across SHIP's seven settings: Healthy Eating in Community Settings, Active Living, Commercial Tobacco-Free in Community Settings, Child Care Settings, School Settings, Workplace Settings, and Health Care Settings. (Note: Mental Well-Being strategies are specific to Child Care, Schools, Workplaces, and Health Care.)

In each setting:

- Healthy Eating expands access to nourishing, affordable, culturally relevant foods.
- Active Living increases safe, accessible opportunities for physical activity.
- Commercial Tobacco-Free efforts create environments that support non-use.

- SHIP Mental Wellbeing strategies are intended to help settings consider their environments to create positive, mentally healthy environments through policy, systems and environmental change. Healthcare strategies include creating linkages between settings and mental wellbeing resources.

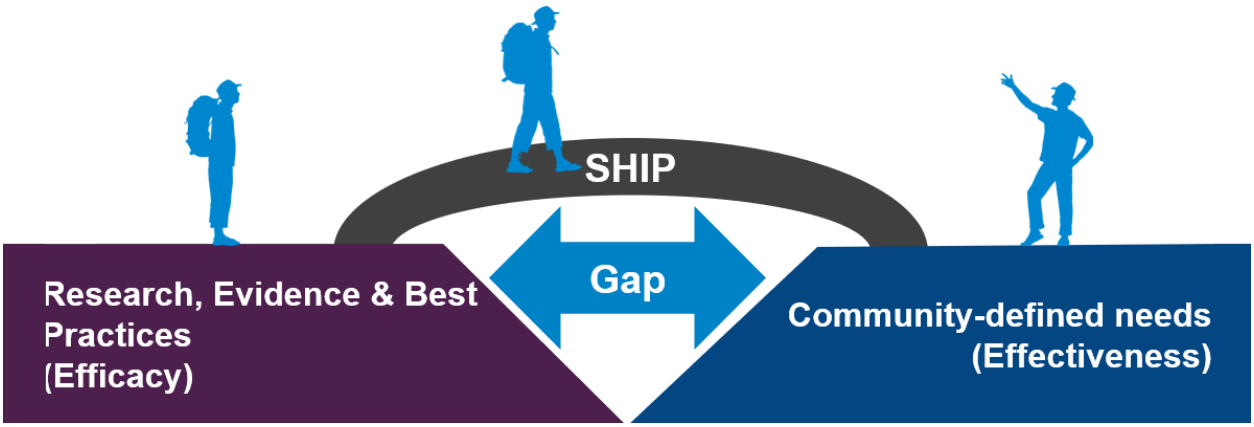
Together, these strategies drive community-level change toward a healthier Minnesota.

Strategy Guides are a Means to Better Demonstrate SHIP's Value

Building on SHIP's causal theories of change, SHIP 6 introduces new tools designed to better align strategy implementation with the intended long-term health outcomes. To operationalize these theories in a consistent, measurable way, SHIP is launching Strategy Guides and the SHIP Information System (SIS). These tools translate the high-level theories into practical guidance, setting clear expectations for implementation, strengthening fidelity to evidence-informed practices, and improving how we capture and demonstrate impact over time.

As part of SHIP 6 planning, all settings subject matter experts (SMEs) were tasked with creating operational standards and expectations for every strategy that LPH might choose to implement. These "standards" should provide you with some guidance when it comes to specific best practices for strategy implementation. The benefit is two-fold: to provide you with an assessment of where you are within the implementation process, as well as a roadmap for where you're headed. As you provide information back to us via the SHIP Information System, that information will help us make updates on our end when it comes to the best ways in which to define both the fidelity and impact of each strategy. Since this work is based on a Theory of Change, the way the work happens in the field should hold MDH accountable in how we're refining the standards by which to measure progress. By testing the Theory of Change, we are working to close the gap between program efficacy and effectiveness.

Think of SHIP as a bridge between efficacy and effectiveness. The better the SHIP strategy, the smaller the gap between the two. Strategy Guides and the data points collected through the SIS will allow us to continuously evaluate effectiveness of implementation through an ongoing feedback cycle between fidelity (accurately defining the strategy) and impact (looking at the perceived result of the strategy). As you review the individual strategy guides, they should more clearly articulate the progression of activities as well as the measurable indicators we'll be asking you all to report on.



Key SHIP terms and definitions

Action Steps: sub-activities that support an activity to complete a PSE change in the schools setting.

Activities: the steps needed to complete a strategy or sub-strategy, including completing PSE changes.

Active Living: a way of life that integrates physical activity into everyday routines, such as walking to the store and park or bicycling to school and work.

Administrative Costs: the expenses of doing business that are necessary for the overall operation of the organization and the conduct of the activities it performs. Administrative costs incurred as part of the grant program should be reasonable to provide necessary program support and directly billed to the appropriate budget line item (i.e. salaries and fringe for accounting support, human resources or administrative staff and general office supplies and expenses) and not included as part of an organization's indirect costs.

All-Call Community Partner Award: This award recognizes a PSE (policy, systems, and environmental change) project that received SHIP funding through an open, publicly shared invitation issued by a LPH SHIP grantee. The invitation, shared through public platforms such as newspapers, websites, or social media, welcomes organizations within the jurisdiction to submit a funding request without prior contact or consultation with LPH SHIP staff to confirm alignment with SHIP goals.

- LPH SHIP Grantees are strongly encouraged to host a webinar or provide a publicly accessible FAQ to explain SHIP's purpose, eligible strategies, and expectations for potential applicants.

Allowable Cost: a cost incurred by a grantee that is reasonable for the performance of the approved activities; in conformance with any limitations or exclusions set forth in this guidance; consistent with grantee policies and procedures; accorded consistent treatment; and determined in accordance with Generally Accepted Accounting Principles (GAAP).

Application: request for SHIP funding submitted by a grantee to MDH.

Appropriated Funds: funds authorized by the Minnesota Legislature and signed by the Governor that provides authority to permit MDH to incur obligations or to make payments for specified purposes.

Approved Budget: financial expenditure plan, including any revisions approved by MDH for the grant-supported project. The approved budget consists of SHIP grant funds and non-SHIP matching funds.

Assessment: a deliberative process of gathering data, both qualitative and quantitative to develop a snapshot and tell the story of a community's current health situation with health equity as a framing lens. It provides comprehensive information about a community's current health status, needs, and challenges.

- **Needs Assessment:** determines who needs the program/intervention, how great the need is, and what can be done to best meet the need.

Authentic Community Engagement: equity-related goals should be defined by the communities the work is focused on, within SHIP parameters. Partnerships with communities are not intermittent, public health listens to the community, community leads the work, partnerships are long-lasting and sustaining, and engagement is not used to confirm or advance pre-existing ideas.

Award: funds provided to a grantee to carry out SHIP activities.

Awareness: knowledge or perception of SHIP work throughout Minnesota. Our goal is to increase awareness of SHIP.

Behavioral Health Setting: providers and facilities that provide treatment to those with mental health and substance use disorders.

Bias: the action of supporting or opposing a particular person or thing in an unfair way due to allowing personal opinions to influence one's judgement.

Budget Period: the interval of time into which the project period is divided for budgetary and funding purposes. SHIP annual budget periods are November to October.

Calls to Action: (1) **Internal actions** and communications that include SMARTIE goals and include what to do internally as a staff member to make SHIP clear. (2) **External actions** inspire others to engage in public health partnerships leading to policy, systems, and environmental (PSE) change.

Capacity Building: acknowledging, leveraging, and building upon skills, knowledge/expertise, resources, and systems/structures of SHIP partners to effectively implement and sustain SHIP PSE changes.

Capital Improvement: a permanent structural alteration

Carryforward funds: unspent grant funds that remain from a budget of one fiscal year after the last invoice of that year is processed. For SHIP, the last invoice is the month of October and carryforward funds must be spent by June 30 of the next fiscal year.

Change: the process of modifying policies, systems, and/or environments in a sustainable way that promotes equitable health outcomes for everyone.

CHB: Community Health Board

Child Care Setting: A licensed or licensed-exempt group setting where young children ages newborn through age five, are cared for. This includes childcare centers, preschools, family-based childcares, Family, Friends, and Neighbors (FFN) childcare providers, and Head Start programs. New to SHIP 6, before and after-school programs, offered in the community, and not affiliated with a school district, also fall under the auspices of the childcare setting.

- Family based: licensed or unlicensed care provided in a private home by an adult who lives the home.
- Family, Friends, and Neighbor providers: Family members, friends, neighbors who provide care for children. Typically, children from low-income households or who are members of minority, cultural groups.
- Before and after-school programs in community: non-profit organizations, not affiliated with a school district, that offer before or after school programs and care for children who are typically 6 through 12 years of age.
- Childcare centers: where more than 10 children, ages six weeks to age 12 receive care. Typically owned and managed by a private company. They may have multiple sites.

Closeout: the process by which MDH determines if all applicable administrative actions and all work required by the grant have been completed by the recipient and the awarding agency for a project.

Collaborative Workplace Model: A model to assist LPH SHIP work with multiple employers at one time to impact a larger number of employers while also providing opportunity for employers to learn from and support each other.

Competency: interchangeable with skill or understanding (see Skills definition).

Community: a diverse group of people whose connections and relations are shaped by geography, shared resources, needs, experiences, culture, and/or shared environments in settings such as worksites, schools, and organizations.

Community-Clinical Linkages: connections between healthcare providers, community organizations, and public health agencies that improve patients' access to a combination of medical care services and non-clinical community-based resources that promote health.

Community Engagement: the process of intentionally connecting with the community by working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting them. This is critical because the way the work is done with communities can advance or hinder health. This provides flexibility for LPH SHIP to respond to local conditions and needs while also incorporating the core concepts embedded in our definition of "authentic community engagement."

Community Food Security: a situation in which all community residents obtain a safe, culturally acceptable, nutritionally adequate diet through a sustainable food system that maximizes community self-reliance and social justice.

Community Leadership Team (CLT): an advisory board for LPH SHIP that meets periodically and engages a diverse set of interest holders to create and advance health in their communities through SHIP PSE work. CLTs provide opportunity to practice sharing power and leadership by ensuring that SHIP PSE work is modeled after the CLT's feedback, requests, and conversations. They provide direction and support for SHIP work, while creating vital connections and helping to assure accountability.

Community Leadership Team (CLT) Alternative: an alternative to the use of a Community Leadership Team (CLT) that is designated to harness the voice of community members, their strengths, and the resources of multiple community partners to advance SHIP policy, systems, and environmental changes with the goal of creating the conditions and sustainable leadership that will support the health of all communities. A listing of acceptable CLT alternatives is listed in the SHIP 6 Health Equity and Community Engagement Guide.

Commercial Tobacco: Tobacco products manufactured and sold by the tobacco industry, including cigarettes, e-cigarettes, cigars, and chew. Commercial tobacco is different from the traditional or sacred tobacco, also known as Cansasa, Asemaa, or Kinnikinnick, and that are used by some American Indian communities for sacred purposes.

Community Partner Award: funding awarded to community partners by LPH SHIP by granting their local SHIP funds (awards) to their local community partners (schools, worksites, etc.) to implement SHIP PSE strategies/projects no matter the method, process, or length of partnership.

Complete Streets: a transportation planning and design strategy that aims to make roads safe and accessible for all users.

Comprehensive Plans: a specific type of a long-range plan used by local governments to create a shared vision, community goals, policies, and action steps for guiding the physical, social, and economic development of a municipality and its environment.

Conditional Allowable: a potential SHIP fundable expense that OSHII has determined requires review before the expense is incurred regardless of the dollar amount.

Conflict of Interest: personal participation in decisions, approvals, disapprovals, recommendations, advice, investigation, or otherwise any proceeding, application, request for a ruling or other determination, contract, award, cooperative agreement, claim, controversy, or other particular matter in which SHIP funds are used, where to their knowledge, or their immediate family, partners, organization other than a public agency in which they are serving as an officer, director, trustee, partner, or employee; or any person or organization with whom they are negotiating or has any arrangement concerning prospective employment, has a financial interest, or has less than an arms-length transaction.

Connection: create and distribute authentic messages and success stories that engage the public and deepen their appreciation of our health partnerships, leading to SHIP policy, systems, and environmental (PSE) change.

Core Component: Overall pieces of how SHIP operates that LPH and OSHII need to have a base knowledge/skill in and is not exclusively connected to any one setting or content area(s); instead, core components are woven throughout SHIP and represent public health best practices. If planning a Core Components Project, see Project definition.

List of Core Components:

- Relationship Building
- Capacity Building
- Technical Assistance and Training
- Evaluation
- Assessment and Surveillance
- Community Engagement/Voice
- Health Equity
- Communications
- Trauma Responsiveness

Continuous Quality Improvement (CQI): a progressive incremental improvement of processes that can include operations, outcomes, systems, and work environment.

Culturally Relevant Food: food that reflects and respects the traditions, preferences, dietary practices, and cultural identities of a particular community or population.

Data: information collected to be examined, considered, and used to help decision-making.

Direct Cost: a cost that can be identified specifically with a particular SHIP workplan (e.g. grant, contract, project, or function).

Environment: settings and spaces within which organizations operate, and within which people live, work, study, play, and pray. They can be tangible (physical structures, "the built environment") or intangible (cultural, social, or economical dynamics).

Environmental Changes: changes to the physical/tangible environment.

Equipment: tangible personal property having a useful life of more than one year and a per-unit acquisition cost, which equals or exceeds $10,000.

Equity Project: a shorthand reference to a project that will be highlighted as showing progress on equity work or as a success story for its particularly positive impact on health equity and its success in adhering to the equity fidelity steps. All SHIP projects should be centering equity and community engagement, therefore an "equity project" will be selected as the best representation of these efforts.

Evaluation: determination of the value, nature, character, or quality of something or someone.

- Program Evaluation: the process of systematically gathering empirical data and contextual information about a program/intervention. Specifically answering the who, what, why, how, and whether questions that will assist in assessing a program/intervention's planning, implementation, and/or effectiveness.

Fidelity Steps: core implementation best practice(s) that focus on the process of implementation. These are action steps used to define the unique nature of the strategy, differentiating it from other strategies. (e.g. Quit Partner Referral fidelity requires that partner site(s)/patients/clients have improved access to Quit Partner services).

Evaluative Thinking: Adopting a mindset of learning from your efforts and using that to make better decisions for greater impact. (Source: Patton, MQ. 2018)

Evidence: data that are used with appropriate analysis to support a claim being made.

Fiscal Agent: the organization responsible for providing and maintaining fiscal oversight of grant expenditures and meeting all the requirements related to such oversight. It also refers to the individual assigned by the grantee to perform the required financial reporting and monitoring.

Focus Areas: formerly "contexts" in SHIP 5. The SHIP 6 focus areas are Commercial Tobacco-Free, Healthy Eating, Active Living, and Mental Wellbeing.

Food and Nutrition Security: having reliable access to enough high-quality food to avoid hunger and stay healthy.

Foundational Practices: SHIP Setting specific action steps that occur in the early stages of a SHIP project. They can include relationship building, assessment, and capacity building of LPH and partners specific to a SHIP project. If planning a Foundational Practices Project, see Project definition. See sections below for additional information on best practices and projects.

FTE: full-time equivalent.

Goal: the end towards which effort is directed.

Grant: a financial assistance mechanism whereby funding is provided to carry out approved workplans.

Grant Monitoring Visit: an on-site, phone, or virtual visit/meeting that involves both state granting agency staff and the grantee. It occurs before final payment is made to review and ensure grant progress, address any problems before the end of the grant period, and to build rapport between the state agency and the grantee.

Grant Period: The start and end date of the grant contract agreement.

Grantee: the CHB, group of CHBs, or Tribal Government to which a SHIP grant is awarded, and which is responsible and accountable for the use of the funds provided and for the performance of grant-supported work.

Health Care Setting: a Setting where a provider of health services or health information practices.

Healthy Eating: SHIP work that emphasizes fruits, vegetables, and whole grains. Dairy and protein may also be part of health eating efforts, but this is less of an emphasis for SHIP.

Health Literacy: the degree individuals have the ability to, and organizations can enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

HHS: Health and Human Services

Holistic: parts of something are interconnected and can be explained only by reference to the whole. For example, people are involved with and have other priorities in their life outside of SHIP work and goals. This can be mutually beneficial and/or limiting, but it needs to be kept in mind when building and maintaining relationships and capacity with partners.

Inclusivity: operations, interactions, and materials conducted or created in manners so that all involved feel they belong and are respected for who they are. *Previously known as social connection.*

Indirect Costs: Expenses of doing business that cannot be directly attributed to a specific grant program or budget line item. These costs are often allocated across an entire agency and may include executive and/or supervisory salaries, fringe, rent, facilities maintenance, etc.

In-kind: a non-cash contribution of the fair market value of goods (items) or services (time/labor) that support grant work by the grantee, partners, or other third parties.

Leveraged Funds: grant awards or cash contributions that are not SHIP funds and are spent for SHIP-related work. These can come from local, state, or federal sources.

LPH: Local Public Health.

Local and Regional Food Systems: food systems where production, aggregation, storage, processing, distribution, consumption, and food recovery and recycling happen in the locality or region where the final product is marketed to consumers.

Locally Led Evaluation (LLE): Evaluations that are done by LPH SHIP staff to learn about what needs to be continued, modified, or adapted about work within an approved project. There are three types of LLEs.

1. **Shared Partner Reflection:** SHIP Grantee asks their partners engaged in a PSE project about three learnings they had while implementing a PSE project and determine next steps from these learnings.
2. **Grantee-led Evaluation:** SHIP Grantee determines evaluation questions about what they want to learn about a PSE project that will inform the next steps of the project. They answer these questions by completing a process and outcome evaluation.
3. **Community-led Evaluation:** SHIP Grantee and community co-determine evaluation questions about what they want to learn about a PSE project that will inform next steps of the project. They answer these questions by completing a process and outcome evaluation together.

Local Match: local leveraged funds or local in-kind funds that are spent for grant-related costs but are not SHIP funds and that are reported towards the 10% required match of the full SHIP grant award. Grantees cannot use state or federal funds as matching dollars for the SHIP grant.

Matching funds: the value of allowable third-party in-kind contributions to the allowable costs of a SHIP project not borne by the SHIP grant.

Memorandum of Understanding (MOU): an informal agreement between two or more parties.

Mental Wellbeing: a positive state of emotional, psychological, and social health. It is not merely the absence of adversity; it requires a sense of belonging achieved through authentic relationships and emotionally healthy environments.

Monitoring/Grant Monitoring: an overall system of reviewing, tracking, and reporting on SHIP grant funds to provide accountability and oversight, measure performance, discover best practices and new work, ensure proper spending, provide assistance as needed, and identify

opportunities for improvement. This can be accomplished through technical assistance, desk review, and ongoing communication.

Multi-disciplinary team-based care: professionals from different disciplines who come together to provide comprehensive care and support for patients or clients. The team works collaboratively; each member bringing their specialized skills and expertise to develop and implement coordinated services and care plans tailored to the individual's unique needs.

My Life, My Quit: a free, confidential program to help Minnesota teenagers, ages 13-17, quit commercial tobacco and nicotine, including vaping.

Outcome Evaluation: measures effect and changes that result. Assesses the effectiveness of the strategy and respective PSE change(s). Short-term and medium-term outcomes in the program/intervention and to what extent they are being achieved.

Partner: an organization/agency, city/county, or group of partners working on a SHIP PSE change at a defined PSE site. There are 3 types of partners for SHIP 6.

Partner Site: an organization or agency who will/is/has implemented a SHIP PSE change at a physical location (not city or county). There may be more than one Partner Site on a project or Strategy.

City or County Partner: a city or county agency who will/is/has implemented a SHIP PSE change that will impact the geography or jurisdiction of a city or county.

Collaborative Partner: a partner that is a group of partners or people who mainly support SHIP PSE work. They may or may not make PSE changes. There are 6 types of collaborative partners.

Coalition: a special type of partnership that brings together a large, diverse group of people and organizations. They are typically organized around a specific goal and with an intentional focus. They can be short or long term but once the goal is accomplished, a coalition may sunset or move to future work and a different goal.

Network: The set of all actors and the relational ties among them. They are more of a general interest group; including different partners who are generally interested in a topic and different sub-groups branch off for more focused work. They are ongoing and long term; even as specific projects end. They are useful for sharing information and deepening relationships.

Food Access Network (or similar group): community based, cross-sector groups that work collectively to identify and solve complex issues within their food systems. These networks, through mutual learning and collaboration, can identify the best strategies to improve food security, prevent diet-related chronic diseases, and implement food access strategies in the community. They can also influence policy at the local and/or state level.

Community of Practice (CoP): any group of people with a shared interest who, by interacting, learn from one another and hone their abilities to further their individual development and, ideally, the development of the field.

Non-Workplace Collaborative: a learning process with multiple people and/or organizations over the course of several months (9-12), which creates a rich learning environment that leads to long-term, impactful change and broader reach.

Policy Council: structured groups that allow for representation from various sectors and community members to provide direction and voice on local policy and programmatic management (e.g. Park Advisory Board).

Patient Centered Medical Home (PCMH) Model: a quality-driven comprehensive, whole person, culturally appropriate, and team-based approach that coordinates patient care across the health system.

Patient Self-Management: increasing the knowledge, skills, and confidence a person has in managing their own health and care.

Per Diem: a specific amount of money that an organization allows an individual to spend per day to cover living expenses (e.g. meals and lodging) while traveling for work.

Pilot/Pilot Project: a small-scale test run of a new concept, process, product, or service before full-scale implementation. It helps organizations assess feasibility, identify potential challenges, and refine their approach based on real-world feedback. It minimizes risks and costs to be able to evaluate the effectiveness of the idea and learn about unintended or nonoccurrence aspects to make improvements. The key characteristics of a pilot project includes being of limited scope and limited to a one-year timeline.

Policies: laws, ordinances, resolutions, mandates, regulations, guidelines, rules, or written practices. They are in writing, set expectations that people/organizations will follow, and are enforceable beyond social and cultural norms.

Policy Change: changes to policies at the organizational level. Not only refers to the enactment of new policies but includes the change in or enforcement of existing policies.

Population Health Management: a method for improving the health of a group of people by using data to identify and address health needs.

Practices: unwritten personal or organizational norms. They are typically deeply rooted in customs, enforced by social or cultural norms, and/or consistently follow patterns of behavior or activity.

Pre-/Prior Approval: the written permission provided by MDH before a grantee may deviate from the approved budget and/or workplan for certain expenditures.

Prioritization: a process in which community issues are ranked in order of importance and elevated for action planning. It allows us to focus on what truly matters; to make the most efficient use of our time and resources to address the greatest needs.

Priority Population: population groups who are priorities for health interventions due to significant health disparities related to demographic or environmental factors. They represent a diversity of communities, demographics, identities, statuses, and lived experiences that should be prioritized in SHIP's mission to improve the public's health. Used when describing where efforts and resources should be concentrated for interventions.

Process Evaluation: measures effort and the direct outputs of programs/interventions. Helps understand what, if any, modifications are needed to improve the strategy and adjust the PSE change(s). Can be done one-time or continuously and is used to improve the program/intervention.

Professional Development: specific skill building opportunities exemplifying key programmatic elements to equip partners (e.g. LPH, SHIP, OSHII staff, community partners) with knowledge, skills, and attitudes needed to increase individual and organizational agency (i.e. understanding, ability, capacity). *OSHII TA & Training Core Terms are interrelated. The operationalization of these core terms propels the continuous cycle of learning and improvement of the SHIP TA & Training program.*

Project: the work needed to accomplish SHIP goals. Projects have goal(s), a summary of the work, and build skills for SHIP 6 work. There are 3 types of projects in SHIP 6.

A project can be at and collaborated on with one or more partners.

Each project will have 1 SMARTIE goal.

The strategies are used to meet the project goals.

A project can have multiple Settings.

A project has a defined population.

PSE Project: implementing one or more strategies that work together on common goals within a defined timeline. A project is a situation that you want to find an answer to, a response to a problem, or an opportunity that addresses needs and priorities in the SOAP or other assessments and prioritization processes.

Core Components Project: a structured initiative that builds the base knowledge and/or skills of LPH SHIP staff with a defined start and end date and SMARTIE goal. The project is focused on one or more SHIP Core Components.

Setting Foundational Practices Project: SHIP Setting specific preliminary efforts to explore and identify potential policy, systems, and environmental (PSE) changes; involving data review and interest holder engagement before formal implementation. In some Settings these are required, and for some they are a best practice to consider.

Project Period: the total time for which support of a project has been approved.

PSE: policy, systems, and environment.

PSE Change: refers to deliberate, sustainable modifications to policies, systems, and/or environments that put healthy choices within reach for defined populations. Ideally, they are long-lasting and brought about from fully implemented SHIP Strategies in accordance with the Strategy Guides and Implementation Guide guidance.

Quit Partner: Minnesota's family of free programs to help residents who want to quit smoking, vaping, chewing, or using other commercial tobacco products.

Reach: the number of people living, working, learning, playing, or seeking services in SHIP partner sites working on each SHIP Setting.

Reimbursement Basis Only: also known as Cost Reimbursement Payment; a type of grant payment in which the grantee incurs the expenses before requesting repayment from the grantor. This means the cost must be paid by the grantee before it can be reimbursed. Expenditures on the invoice submitted to MDH should agree with expenditure accounting records.

Relationship Building: holistic, interpersonal communication and skills (building trust, cultural awareness, etc.) that create and facilitate on-going, mutually beneficial partnerships with individuals /community organizations at SHIP partner sites to work toward successful SHIP PSE change.

Reports (Interim and Final): a grantee report that contains information on the comparison of actual accomplishments to objectives established for the period.

Safety: the state of being safe; freedom from the occurrence or risk of injury, danger, or loss in physical settings and interpersonal interactions.

Safe Routes to Parks (SRTP): a strategy to increase park usage and improve population health by creating safe walking and biking connections to parks; ensuring everyone can easily access great parks.

Safe Routes to School (SRTS): a federal and state supported program that promotes walking and biking to school through education, encouragement, and environmental changes. Comprehensive SRTS initiatives incorporate each of the 6 E's (education, engineering, encouragement, evaluation, engagement, equity).

Safe Systems: a public health framework to approach transportation safety that aims to eliminate serious injuries and fatalities for all road users based on the Health Impact Pyramid, which helps to identify strategies that have the greatest impact on population health while requiring the least individual effort. It combines the Safe Systems and Vision Zero approaches.

Screen, Counsel, Refer, Follow-Up (SCRF): a clinical workflow that determines criteria and accountabilities for screening, counseling, and referring patients as part of a closed loop system. (i.e. eventual outcomes are communicated back to the person who initiated the process)

School Setting:

- A public school (including charter schools) or nonpublic school (including parochial schools but excluding home schools serving a single family) in which students from kindergarten through transition programs (students aged 18 - 21 who continue to need special education services) are provided instruction.

- Local Statewide Health Improvement Partnership (SHIP) staff may partner with Minnesota state statute defined school-based Community Education and with school coordinated youth before and after-school enrichment programs that are specifically connected to SHIP statute language (e.g., tobacco use or exposure, poor diet, and lack of regular physical activity). This excludes community-based youth programs such as those through parks and recreation, the YMCA, or faith-based organizations.

Service Contract: a contract in writing with individuals or organizations that allocates LPH SHIP funds to perform work associated with SHIP workplans (i.e. evaluation, communication, and/or other LPH SHIP staff duties) for a specified duration.

Setting: the place or societal context in which people engage in daily activities in which environmental, organizational, and personal factors interact to affect health and wellbeing.

> From the World Health Organization: Healthy Settings key principles include community participation, partnership, empowerment, and equity. A setting is where people actively use and shape the environment; thus, it is also where people create or solve problems relating to health. Settings can normally be identified as having physical boundaries, a range of people with defined roles, and an organizational structure. Examples of settings include schools, work sites, hospitals, villages and cities. Action to promote health through different settings can take many forms. Actions often involve some level of organizational development, including changes to the physical environment or to the organizational structure, administration and management. Settings can also be used to promote health as they are vehicles to reach individuals, to gain access to services, and to synergistically bring together the interactions throughout the wider community." (Health Promotion, WHO).

SHIP Employer Wellness Assessment (SEWA): an assessment tool that is completed by the employer on an annual basis with the goal of helping them understand what wellness programs can offer and provide a baseline of their current wellness initiatives. Results are used to help set goals for strategy work with SHIP.

SHIP Grantee: the CHB or group of CHBs that have entered into a grant agreement contract with MDH to receive SHIP funds to implement SHIP PSE work and fulfill the requirements set forth.

SHIP Information System (SIS): the virtual structure that houses the majority of SHIP 6 information for each SHIP Grantee. It includes several forms including general SHIP grantee information, staffing, workplans, financial requests, technical assistance requests, and updates. It will be used by LPH staff for planning SHIP work, submitting requests, and updating SHIP Grantee information. It will be used by OSHII staff for monitoring and planning technical assistance. The forms are interconnected and relational to each other, so different aspects of the grant can be shown overall and thus reduce/eliminate duplication of information between forms.

SHIP Overall Assessment and Prioritization (SOAP): a process of gathering, interpreting, and sharing SHIP-related data and community experiences to develop SHIP priorities (issues that are ranked and elevated based on their importance). A SOAP requires genuine community engagement, the use of local data to describe health disparities in Active Living, Commercial Tobacco, Healthy Eating, and Mental Wellbeing.

SHIP Grantees and their Local Public Health Departments will use the priorities developed by the SOAP for SHIP 6 planning including PSE project development, partner recruitment, and strategy selection. Data from SOAP can also be used to establish measures to track progress.

SMARTIE goal: a goal with **S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime Bound, **I**nclusive, and **E**quitable components

Smoking: inhaling, exhaling, burning, or carrying any lighted or heated product containing, made, or derived from nicotine, tobacco, cannabis, or other substance, whether natural or synthetic that is intended for inhalation. Smoking includes carrying or using an activated electronic delivery device. Smoking does not include the use of traditional or sacred tobacco

used by many American Indian, Alaska Native, and Indigenous communities for spiritual and medicinal purposes.

Social Determinant of Health (SDoH): non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age. The wider set of forces and systems shaping the conditions of daily life, and those that are put in place to deal with illness such as the physical environment, economics, social policies, resources, and politics. This term is mainly used in SHIP for discussing social, economic, and environmental factors that affect a person's health and access to health care.

Start-Up Costs: expenses for core components/foundational practices related to SHIP PSE work outlined in the implementation guide.

Strategy: the evidence-based/theory-based body of work that is assigned an evidence rating using the Results First categories (*previously known as statewide and flexible activities in SHIP 5*).

Strategy Guide: a guide that identifies the action steps needed to fully implement a Strategy's PSE change.

Purposes of a Strategy Guide:

1. A tool for LPH to use to guide them as they implement strategies (an implementation road map).
2. Highlight key fidelity steps that make the strategy uniquely itself.
3. Illustrate & describe how "incremental" PSE steps support the overall goal of the strategy/successful PSE.
4. Used to guide TA with trends.
5. Used to measure the progress of strategies and understand the extent to which we are meeting our goals.

Stipend: payment to an individual who provides work or service for the benefit of the LPH SHIP program. Cannot be used to fund service contracts.

Supplies: all tangible personal property other than those described in the definition of equipment.

Surveillance: systematic data collection that is related to planning of public health practices. Observations without a specific intervention.

Suspension: a temporary withdrawal of the grantee's authority to obligate grant funds pending corrective action by the grantee as specified by MDH or a decision by MDH to terminate the grant.

Systems: process, procedures, relationships, and power structures in a community or organization. The way communities and organizations operate or do their work.

Systems Changes: changes made to the rules, structures, or processes within an organization that change the way they operate or do their work.

Technical Assistance (TA): on-going and strategic support exemplifying key programmatic elements addressing a specific question or need to equip partners (e.g. LPH, SHIP, OSHII staff, community partners) with knowledge, skills, and attitudes needed to increase individual and organizational agency (i.e. understanding, ability, capacity). *OSHII TA & Training Core Terms are interrelated. The operationalization of these core terms propels the continuous cycle of learning and improvement of the SHIP TA & Training program.*

Termination: permanent withdrawal of a grantee's authority to obligate previously awarded grant funds before that authority would otherwise expire; including the voluntary relinquishment of that authority by the grantee.

Terms of Award: all legal requirements imposed on a grantee by MDH, whether by statute, regulation, or terms in the grant agreement. The grant agreement includes both standard and SHIP specific provisions that are necessary to attain the objectives of the grant, facilitate post-award administration of the grant, conserve grant funds, or otherwise protect MDH's interests.

Training: Delivery of content exemplifying key programmatic elements and SHIP core components through a learning experience or series to equip partners (e.g., LPH, SHIP, OSHII staff, community partners) with knowledge, skills, and attitudes needed to increase individual and organizational agency. Training will ensure equitable access and availability to all partners, while also aiming for applicability to SHIP PSE work. *OSHII TA & Training Core Terms are interrelated. The operationalization of these core terms propels the continuous cycle of learning and improvement of the SHIP TA & Training program.*

Trauma Responsive Approach (TRA): an approach to embed trauma-informed principles into the way we interact with each other, in our materials and approaches, to prevent traumatizing and re-traumatizing staff, partners, and community members to build authentic relationships and organizations. Also known as trauma-informed approach (TI).

Trust/Trustworthiness/Transparency: operations are conducted, and decisions are made in a manner of consistency, respect, and fairness as to build and maintain credible reliability (trust). SHIP enhances, elevates, and nurtures relationships by aligning SHIP storytelling/messages with the MDH brand.

Unallowable Costs: items for which SHIP funds cannot be used. These may not be purchased or reimbursed with SHIP funds.

Unobligated Balance: a portion of the SHIP grant funds that have not been obligated by the recipient at the close of the budget period.

Vision Zero: a strategy to eliminate deaths and serious injuries from traffic crashes with a systems focus.

Whole Person Health: assessing people as a whole, not just separate organs or body systems, and considering multiple factors that promote either health or disease.

Workplace Setting: a location, permanent or temporary, where an employee performs work or work-related tasks.

Workplan: detailed description of projects in the SHIP Information System (SIS).

Zoning: Codes (building, subdivision, and zoning) that regulate land use as defined by the comprehensive plan and impact the form of buildings and therefore the access and opportunities for active living.

- **Land Use:** determined by comprehensive plans and guides what land can be used for, such as residential, business, park space, or a mixed use.

What is PSE Change?

A PSE Change refers to deliberate, sustainable modifications to **p**olicies, **s**ystems, and/or **e**nvironments (PSE) that put healthy choices within reach for defined populations. Ideally, they are long-lasting and brought about from fully implemented SHIP Strategies with fidelity and tracked through documentation and evaluation in accordance with the Strategy Guides and Implementation Guide guidance.

Core Elements of a Successful PSE Change

The SHIP 6 PSE model follows a 7-step process:

1. Engage – Build relationships with partners and community members
2. Scan – Conduct environmental scans (e.g., audits, reviews)
3. Assess – Use data and community input to identify priorities
4. Review – Determine feasibility and readiness of proposed strategies
5. Promote – Educate stakeholders and raise awareness about the change
6. Implement – Execute the PSE strategy with clear documentation
7. Evaluate – Capture results, unintended effects, and lessons learned

How the PSE Framework Supports SHIP 6 Implementation

The 7-step PSE framework serves as the foundation for aligning SHIP 6 strategies with local implementation. Each step connects to specific types of SHIP projects, helping clarify where core components, foundational practices, and PSE projects are best applied:

- Engage – Core Component projects (e.g., partner development, CLTs)
- Scan – Core Component projects (e.g., community audits, readiness scans)
- Assess – Core Component and Foundational Practice projects (e.g., assessments using equity tools)
- Review – Foundational Practice projects (e.g., reviewing readiness and feasibility)
- Promote – Foundational Practice and PSE projects (e.g., policy education, outreach)
- Implement – PSE projects (e.g., actual implementation of a new food policy or safe route)
- Evaluate – PSE and LLE projects (e.g., tracking fidelity, reach, TOC-linked evaluation)

Summary

PSE change in SHIP 6 is about more than checking a box. It emphasizes meaningful engagement, evidence-informed decisions, and structural improvements that are sustainable and measurable. Flexibility is preserved for local implementation, but alignment with long-term goals and equity principles remains central.

Equity Statement

- The Statewide Health Improvement Partnership (SHIP) is committed to advancing health equity in the state of Minnesota. Local Public Health SHIP (LPH SHIP) and their partners will collaboratively work to eliminate health inequities in their communities through continuous and robust community engagement where communities identify and implement strategies for change. Through collaboration, relationship building and engaging with community members being impacted, LPH SHIP can create a shared understanding of the conditions that create health. By using an equity lens when working on policy, systems, and environmental change to realize community health will improve through efforts to obtain community voice input, intentional engagement activities and evaluating local data sources.
- State and LPH SHIP staff shall prioritize and implement strategies and activities with individuals and communities that have suffered from systematic oppression. People of color, American Indians, LGBTQ+ communities, individuals with disabilities, immigrants and refugees, and residents in rural areas all face barriers rooted in decades of systemic inequities that need to be addressed.
- For reference, the community engagement/health inequities mandate focus is referenced can be found directly in Minnesota State Statue; §145.986 STATEWIDE HEALTH IMPROVEMENT PROGRAM.
- Subd. 1a. Grants to local communities.
- (b) Grantee activities shall:
  - (2) be based on community input;

    and
- (6) address the health disparities and inequities that exist in the grantee's community.

Getting Started

SHIP is complex and multilayered. As such, SHIP can be daunting at times, especially for those who are new in their roles. OSHII staff recognize this and encourage LPH SHIP staff to reach out with any questions or requests for support. The checklist below is a listing of activities new SHIP staff are encouraged to complete on their first day. This checklist is also intended to be an on-going resource for all SHIP staff.

Day One Checklist

- Review and bookmark the Minnesota Department of Health (MDH) SHIP website.
- Review the SHIP State Statute.

- Sign up for the Making It Better Newsletter.
- Connect with the Office of Statewide Health Improvement Initiatives (OSHII) and your Community Specialist.
  - Contact Lead Community Specialist Alice Englin (alice.englin@state.mn.us) if you don't know your Community Specialist and see this SHIP Community Specialist Map.
  - Set up a LPH SHIP Staff Orientation with your Community Specialist.
  - Review the OSHII Organizational Chart.
- Getting Started in Basecamp
  - Sign up for Basecamp (contact your Community Specialist if you need Basecamp support)
  - Key Basecamp Teams to join on day one includes Local SHIP Staff, Health Equity and Community Engagement, Compass, and Communications.
- Other Teams include Child Care, Commercial Tobacco Prevention Network, Health Care, Healthy Eating in the Community, LPH SHIP Evaluation, Active Living in Community, Mental Wellbeing, Schools, and Workplace Wellness.
  - "How to Find things in Basecamp" document Contact your Community Specialist
- See the Compass Team Calendar listing of Co-Learning Calls/Coffee Chats/Small Groups/Health Equity Networks trainings and add calls related to your SHIP work to your calendar (i.e., click on each event for a direct link to add to your calendar).
  - See the top right icon with your initials or picture to edit your Basecamp notification settings.
- Review the SHIP Implementation Guide (this guide, located on Basecamp in the Local SHIP Staff team/ Docs & Files).
- See the "How to navigate and search a pdf document" resource in the Basecamp Local SHIP Staff Team/Docs & Files.
- Read the "Introduction to SHIP 6 Section" and the "Getting Started Section" and the "Grant Monitoring Section." Note that each LPH SHIP Partner has a unique approach to developing budgets, tracking expenses, invoicing, and completing SHIP evaluation requirements. Connect with your local supervisor with any questions.
  - Review and save the SHIP Acronym Listing in the "TA and Training" section of the SHIP Implementation Guide.
- Learn about the Minnesota Health Equity Networks.
  - Connect with your Regional Coordinator.
  - Review the "Creating Health Equity in Minnesota" webpage.
- Connect with local UMN Extension staff.
  - What is Extension working on in your county?
  - Does SHIP and Extension work align?

    - Sign up for your regional Extension newsletter(s) from the Basecamp Local SHIP Staff Team/Docs & Files.
- Get access to the SHIP Information System
    - Contact Kim Engwer-Moylan (kim.engwer-moylan@state.mn.us) to request access.
    - Review Projects and Workplans in the SHIP Information System once you have access.
- Get access to SHIP Peer Support.
    - Contact Brian Bluhm (brian.bluhm@state.mn.us) and your Community Specialist for assistance (e.g., peer shadowing, New SHIP Staff Peer Networking group on the first Wednesday of each month)
- Review SHIP Training Information (most are in the Local SHIP Staff Basecamp Team/Docs & Files)
    - New LPH SHIP Orientation PowerPoint and Outline
    - New LPH SHIP Orientation PowerPoint (Local SHIP Staff Basecamp Team)
    - SHIP 101 - PSE
    - Policy System Environmental (PSE) Change Framework
    - PSE Change Training Series (Docs & Files -Foundational Skills
    - Systems Approaches to Healthy Communities – PSE Training (UMN Extension Training offered for free through registration)
- Learn about Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) in your community and region. Talk with your supervisor for local resources and connect with your Community Specialist to learn more about MDH resources.
- Sign Up for Newsletters based on workplan activities and interests. Subscribe here: Minnesota Department of Health (govdelivery.com)
- Newsletters include: Making It Better, MN Healthy Workplaces newsletter, and Resilience Learning Community

LPH SHIP Orientation

New LPH SHIP staff are required to participate in an OSHII-led year-long SHIP orientation process. This orientation process provides new staff with background information about SHIP, an overview of the roles of OSHII and other MDH staff, and specific details about grant requirements including financials and budgets, work plan development, reporting and evaluation. The orientation also provides an opportunity for new SHIP staff to ask questions and build connections with OSHII and other MDH staff. See the LPH SHIP Orientation Process Diagram on Basecamp (Local SHIP Staff Team/Docs & Files) for more information and contact your Community Specialist if you'd like to learn more. Please contact your CS about new staff within their first week of starting, if not before.

SHIP Guidelines for Education vs. Lobbying

LPH SHIP partners are required to ensure funds are not used for lobbying, which is defined as advocating for a specific public policy after it has been formally introduced to a legislative body. Educating people about the importance of policies as a public health strategy is encouraged with SHIP funds. Education includes providing facts, assessment data, reports, program descriptions, and information about budget issues and population impacts, but stopping short of making a recommendation on a specific piece of legislation. Education may be provided to public policymakers, other decision-makers, specific stakeholders, and the general community. Lobbying restrictions do not apply to internal or non-public policies. LPH SHIP partners may not use SHIP funds to participate or intervene in any political campaign on behalf of, or in opposition to, any candidate for public office.

LPH SHIP partners may make educational materials available to the public and governmental bodies, officials, and employees. These materials may not advocate the adoption or rejection of an official action, but may contain facts, analysis, studies, and research.

LPH SHIP partners may use other funding sources to influence an official action of a local governmental unit or tribal government, in accordance with federal and state laws, local policies, and funding restrictions, but they are required to clearly document which activities are covered by which funding source.

LPH SHIP partners may not use grant funds to influence state legislation or administrative rules.

See the **"Rules of the Road for Public Health Advocacy"** in the **Communication Team on Basecamp**

Common SHIP Acronyms

A

ACES – Adverse Childhood Experiences

ADA – Americans with Disabilities Act

ALA - American Lung Association

ANSR – Association for Nonsmokers Minnesota

AT – Active Transportation

ATOD - Alcohol, Tobacco, and Other Drugs

B

BIPOC – Black, Indigenous, and People of Color

BOLD - Building Our Largest Dementia Infrastructure

BRFSS - Behavioral Risk Factor Surveillance System

BRIC - Building Resilient and Inclusive Communities

C

CACFP - Child and Adult Care Food Program

CAP - Community Action Program

CCL – Community-Clinical Linkages

CDBG - Community Development Block Grant

CDC - Centers for Disease Control and Prevention

CHB - Community Health Board

CHA - Community Health Assessment

CHNA - Community Health Needs Assessment

CHIP - Community Health Improvement Plan

CHW - Community Health Worker

CLT - Community Leadership Team

CMI - Communities Most Impacted

CoP – Community of Practice

CTC – Child and Teen Checkups

CTF - Commercial Tobacco-Free

CSA – Community Supported Agriculture

CSUP – Cannabis and Substance Use Prevention

D

DCYF – Minnesota Department of Children, Youth, and Families

DEED – Minnesota Department of Employment and Economic Development

DEI – Diversity, Equity, and Inclusion

DHS - Minnesota Department of Human Services

DNR – Minnesota Department of Natural Resources

E

EBT - Electronic Benefit Transfer

ECE - Early Childhood Education

ECFE – Early Childhood Family Education

EHR - Electronic Health Record

EMR – Electronic Medical Record

EPOC - Evaluation Point of Contact (LPH SHIP)

F

FOA – Funding Opportunity Announcement

FTE - Full-Time Equivalent

FFA – Future Farmers of America

FMNP – Farmers Market Nutrition Program

FY – Fiscal Year

H

HAFA - Hmong American Farmers Association

HAP - Hmong American Partnership

HE - Health Equity

HIA – Health Impact Assessment

HOTM – Harvest of the Month

I

IBCLC – International Board-Certified Lactation Consultant

IEP – Individualized Education Program

L

LGBTQ+ - Lesbian, Gay, Bisexual, Transgender, Queer, Plus

LGU – Local Government Unit

LOI – Letter of Inquiry

LOS - Letter of Support

LPH - Local Public Health

LPHA – Local Public Health Association of Minnesota

M

MFMA – Minnesota Farmers Market Association

MDA – Minnesota Department of Agriculture

MDE – Minnesota Department of Education

MDH - Minnesota Department of Health

MECSH – Maternal Early Childhood Sustained Home Visiting

MFH – Multi Family Housing

MnDOT - Minnesota Department of Transportation

MMB - Minnesota Management and Budget

MNIT - Minnesota Information Technology

MPCA – Minnesota Pollution Control Agency

MPHA – Minnesota Public Health Association

MSS – Minnesota Student Survey

MWB – Mental Wellbeing

N

NAPS – Nutrition Assistance for Seniors

NAMI - National Alliance on Mental Health

NIH – National Institute of Health

NFPO – Not for Profit Organization

NGO – Non-governmental Organization

NPO – Non-Profit Organization

NSLP - National School Lunch Program

O

OSHII - Office of Statewide Health Improvement Initiatives

P

PCN – Positive Community Norms

PHLC – Public Health Law Center

PLC – Professional Learning Community

POP - Power of Produce Program

POS - Point of Sale

PSE – Policy, System, Environmental Change

Q

QI - Quality Improvement

R

RBA - Results-Based Accountability

RDC – Regional Development Commission

RFP – Request for Proposal

ROI – Return on Investment

RPC - Regional Prevention Coordinator

RSDP - Regional Sustainable Development Partnership

RTCC - Regional Transportation Coordination Council

RTP – Recreation Trails Program

S

SAIL – Students Achieve Integrative Learning

SBP - School Breakfast Program

SCHSAC – State Community Health Services Advisory Committee

SEWA – SHIP Employer Wellness Assessment

SFH - Single Family Housing

SFMNP – Senior Farmers Market Nutrition Program

SHI – School Health Index

SDoH – Social Determinants of Health

SHIP - Statewide Health Improvement Partnership

SNAP - Supplemental Nutrition Assistance Program

SOW – Statement or Scope of Work

SPAN - State Physical Activity and Nutrition Program

SRTS - Safe Routes to School

SUD – Substance Use Disorder

SVI - Social Vulnerability Index

T

TA - Technical Assistance

TA&T - Technical Assistance and Training

TFAP – The Emergency Food Assistance Program

CTFC - Commercial Tobacco-Free Communities grant program

TIP - Trauma-Informed Practice

TOD – Transit Oriented Development

TTS – Tobacco Treatment Specialist

TZD - Toward Zero Deaths

U

UMN – University of Minnesota

W

WSCC - Whole School, Whole Community, Whole Child Model

WIC - Women, Infants and Children

Grant Monitoring

Objectives

Grant monitoring is the systematic and routine collection of information from LPH SHIP regarding their implementation of SHIP. Monitoring is checking progress against plans.

For the purposes of SHIP, grant monitoring seeks to accomplish six main goals:

- To provide LPH SHIP-specific updates for SHIP Legislative Reports
- To learn from experiences and improve practices and activities in the future
- To have internal and external accountability of the resources used and the results obtained
- To make informed decisions on the future of SHIP
- To promote empowerment of LPH SHIP and their interest-holders
- To help LPH SHIP identify when and where technical assistance or training is needed based on information communicated through the grants management process

Furthermore, monitoring allows results, process, and experiences to be documented and used as a basis to steer decision-making and learning opportunities. In addition, the data acquired through monitoring can be used to inform evaluation.

Grant Monitoring Process

SHIP grant monitoring has six main components:

- Site visits
- Review of invoices and expenditures
- Review of budget and workplan changes
- Bi-Annual and Year-End reports
- Project updates
- Funding request review

Site Visits

Community Specialists (CS) complete site visits to better understand LPH SHIP work and to meet requirements from the MDH Office of Grants Management. Site visits will occur once per grant year for each LPH SHIP. Additional site visits will occur if the Settings staff, Community Specialists, or OSHII Leadership determines it necessary for LPH SHIP to address specific barriers.

Site visits will be scheduled at a time that is mutually convenient for LPH SHIP and their respective CS.

What to Expect from a Site Visit

A Site Visit Agenda draft will be sent to LPH SHIP once the site visit is scheduled. LPH SHIP may wish to show the CS what they are working on in their community and introduce them to staff, community partners, or contractors. CS staff will explicitly discuss the following:

- Status of SHIP efforts and updates on work plan progress
- Financials
- Required Office of Grants Management form to be completed by MDH
- Community engagement, health equity, and partnership building progress
- Technical Assistance/Training received
- LPH SHIP questions

Project Updates

As part of Bi-Annual Reports provide a project update on each project in the work plan.

If you would like to be contacted by OSHII staff regarding a project, submit a Technical Assistance/Training request in the SHIP Information System.

Invoices

LPH SHIP should send invoices to: Health.SHIP-Invoices@state.mn.us

The subject line should read: (LPH SHIP name)-(month)-Invoice

Invoices must be sent within 45 days from the end of the month, as outlined in the grant agreement contract. Once the invoice is received, the Community Specialist has five business days to review the invoice, electronically sign it, and submit to the MDH Finance Department for processing. Likewise, LPH SHIP are expected to respond, within five business days, to any requests for additional information from CS staff regarding invoices. LPH SHIP who do not respond promptly risk a delay in the processing of their invoice and payment.

See the SHIP 6 Financial Guide for additional information.

Budget and Work Plan Changes

MDH recognizes that work plans will evolve and change during the grant period. It is expected that LPH SHIP will continually update their work plans and budgets to reflect their most current work.

Budgetary items and changes need approval as outlined in the Financial Guide. CS staff will respond to budget related requests within five business days, but due to the need to consult with Content staff, more time may be required to provide approval or denial. The CS will keep LPH SHIP updated on the review process and if possible, provide an estimated timeframe for a response.

Funding Request Review

LPH SHIP may only request the use of SHIP funds for projects that are approved by OSHII staff in the workplan. Funds may not be requested for projects not listed and approved in the SHIP Information System workplan.

LPH SHIP must submit all proposed requests for service contracts and community partner awards in the amount of or more than $5,000 via the SHIP Information System for prior approval. Further detail about this process can be found in the Financial Guide and on Basecamp. CS staff will strive to review financial requests within five business days, but due to the need to consult with settings staff more time may be required to provide approval or denial. Failure to obtain prior approval before a service contract or community partner award begins may result in MDH refusal to pay for the contract.

If LPH SHIP determines that an under $5,000 expense is allowable using the Guiding Questions in the Financial Guide, the expense is required to be added to the Under $5,000 Tracker for the related project in the SHIP Information System. Internal equipment and expenses under $5,000 such as mileage, office supplies, computers for LPH SHIP staff do not need to be included on this Tracker, this Tracker is for Community Partner Award or Service Contract expenses under $5,000.

Reporting for LPH SHIP

A Bi-Annual Report is required to assist OSHII Staff in monitoring the progress of LPH SHIP. Components of the Bi-Annual report will be communicated to LPH at least six weeks prior to the due date. Bi-Annual Reports are intended to capture the implementation of SHIP strategies, activities, and actions, provide LPH SHIP an opportunity to showcase their accomplishments, identify barriers to success, and assist in gathering information to monitor the progress of SHIP work. Some questions will require LPH SHIP to gather information directly from their partner sites.

An annual report is also required from LPH. Components of the Annual report will be communicated to LPH at least six weeks prior to the due date.

LPH SHIP are required to submit reports to MDH as outlined in their grant contract. MDH may revise the reporting format to enhance utility and decrease reporting burden. MDH will provide reporting form templates to LPH SHIP via Basecamp. LPH SHIP are encouraged to provide feedback on this process, particularly if they feel that some aspect of their SHIP work is not being captured.

When reporting and choosing the update status of a project, be sure to consider the following:

- A delayed PSE project refers to situations where work toward a SHIP Strategy is not progressing due to unforeseen or documented barriers. Delays may result from internal or external factors such as staffing changes, partner turnover, policy barriers, community engagement timelines, or shifts in organizational or community priorities.
- LPH SHIP staff should document the reason for the delay, communicate with MDH staff as needed, and update the timeline and planned actions in the PSE project form, evaluation forms, or progress reports (the form used will depend on the type and stage of the work).

This allows for continued support from MDH Staff and ensures accountability for LPH SHIP partners and MDH.

A PSE project may be considered “delayed” if:

- Progress toward the original objective is still actively underway (e.g., meetings are happening, data are being collected, or partners remain engaged).
- A revised timeline has been established and documented, with implementation expected to continue within the same funding cycle (e.g., within 6–12 months).
- Communication with partners and interest-holders remains active.
- Delays do not result in complete inactivity or indefinite postponement.

A PSE project may be considered to have “insufficient progress” if:

Delays exceed 12 months without documented progress or rationale. In these cases, the project will require review with MDH staff which may result in reclassification (e.g., as a pre-PSE/discovery activity, as a new strategy altogether, or the cancellation of the project).

SHIP 6 Requirements

Category	Tier 1	Tier 2	Tier 3
Core Component Projects (not required)	Core Component projects are allowed all 5 years; Year 1 allows all projects to be Core Components, if necessary. They need a scope of work, SMARTIE goal, and milestones. They will have a timeline of at most one year and must have a check-in with the CS and relevant staff every 3 months. Reporting on the projects will still be biannually.		
Settings Requirements (Foundational Practices and PSE Projects)	Projects must reach all six (6) required settings at least once over 5 years. Foundational Practices Projects are allowed with a scope of work, SMARTIE goal, and milestones. They will have a timeline of at most one year and must have a check-in with the CS and relevant staff every 3 months. Reporting on the projects will still be biannually. Foundational Practices and PSE projects are encouraged but not required in Year 1.	Projects must reach all six (6) required settings at least twice over 5 years. Foundational Practices Projects are allowed with a scope of work, SMARTIE goal, and milestones. They will have a timeline of at most one year and must have a check-in with the CS and relevant staff every 3 months. Reporting on the projects will still be biannually. Foundational Practices and PSE projects are encouraged but not required in Year 1.	Projects must reach all six (6) required settings every year starting no later than Year 2. Foundational Practices Projects are allowed with a scope of work, SMARTIE goal, and milestones. They will have a timeline of at most one year and must have a check-in with the CS and relevant staff every 3 months. Reporting on the projects will still be biannually. Foundational Practices and PSE projects are encouraged but not required in Year 1.
Workplan	Workplan timeframe is one year (November-October). Minimum of 1 project per year (5 projects in 5 years). Projects must be reviewed and approved by the CS and Settings staff before LPH may start work. Each LPH SHIP Grantee must identify and select at least one strategy that is evidence based by the end of year 2. Implementation on at least one evidence-based strategy must begin by the end of the 5-year grant cycle. PSE project reports are due biannually.	Workplan timeframe is one year (November-October). Minimum of 3 projects per year (15 projects in 5 years). Projects must be reviewed and approved by the CS and Settings staff before LPH may start work. Each LPH SHIP Grantee must identify and select at least one strategy that is evidence based by the end of year 2. Implementation on at least one evidence-based strategy must begin by the end of the 5-year grant cycle. PSE project reports are due biannually.	Workplan timeframe is one year (November-October). Minimum of 5 projects per year (25 projects in 5 years). Projects must be reviewed and approved by the CS and Settings staff before LPH may start work. Each LPH SHIP Grantee must identify and select at least one strategy that is evidence based by the end of year 2. Implementation on at least one evidence-based strategy must begin by the end of the 5-year grant cycle. PSE project reports are due biannually.

Category	Tier 1	Tier 2	Tier 3
Equity Inclusion	One equity success story is submitted per year that highlights a priority population experiencing health inequities that is served as part of an approved **PSE project** in the workplan, not a separate project. The equity success story can span 5 years. One strategy with an equity focus, within a PSE project, must be reported on biannually.		
Community Engagement/ Voice through CLT or CLT Alternatives	Each SHIP Grantee must demonstrate evidence of sustained community engagement through a CLT and/or CLT alternatives.		
SHIP Assessment and Priorities	Decisions and projects are rooted in local data. If a SHIP Grantee has existing assessment(s) and priorities (e.g. CHA/CHIP) for their jurisdictions they want to use, then, during the application, each LPH within the SHIP Grantee will submit at least one problem/opportunity (P/O) statement for each SHIP focus area. If a SHIP Grantee does not want to use existing data from their jurisdictions, then they must do a SHIP overall assessment and prioritization (SOAP) process. At application, the SHIP Grantee will submit a SOAP plan to be completed within 18 months of the start of SHIP 6 (completed by May 1, 2027) and report on its completion.		
Evaluation	10% of budget must be used towards evaluation and/or assessment. Annual level 1 Evaluation (internal reflection) for each PSE Project in the Workplan. Two Locally Led Evaluations (LLE) are required over 5 years. • The first LLE needs to be a level 2 (Shared Partner Reflection), level 3 (SHIP Grantee-led), or level 4 (Community-led) evaluation. It must start by the end of year 2 (Oct 31, 2027). • The second LLE needs to be a level 3 (SHIP Grantee-led) or level 4 (Community-led) evaluation. It must start by the end of year 4 (Oct 31, 2029).	10% of budget must be used towards evaluation and/or assessment. Annual level 1 Evaluation (internal reflection) for each PSE Project in the Workplan. Two Locally Led Evaluations (LLE) are required over 5 years. • The first LLE needs to be a level 2 (Shared Partner Reflection), level 3 (SHIP Grantee-led), or level 4 (Community-led) evaluation. It must start by the end of year 2 (Oct 31, 2027). • The second LLE needs to be a level 3 (SHIP Grantee-led) or level 4 (Community-led) evaluation. It must start by the end of year 4 (Oct 31, 2029).	10% of budget must be used towards evaluation and/or assessment. Annual level 1 Evaluation (internal reflection) for each PSE Project in the Workplan. Two Locally Led Evaluations (LLE) are required over 5 years. • The first LLE needs to be a level 3 (SHIP Grantee-led), or level 4 (Community-led) evaluation. It must start by the end of year 2 (Oct 31, 2027). • The second LLE needs to be a level 4 (Community-led) evaluation. It must start by the end of year 4 (Oct 31, 2029). The two evaluations cannot be completed on the same project.

Category	Tier 1	Tier 2	Tier 3
	The two evaluations cannot be completed on the same project.	The two evaluations cannot be completed on the same project.	
Communications	Each SHIP Grantee submits two success stories via the SHIP Success Story Survey form; one submitted by April 30 and one submitted by November 30 each year. MDH is given advance notice of media interviews/requests. LPH must conform to SHIP brand/logo standards including supporting the statewide vision, tagging social media posts (@mnhealth), and using MDH approved items, including those that require preapproval.		
Staffing	0.75 FTE No minimum FTE if split with multiple staff. Designate a primary SHIP coordinator contact Designate an evaluation point of contact (EPOC)	1.0 FTE No minimum FTE if split with multiple staff. Designate a primary SHIP coordinator contact Designate an evaluation point of contact (EPOC)	1.0 FTE No minimum FTE if split with multiple staff. Designate a primary SHIP coordinator contact Designate an evaluation point of contact (EPOC)
Grant Management	At least one SHIP Grantee staff participates in annual site visits. Each SHIP Grantee must have a 10% local match of the SHIP grant award over the 5 years. Verification of local matching funds will occur annually for every SHIP Grantee. Each SHIP Grantee reports on required local match and leveraged funds. All components of bi-annual and annual reports by designated due dates will be submitted. Adhere to all due dates. Adhere to all requirements as outlined in the implementation and financial guides. Each LPH SHIP Grantee must complete a Conflict-of-Interest Form with the application.		
Budgets	Each SHIP Grantee submits annual budgets with appropriate updates, including for carryforward. Budget periods are one year (November – October). All SHIP staff paid with SHIP funds are required to be listed on the budget. Each SHIP Grantee must have a 10% local match of the SHIP grant award on their budget. Travel for the staff attending the Regional and Statewide meetings is required to be listed in the budget. Each SHIP Grantee must adhere to MDH Indirect Cost Guidance for CHBs.		
Invoices	Each SHIP Grantee submits monthly invoices. Verification of local matching funds will occur annually for every SHIP Grantee.		

Category	Tier 1	Tier 2	Tier 3
	Each SHIP Grantee must adhere to MDH Indirect Cost Guidance for CHBs.		
Technical Assistance (TA)/Training	At least one SHIP staff from each SHIP Grantee attends the Regional and Statewide meetings. New SHIP staff complete the OSHII-led orientation process.		
Certifications	LPH must have or be working towards a Commercial Tobacco-Free (CTF) worksite policy. Every County and City CHB must complete a certification form.		

SHIP 6 Overall Assessment and Prioritization

Purpose

The purpose of the SHIP Overall Assessment and Prioritization (SOAP) process is to ensure that SHIP 6 PSE projects and strategies are genuinely driven by community priorities as indicated in the SHIP Statute[1]. and help determine where SHIP 6 resources should be allocated to address the greatest needs. The benefits of conducting a SOAP include:

- Improved community engagement and collaboration in defining community needs.
- Increased knowledge about community to inform SHIP projects and strategies.
- Better defined benchmarks for PPPI/SHIP projects and strategies.

SOAP Vision and Goals

Vision (Aspirational)

The vision for SOAP is that, by the end of SHIP 6, 80% of all PSE projects and strategies are community and data informed[2] This is a vision, not a requirement, and will be tracked by MDH OSHII staff to determine TA needs and evaluate the process. MDH OSHII staff acknowledge that some projects may not fall under one of the SHIP 6 priorities and that is okay.

Goals (Practical)

MDH OSHII staff have two goals for SOAP:

- Provide high quality technical assistance and guidance for SOAP to make this process useful, not burdensome.
- Increase the percentage of PSE projects that address LPHs' SHIP 6 priorities (baseline percentage to be determined at the start of SHIP 6).

[1] SHIP Statute 145.986 requires that SHIP strategies are driven by community input and address the health disparities and inequities.

[2] Source: P2_Assessment_Final.docx] (paraphrased)

Advancing Equity through SOAP

Public health programs that are driven by genuine input and collaboration from communities most impacted by inequities are core components for advancing health equity. A core component of SOAP is to bring together Local Public Health staff and community members to address structural health inequities related to active living, healthy eating, commercial tobacco use, and mental wellbeing.

> ***IF*** *adequate and accurate data are collected and prioritized by communities most impacted by inequities and used to guide SHIP 6 programming,*
>
> ***THEN*** *SHIP 6 will be community driven and address health inequities.*[3]

SOAP Key Definitions

An assessment is a deliberate process of gathering data, both qualitative and quantitative to develop a snapshot and tell the story of a community's current health situation with health equity as a framing lens. The assessment provides comprehensive information about a community's current health status, needs, and challenges.

Prioritization is a process in which community issues are ranked in order of importance and elevated for action planning. Prioritization allows us to focus on what truly matters; to make the most efficient use of our time and resources to address the greatest needs.

A SOAP or SHIP Overall Assessment and Prioritization is a process of gathering, interpreting, and sharing SHIP 6-related data and community experiences to develop SHIP priorities (issues that are ranked and elevated based on their importance). A SOAP requires genuine community engagement, the use of local data to describe health disparities in Active Living, Commercial Tobacco, Healthy Eating and Mental Well Being.

Opportunity/Problem Statements are that describe opportunities or problems by SHIP focus areas (healthy eating, active living, commercial tobacco and mental wellbeing) by county or city for city-based CHBs that are entered into the SHIP Information System.

SHIP Grantees and their Local Public Health Departments will use priorities and opportunity/problem statements for SHIP 6 planning including PSE project development, partner recruitment, and strategy selection. Data from SOAP can also be used to establish measures to track progress.

SOAP Requirements

1. Starting with the Application

As part of the **SHIP 6 application**, SHIP Grantees submit either Assessment and Prioritization Summary, Evaluation, and Opportunity/Problem Statements or SOAP Plan.

[3] Source: P2_Assessment_Final.docx] (paraphrased)

- If the SHIP Grantee has an assessment and prioritization process that can be used for SHIP 6, then they will submit an Assessment Summary, SOAP Evaluation, and Opportunity/Problem Statements as part of their SHIP 6 Application.
- If the SHIP Grantee does NOT have an assessment that can be used for SHIP 6, then they will submit a SOAP Plan to conduct a SHIP Overall SHIP Assessment and Prioritization process as a part of the application.

2. By May 1, 2027 (18 months after the start of SHIP 6)

All SHIP Grantee must have completed the following:

- Assessment and Priorities Summary (APS): SHIP Grantees can use the Assessment and Prioritization Summary Template or their own document. The APS is uploaded into the SHIP Information System.
- SOAP Evaluation: Submit the evaluation via the SHIP Information System before or at the same time the Assessment Summary is submitted.
- Opportunity/Problem Statements (O/P statements): Once the Assessment Summary is approved by MDH OSHII, SHIP Grantees can enter O/P statements in SHIP Information System.

3. SOAP Expenses

Submit a Financial Request for approval of a SOAP expense. All SOAP expenses must be approved before money is spent.

4. Authentic Community Engagement

All assessment and prioritization processes used for SHIP 6 must include authentic community engagement and collaborative participation.

PSE projects that are driven by genuine input and collaboration from communities most impacted by inequities are crucial for advancing health equity in SHIP 6. For PSE projects to be driven by communities, authentic community engagement must be part of SOAP. Community members can participate in SOAP in a variety of ways including:

- Inform the SOAP process through an advisory/information sharing role.
- Participate in the SOAP process, engaging other community participation in the process.
- Share lived experiences around healthy eating, active living, commercial tobacco-free living, and mental wellbeing.

Community residents are essential partners in the SHIP Grantee's SOAP process and can contribute in several meaningful ways. First, they can inform the SOAP process by serving in advisory or information-sharing roles, offering guidance and local insight to help shape the assessment process. Residents can actively participate in the SOAP process, helping engage and mobilize broader community involvement to ensure the work reflects diverse voices and experiences. They can also share their lived experiences related to healthy eating, active living, commercial tobacco-free living, and mental wellbeing, providing powerful, real-world

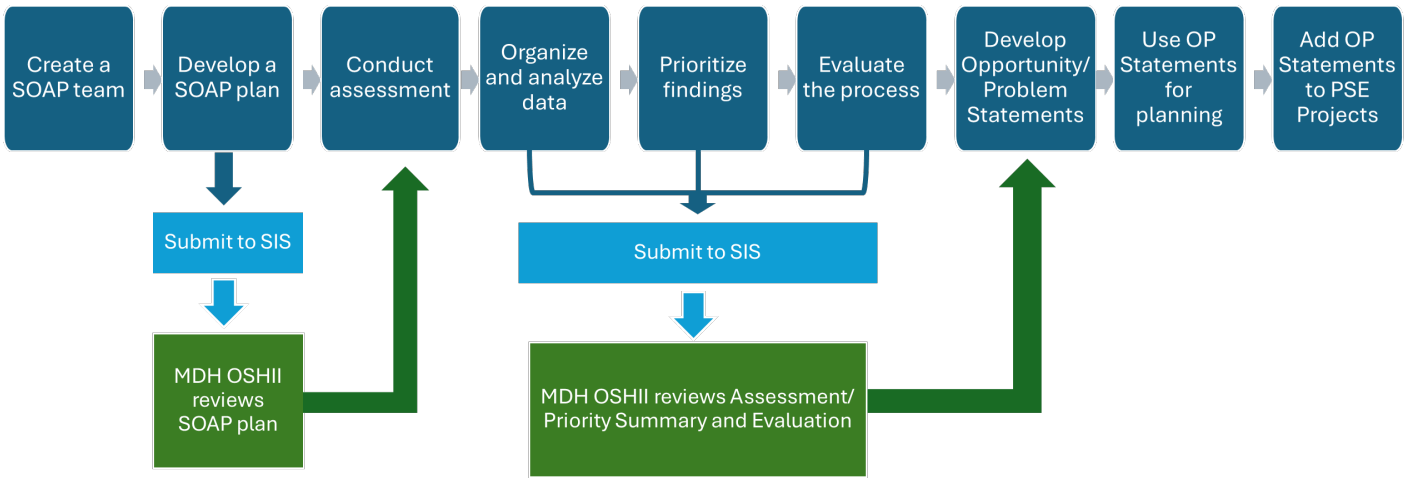
perspectives that ground the SOAP in the community's reality. These roles not only strengthen the SOAP process but also foster community ownership and trust.

5. Using Existing Assessment and Prioritization Processes

- Existing assessment and prioritization processes (e.g., CHA/CHIP or CHNA) that align with SHIP 6 and SOAP steps can be used for SHIP 6's overall assessment and prioritization process.
- If you have an assessment and prioritization process (e.g., CHA/CHIP) that is going be completed within the first 18 months of SHIP 6, you can use this for your SOAP.
- If you have an assessment and prioritization process (e.g., CHA/CHIP) that will be completed after the first 18 months of SHIP 6, you can amend an O/P statement to support the addition of PSE project and strategies based on new findings/priorities.

SOAP Steps

FIGURE 1: SOAP PROCESS DIAGRAM



The SOAP process is conducted in 9 steps:

1. Convene a SOAP team
4. Develop a SOAP Plan
5. Conduct an assessment
6. Organize and analyze data
7. Prioritize findings
8. Evaluate the process
9. Develop Opportunity/Problem Statements
10. Use Opportunity/Problem Statements for planning

11. Add Opportunity/Problem Statements to PSE Projects

MDH OSHII staff have created templates and guidance document to help with the steps and will provide individual and group technical assistance throughout all these steps. The follow describes these steps in more detailed and links to resources for each step.

1. Create a SOAP Team

The first step in the SOAP process is to **create a SOAP team**. This involves defining the scope of work, recruiting diverse stakeholders and community members, assigning clear roles, establishing collaborative structures, and building trust and capacity for effective teamwork.

- Define the purpose and scope of the assessment.
- Determine the expertise and representation needed on the team and list potential partners e.g. hospitals, schools, community-based organizations, tribal representatives, and local government.
- Engage community members, including residents, especially from impacted groups, to ensure community voices and lived experiences guide the process.
- Create a SOAP team charter, establishing the team's charge, member roles and responsibilities, and set expectations for participation, communication, and decision-making.

2. Organize and plan your assessment and planning process[4]

The second step in the SOAP process is to **organize and plan the assessment**. The plan will be developed with your SOAP team. Once completed, the plan will be submitted to MDH OSHII staff via SIS. This step includes:

- Reviewing current and previous community assessments with your SOAP team.
- Choosing, adapting, or designing assessment and planning model.
- Developing a work plan and timeline.
- Submitting your SOAP plan to the SIS.

SOAP Plan

What is it?

A SOAP plan describes the steps to implement an assessment and prioritization process. SHIP Grantees can use the SOAP plan Template or their own document. The SOAP Plan is uploaded into the SHIP Information System. One SOAP plan can be submitted for the entire SHIP Grantee jurisdiction but must be structured so that priorities can be developed for each Local Public Health Department.

[4] These steps are based on MDH Public Health Practice's Community Health Assessment and Planning. Additional resources on assessment and prioritization can be found on their website: https://www.health.state.mn.us/communities/practice/assessplan/lph/index.html

The SOAP process should take no longer than 18 months. For SHIP 6, MDH recommends doing a SOAP within the first 2 years of SHIP 6.

- SHIP funds used for SOAP are conditional allowable meaning a financial request must be submitted to use SHIP funds for the assessment and prioritization process.
- A SOAP for SHIP 7 can be part of the last two years of SHIP 6 and must be approved by your Community Specialist.

MDH Review of SOAP Plan

OSHII staff will review the SOAP Plan and notify the SHIP Grantee when they can proceed to Step 2. OSHII will take no more than a week to review. The review is intended to identify technical assistance needs, assist with methodology, and identify potential data sources. This is a way for our OSHII SOAP team to touch base, learn about your plan, and facilitate the process.

RESOURCES

SOAP Plan Template
SOAP Team Charter

3. Conduct a SHIP 6 Assessment

The assessment will be tailored to the community and should include data for each county within the SHIP Grantee jurisdiction. Not all data will be available by county, and that is okay. For those SHIP Grantees that are city based, ideally the data would be by city. The assessment step includes:

- Establishing a vision for the ideal state of your community as related to SHIP 6 focus areas (Healthy Eating, Active Living, Mental Wellbeing, and Commercial Tobacco).
- Designing assessment (methods, methodology, and data collection tools).
- Gathering and compiling data from a variety of secondary sources with SOAP team.
- Gathering and compiling lived experiences of community members (i.e. qualitative data)

RESOURCES

- SHIP 6 Data Sources: https://3.basecamp.com/3777019/buckets/4020822/vaults/8595287274
- County-level Indicators: A spreadsheet provides links to county-level health data from various sources. MDH has gathered these indicators to assist Minnesota's local health departments and community health boards in their community health assessment and community health improvement planning processes. https://www.health.state.mn.us/communities/practice/assessplan/lph/countyindicators.html

4. Organize and Analyze the Data

Compile the results from the assessment into a summary. SHIP Grantees can use the Assessment and Prioritization Summary template or another template. Data must be compiled or each county or cities (CHBs that are cities) and at a minimum, analyze data by demography, socioeconomic status, gender, age, race, ethnicity, and other common population subgroups.

Review summary with SOAP Team, SHIP staff, LPH leadership, CLT and other groups and the community to determine SHIP priorities.

SHIP 6 Assessment and Prioritization Summary

What is it?

The Assessment and Prioritization Summary summarizes the data used for the assessment to facilitate the development of priorities and Opportunity/Problem Statements. The template is an Excel file with five tabs, a general information tab for demographics, social determinants of health, and health outcomes and one for each SHIP focus area (healthy eating, active living, commercial tobacco, and mental wellbeing. Each tab has sections for quantitative and qualitative data, and priorities. The quantitative section lists indicators. The SOAP team and their community partners can decide which indicators they should include. It is encouraged to include additional indicators. The list in this template is by no means exhaustive.

If a SHIP Grantee has more than one local public health department, then summary should be broken down by county or city (if the CHB is city-based). The summary will be used to create the Opportunity/Problem Statements and help document the sources and year of data used in the assessment. This documentation will facilitate future data updates.

What is required?

SHIP Grantees are required to upload an Assessment and Prioritization Summary either:

- as part of the application, if they have existing data

  OR

- when they have completed the SOAP process.

RESOURCES

- Basecamp folder: https://3.basecamp.com/3777019/buckets/4020822/vaults/8595287274

5. Prioritize Findings

This is where the SOAP team and others review the findings to determine SHIP 6 priorities. The SHIP Grantee should engage interested parties in a conversation to prioritize issues and opportunities based on the data and information available. NACCHO's prioritization guide offers several different prioritization processes that could be used. Regardless of the method used to prioritize, discuss with the SOAP team and/or community what criteria should be used to narrow down potential priorities. Criteria might include (not an exhaustive list):

- Burden and severity of problem (size/magnitude)
- Impact on Health Equity (disparities by race, income, geography and other Social Determinants of Health.

- Community Input (community concern, interest, prioritization of gaps/need).
- Availability of Resources and Feasibility (scope of SHIP, collaborating partners, funding etc.)

A priority is a short statement that should include *at least one* of the following:

- Race/ethnicity (BIPOC, Latino, African American)
- Geography (e.g., city, town, neighborhood, rural/urban, SVI)
- Age (e.g., youth, elderly, 18-24 years)
- Special populations (e.g., LBGTQ, foreign-born populations, low wage workers)
- Other

The priority can also include:

- SHIP focus area (e.g., active living, healthy eating, tobacco use, mental wellbeing)
- Health condition (e.g., diabetes)
- Social determinant of health (e.g. access to care, built environment)

Add priorities to the Assessment and Prioritization Summary and upload it to the SIS.

OSHII acknowledges that some community priorities are beyond the scope of SHIP. It is important to make sure those working on the SHIP priorities understand the scope of SHIP work and understand that not all priorities can be addressed through SHIP.

RESOURCES

- NACCHO Guide to Prioritization Techniques, https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf
- Community Toolbox: Developing and Using Criteria and Processes to Set Priorities, https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/criteria-and-processes-to-set-priorities/main

6. Evaluate the Process

The OSHII SHIP staff has created a short evaluation that part of the Assessment and Prioritization Form in SIS. The purpose of the evaluation is to gather feedback on the process and understand the involvement of the community in SOAP. The evaluation will be used to improve the SOAP Technical Assistance process and guidance materials. The evaluation should be done with the SOAP team and others who participated in the SOAP process.

RESOURCES

SOAP Evaluation Questions (SOAP Basecamp Team)
URL: https://3.basecamp.com/3777019/buckets/4818655/vaults/665682706

MDH Review Summary and Priority Assessment and Evaluation.

OSHII staff will review the Assessment and Prioritization Summary and Evaluation. OSHII staff will notify the SHIP Grantee when the review has been completed within 5 business days of

receipt. The SHIP Grantee can develop Opportunity/Problem Statements after the review has been completed. Like the review of the plan, the purpose of the review of these documents is for OSHII staff to be understand work that has been done, how the community was involved, how to facilitate the development of the Opportunity/Problem Statements and improve the SOAP Technical Assistance process.

7. Develop Opportunity/Problem Statements

Opportunity/Problem Statements will guide SHIP Projects. One Opportunity/Problem Statement can include multiple sentences that describe who in the community should be a priority for each SHIP 6 focus area and why. The statements come from your assessment data which includes quantitative data (e.g., surveillance systems, vital statistics, surveys) and qualitative data (e.g., community experiences and voice).

Opportunity/Problem Statements should:

- Define/describe the problem or current state - Using key facts, statistics and trend data, identify who is affected by the problem or influenced by the opportunity (demographics), how they are affected and why this issue is significant.
- Describe the gap - Review relevant data, trends, or situational details that help explain why the problem exists and why it matters. Include contributing factors, root causes and challenges to achieving the ideal state.
- Consequences of not addressing the problem or current state - Address the potential negative outcomes; health, social, or economic, if the issue goes unaddressed.
- Identify the ideal state - Explain what it would look like if the problem was solved or opportunity utilized, the benefits of achieving this state and determine desired (measurable) outcomes.
- Have a clear and concise statements - Synthesize the key points into 5-8 sentences, using simple, direct language.

Once Opportunity/Problem statements have been developed enter them into SIS Assessment and Prioritize Form, Opportunity Problem Statements.

What is required?

Each local public health department within a SHIP Grantee is required to have at least one Opportunity Problem statement per SHIP 6 focus area (healthy eating, active living, mental wellbeing, and commercial tobacco) for the SHIP 6, 5-year time frame. If a new assessment is done within the first 3 years of SHIP 6, Opportunity/Problem Statements can be amended to reflect the new findings.

SHIP Grantees are required to have O/P statement:

- as part of the application, if they have existing data

  OR

- when they have completed the SOAP process.

O/P Statements are entered into the SIS via Assessment and Priorities Form using the "SOAP Opportunity Problem Statements" tab.

RESOURCES

Examples of Opportunity/Problem Statements (SOAP Basecamp Team)
URL: https://3.basecamp.com/3777019/buckets/4818655/vaults/665682706

8. Use Opportunity/Problem statements for planning

The purpose of the Opportunity/Problem Statements is to have readily available, easy to understand statements that will help the decision-making process for selecting SHIP 6 PSE Projects and Strategies. It is recommended that the SHIP Grantee have the statements at hand when considering new projects.

9. Connect O/P Statements to PSE Project

To better understand if and how it is guiding SHIP work, MDH asks that SHIP Grantees document which PSE projects are addressing which Opportunity/Problem Statements. The SHIP 6 workplan's PSE project form has a list the Opportunity/Problem Statements for that SHIP Grantee. SHIP Grantees should select the Opportunity/Problem Statements that are relevant to each PSE project. This list includes "not applicable" as an option as MDH does not expect all PSE Projects will be connected to Opportunity/Problem Statements.

As stated earlier in this guide, the vision for SOAP is that, by the end of SHIP 6, 80% of all PSE projects and strategies are community and data informed. Again, this is a vision, not a requirement. MDH OSHII will be tracking the connection of O/P Statements to PSE projects and strategies to determine Technical Assistance needs and evaluate the process.

SMARTIE Goals

Goals are a way to drive success. Without explicit attention paid to inclusion and equity, goals will not produce improved outcomes or support belonging for marginalized communities. They also will not address health disparities which are core to public health program.

For SHIP 6 there are 3 types of projects: PSE Project, Core Components Project, and Setting Foundational Practices Project. Each project entered into the SHIP Information System (SIS) will need to have at least 1 associated SMARTIE goal. See the Key Terms and Definitions section for more information on each type of project.

What does SMARTIE stand for?

- Specific: What do you want to achieve? Thank about the 5Ws: who, what, where, when why
- Measurable: How will you measure or track your progress? Name your measurement approach.
- Achievable: Who is doing what? Name milestones or benchmarks along the way.
- Relevant: What can you achieve considering your people capacity, knowledge, time, money?
- Time Bound: What is a realistic timeframe for your change to happen?

- Inclusive: How are you including the voices of your community—in processes, activities, and decision making? How are you sharing power?
- Equitable: How are you addressing injustice, inequity, or oppression? How does the goal remediate disparities in public health outcomes?

SMARTIE training materials will be available on Basecamp as they become available. Contact your Community Specialist with any questions.

SHIP Core Components

Evaluation

Purpose:

The SHIP Statute (145.986 Subdivision 1e) states the following: "The grant recipient must implement the health improvement plan, evaluate the effectiveness of the strategies, and modify or discontinue strategies found to be ineffective."

The purpose of SHIP evaluation is to fulfill this statue, through a learning and critical thinking approach. Through conducting evaluations, the MDH and SHIP grantees will gather information to understand the effectiveness of strategies. Based on this information and community context, planning decisions can be made about continuing, modifying, or discontinuing SHIP strategies.

Evaluation and Assessment Requirements for SHIP Grantees in SHIP 6:

The framework outlines a variety of ways to include evaluative thinking within SHIP work for LPH and partners engaged in projects.

Requirement 1:

Allocate 10% of the budget to evaluation and assessment work. This 10% of the budget can include, but is not limited to, staff time to complete any evaluation and assessment work, as indicated in requirements; contractor time; evaluation technical assistance; CHNAs and CHAs; materials, supplies, and tools for data collection; and food for events where information is gathered, if your LPH policy allows. All expenses must link to approved SHIP projects and some may need additional prior approvals.

Requirement 2:

Every 6 months for each project (core components, foundational practices, and PSE projects), SHIP grantees will have to provide an updated status to their work. For each status, LPH will be required to answer reflection questions. See the SHIP Information Guide for more details on these questions. (Core Components projects and Foundational practices projects will also require a 3- and 9-month status update in addition to the 6-month status update)

Requirement 3:

Each SHIP Grantee will have to engage in two locally led evaluations (LLE) within a PSE project over the course of five years. There are three types of locally led evaluations (LLE). For more information about the specific questions that will be asked within the SHIP Information System, please see the SIS guide.

1. Shared Partner Reflection

To complete this type of LLE, you will need to ask the partners engaged in a PSE project the following questions:

- Describe 3 learnings from the partners had while implementing this PSE project.
- Describe the next steps are you (the SHIP Grantee) and partners are taking based on these learnings.

12. SHIP Grantee-led Evaluation*

To complete the LPH-led evaluation, the SHIP grantee will determine an evaluation purpose and complete a process and outcome evaluation to fulfill the evaluation purpose. Both the process and outcome evaluations include the following components:

- What do you want to learn about the strategy?
- Information collection methods
- Evaluation project dates
- Who supported different components of the evaluation project
- Summary of findings
- Next steps as a result of the findings

13. Community-led Evaluation*

To complete the Community-led evaluation, the community and the SHIP grantee will determine the evaluation purpose and complete a process and outcome evaluation to fulfill the evaluation purpose. Both the process and outcome evaluations include the following components:

- What do you want to learn about the strategy?
- Information collection methods
  - This evaluation will need to include participatory evaluation methodologies
- Evaluation project dates
- Who supported different components of the evaluation project
- Summary of findings
- Next steps as a result of the findings

*The evaluation plan will need to be entered into the SHIP Information System to be reviewed and approved by the evaluation team. The purpose of this review and approval is to provide project specific evaluation technical assistance and support creating an evaluation with

information that help you learn, modify strategies, and plan future work. The evaluation team is available to work with you to craft the evaluation plans and support you in putting it into the SHIP Information System.

Tiers 1 and 2: To fulfill this requirement**,** SHIP grantees have the following options to meet the 2 LLEs:

> **LLE 1:** Complete one of the following: 1) Shared Partner Reflection; 2) LPH-led evaluation; or 3) Community-led evaluation.

This LLE must be started by the end of year 2, as indicated by selecting one of these three options in the in the SHIP Information System. In addition, for the LPH-led or the Community-led, all of the questions except for the "Summary of findings about what you learned…" and "Does what was learned change how the strategy will be implemented…" questions must be answered to be considered started.

> **LLE 2:** Complete one of the following: 1) LPH-led evaluation; or 2) Community-led evaluation

This LLE must be started by the end of year 4, as indicated by selecting one of these two options in the SHIP Information System. All of the questions except for the "Summary of findings about what you learned…" and "Does what was learned change how the strategy will be implemented…" questions must be answered to be considered started.

Tier 3: To fulfill this requirement, SHIP grantees have the following options to meet the 2 LLEs:

> **LLE 1:** Complete one of the following: 1) LPH-led evaluation; or 2) Community-led evaluation

This LLE must be started by the end of year 2, as indicated by selecting one of the two options in the in the SHIP Information System. All of the questions except for the "Summary of findings about what you learned…" and "Does what was learned change how the strategy will be implemented…" questions must be answered to be considered started.

> **LLE 2:** Complete a Community-led evaluation

This LLE must be started by the end of year 4, as indicated by selecting this option in the SHIP Information System. All of the questions except for the "Summary of findings about what you learned…" and "Does what was learned change how the strategy will be implemented…" questions must be answered to be considered started.

Evaluation Terms and Definitions:

Learning: Gaining knowledge through activities like studying or experiencing new things. (Source: Cambridge Dictionary)

Meaning Making: The process by which people interpret situations, events, objects, or discourses, in the light of their previous knowledge and experience (Source: Zittoun & Brinkmann, 2012)

Impact Evaluation: Measuring long-term or community-wide changes, like reduced disease rates or other broad effects caused by the program. (Source: CDC)

Evaluative Thinking: Adopting a mindset of learning from your efforts and using that to make better decisions for greater impact. (Source: Patton, MQ. 2018)

Watch this video for a more in-depth view of evaluation:
https://youtu.be/AXaLXeNBFjw?feature=shared

What does successful evaluation look like in SHIP 6?

Success in implementing this core component means local public health (LPH) staff are equipped with the skills to carry out evaluations effectively, with the support of OSHII (Office of State Health Improvement Initiatives). OSHII has the data it needs to evaluate SHIP to inform future data-driven decision making. There should be clear evaluation processes to assess needs, evaluate progress, and track outcomes and impact.

The components that make evaluation success, as well as how to use the information collected, was discussed with OSHII and LPH staff. The following graphic is what resulted from these conversations.

Successful Eval Components			→	**Provides Useful Information for:**	
Equity Lens	**Driven by Goals**	Evaluations must be goal-oriented, with clear objectives to assess progress.		**Quality Improvement**	Identifying which processes worked and which didn't and understanding how to modify them.
	Situation & Community Relevant	The evaluation must consider the context and specific needs of the community.		**Understanding Community Needs:**	Assessing whether the needs of the community are being met and ensuring that the program is effectively addressing those needs
	Considers Bias	Evaluators must recognize and address any biases in data collection and interpretation to ensure fairness.		**Creating Communication Materials**	Providing decision-makers and community members with materials that help them understand the program's outcomes, goals, and impacts.
	Rooted in a Learning & Growth Mindset	Evaluations should foster continuous learning and improvements, emphasizing growth.		**Outcomes and Impact Assessment**	Measuring the outcomes and broader impacts of the work, including the cost-effectiveness of the program.
	Ensure Use & Lessons Learned	It's critical that the lessons learned from the evaluation		**Systematic Thinking and Data Collection:**	Answering any specific questions through structured data collection, ensuring

		process are used to make decisions and improve the program.		decisions are based on evidence.

Differences between Program Evaluation & Performance Management

It is important to understand the difference between program evaluation and performance management, because they serve different purposes

	Program Evaluation	**Performance Management (Monitoring)**
Definition	Systematic data collection to assess how well a program is working, including what's happening, how it happened, who is involved, whether it's meeting its goals, and what happens as a result of meeting those goals.	A continuous process of setting performance goals, monitoring progress, and improving performance.
Purpose	Provides insight into program implementation, effectiveness, helps identify improvements, and informs decision-making. Asks questions like "Did the way we set up this program cause desired outcomes?" or "Is the program sustainable?"	Used to improve organizational performance, track progress against goals, and optimize operations. Helps to describe and communicate the work. Asks questions like "Are we meeting our program goals?" or "Are we meeting program requirements and how so?"
Scope	Focused on evaluation questions about specific aspects or components of programs. Need to have defined program components and processes to evaluate.	Broader, ongoing monitoring that covers the entire program or project

References:

1. Patton, M. Q. (2008). Utilization-Focused Evaluation (4th ed.). Sage Publications.
2. Brandon, P. R., & Lombardi, J. (2006). "Program Evaluation." In The SAGE Handbook of Evaluation (pp. 68-84). Sage Publications.
3. Moynihan, D. P. (2008). The Dynamics of Performance Management: From Method to Motivation. Georgetown University Press.
4. Kusek, J. Z., & Rist, R. C. (2004). Ten Steps to a Results-Based Monitoring and Evaluation System. World Bank.

Different Types of Program Evaluation

For more details on program evaluation, please visit: CDC Program Evaluation Framework

Formative evaluation:

- Assesses whether a program, policy, or organizational approach, or some aspect of these, is feasible, appropriate, and acceptable before it is fully implemented. It can include process and outcome measures.

Process or implementation evaluation:

- Assesses how the program, intervention, operation, or regulation is implemented relative to its intended theory of change. It often includes information on processes, content, quantity, quality, and structure of what is being assessed.
- **This type of evaluation is included in the locally led evaluation**

Outcome evaluation:

- Measures the extent to which a program, policy, or organization has achieved its intended outcome(s). It *cannot* attribute causality.
- **This type of evaluation is included the locally led evaluation**

Impact evaluation:

- Estimates and compares outcomes with and without the program, policy, or organization, usually seeking to determine whether a causal relation can be established between the activity and the observed outcomes.

Phases and Steps of Any Type of Program Evaluation

The information below is taken from the following source:

"Sowing & Harvesting: Participatory Evaluation Handbook" by Esteban Tapella, Pablo Rodriguez Bilella, Juan Carlos Sanz, Jorge Chavez-Tafur, and Julia Espinosa Fajardo at German Institute for Development Evaluation (Deval) **evalparticipativa.net/wp-content/uploads/2022/08/SOWINGHARVESTING-FINAL-DOBLES-ALTA.pdf**

Phase 1: Planning Phase

Step 1. Determine who will be involved in the evaluation (the evaluation team)

Think about the who is…

- Affected by the work
    - Perspective they bring: Is the solution successful? How does the solution impact my life?
- Implementing and supporting the work

    - Perspective they bring: Are the efforts we are making worthwhile? Should we keep doing this? Is there anything to modify about our approach?
- Funding the work
    - Perspective they bring: Does this work align with our organizations mission & objectives? What do we need to know to continue to keep funding this work?
- The evaluation team will decide items like the following:
    - What is the evaluation purpose?
    - Where and how information is gathered?
    - How is the information analyzed and gathered?
    - How will the results be disseminated for use?

Step 2. Establish Evaluation Purpose

- The most important decision in designing an evaluation is determining the evaluation purpose and evaluation questions.
- The evaluation purpose refers to what the group wants to learn to solve a problem or make a decision.
- Evaluation purpose guides the process to ensure the evaluation results are used.
- To increase the likelihood that the evaluation results are used, involve more people in deciding the evaluation purpose as that will increase their buy-in and value to the evaluation
- Defining Clear Evaluation Objectives: Set specific, measurable, achievable, relevant, and time-bound (SMARTIE) objectives to guide evaluations.
- Evaluation works best when the purpose is rooted in a desire to learn and grow.
- Instead of “Determine if the project goals were achieved”, a more appropriate question is “Understand the reasons why project goals were or were not achieved.”

Step 3. Establish Evaluation Questions

- Once the evaluation purpose have been identified, establish the evaluation questions.
- The evaluation question refers to the information needed to resolve the problem or situation identified in the objective
- Good evaluation questions should:
    - Responds to an information need or seek to identify a solution
    - Refers to issues that can only be answered by evaluation
    - Have indicators that provide useful information to help answer the clearly answer the question
- Prioritize 2-3 questions with evaluation team based on which one will have added value and usefulness to the project

    - There may be many interesting things you want to know, but you can not collect everything. If you collect everything, that means more work in data collection and analyzing information. If information is collected, there is a responsibility to use the information
- Think about types of answers the evaluation questions will give you, as these are the outcomes of what you are trying to figure out.
    - Short Term Outcomes:
        - Immediate outcomes, like increased knowledge, attitude change, and/or behavior change
    - Medium-Term Outcomes:
        - Measurable changes in community norms or practices
    - Long-Term Outcomes:
        - Assess broad societal or environmental changes, such as improved health outcomes or policy shifts
- You can also compare actual results with the goals set by the evaluation plan

Step 4. Identify information sources & tools to gather information

- Identify information sources to answer the evaluation questions
- Use the evaluation team to identify and access people who can provide information
- Identify several information sources enables information to be gathered from multiple angles, decreasing evaluation bias and increasing rigor
- Using a logic model here can help to identify what and who you can gather information from
- Primary data sources are information from people who have been involved or impacted by the work
    - Primary data collection tools
        - Traditional: surveys, interviews, observation, and focus groups
        - Non-traditional, participatory: photovoice, community asset mapping, dot surveys, ripple effect mapping, community listening sessions, meeting facilitation techniques, and many more
- Secondary data sources are information previously collected from people that may or may not have been impacted by the work
    - Secondary data collection tools
    - Project reports, surveillance data, online blogs or information, government records, newspapers, and many more

Step 5. Plan the timeframe and costs of the evaluation

- **Timeframe:** Evaluation results will need to be communicated to people making decisions about the project
  - Determine when the results will need to be communicated to make project decisions and then figure out what is feasible within that timeframe the availability of resources, including funding, and the questions that can feasibly be answered
  - If the results are not available by decision time, the evaluation may not be worth time and resources, even if the evaluation was designed and implemented well
  - If using a participatory approach, make sure to build in enough time for training and capacity building
- **Costs to consider**:
  - Supplies & equipment
  - Travel
  - Staffing and/or contractor
  - Facilitator (if using participatory methods)
  - Stipends for participants

Phase 2: Implementation Phase

Step 6. Gather and record information

- To increase the likelihood of successfully gathering the desired information:
  - Adapt all tools and techniques to the community or project
  - Provide training on adapted tools and techniques
  - Gather information in an organized way for ease of use and analysis
  - If using participatory methods, thoughtfully choose the facilitator, as they guide the process of information gathering
- Be flexible and open to trying a variety several methods of gathering information, as it is common to find that information is incomplete or difficult to access
- Information can be gathered either quantitatively or qualitatively. With both types of information, you will still need to make meaning of information and draw conclusions.
    - **Quantitative Data & Methodologies:**
      - Answers questions by finding numerical patterns in numerical data, using math and statistics.
      - Data are presented in trends, differences, and averages.
      - Common quantitative data collection methods:
        - Surveys (US Census)

    - Surveillance systems (birth records)

- **Qualitative Data & Methodologies:**
  - Answers questions by finding patterns in ideas, experiences, and feelings.
  - It digs deeper to find the reasons behind why people say or do things.
  - Data are commonly presented in summaries of ideas, experiences, and feelings
  - Common qualitative data collection methods:
    - Focus groups
    - Informational interview
    - Many participatory methods
      - See this tool for examples: evalparticipativa.net/wp-content/uploads/2022/08/SOWINGHARVESTING-FINAL-DOBLES-ALTA.pdf
- **Mixed Data & Methodologies:**
  - Methods that utilize both qualitative and quantitative methods
  - For example, surveys can include both quant and qual if there is a mixture of multiple-choice questions to select specific answers (quant) and open-ended questions, for people to write their opinions (qual).

- **More on data & information collection**
  - Data & information collection is the foundational piece of every evaluation. Effective methods include:
  - Surveys & Questionnaires: To gather information from participants or the target community about their experiences and knowledge.
  - Interviews & Focus Groups: To gain deeper insights into attitudes, opinions, and experiences from program participants or other stakeholders.
  - Observational Data: Collecting data based on direct observation of activities or behaviors.
  - Administrative Data: Using existing records (like health statistics or participation data) to track progress or outcomes.
  - Pre/Post Test: Assessing changes in knowledge, attitudes, or behaviors before and after the program.

Step 7. Analyze Information

- Clean the data
  - Ensure that the data is accurate and complete before analysis

- Review the evaluation objective and questions to guide your analysis and to draw conclusions:
  - **For quantitative analysis:**
    - Complete descriptive analysis first, by calculating totals, averages, trends over time, group differences, etc.
    - If using a participatory evaluation, have participants help to calculate these values and interpret meanings & conclusions
    - Present information via charts, reports, and infographics
  - **For qualitative analysis:**
    - Find patterns in ideas, experiences, and feelings and thematically summarize those patterns
    - If using participatory evaluation, have participants identify the patterns and interpret meanings & conclusions
    - Present information through a variety of mediums, like audiovisual, graphics, text, or narratively.
- Present evaluation results with two overall sections:

1. **Conclusions**

- Present the analysis and meaning making
- How did the information gathered answer the evaluation questions?

2. **Recommendations:**

- What can be recommended for next steps as a result of the conclusion found?
- Evaluation results found XYZ, so this means, we recommend doing ABC next

Phase 3: Use Phase

Step 8. Disseminate the Results

- To ensure a positive transmission of the evaluation results including recommendations, the evaluation team should ensure that the results are:
  - Presented in an attractive way to engage the interest of each target group; and,
  - Correctly interpreted by the groups that are going to use them so that they can be easily turned into improvement measures.
- To make the evaluation results and recommendations appealing, presentation format(s) should be chosen that are most appropriate to each group. Think about the following:
  - Summary or detailed
  - Formal or informal
  - Oral presentation and/or written report

- Visuals and/or no visuals
- Online and/or in-print

Step 9. Put Findings Into Actions

- For each evaluation recommendation the action plan should have, at minimum:
  - Next steps that derive from the findings.
  - Person(s) responsible for these activities.
  - Resources needed.
  - Timeframe.
- The number of next steps depend on the number of partners and their different contexts and resources.
- As next steps are developed it is important to take into account the action plan team's knowledge of the program, and its context and available resources.

Step 10. Monitor the Implementation

- Monitoring the next steps will strengthen the positive effects of the evaluation and help detect future difficulties that might be resolved with a new evaluation.
  - Monitoring the next steps reveals the impact and unintended consequences of the plan and allows for adjustments, using the same analytical approach employed throughout the entire evaluation process.
- Program and evaluation staff meet regularly to review the progress of next steps.

Evaluation Methods and Tools (that are not surveys):

Checklist for a Good Evaluation

AssessingEvaluationQuestionChecklist.pdf

This checklist helps in creating strong evaluation questions by guiding users through criteria like stakeholder engagement, relevance, feasibility, and alignment with program goals. It ensures the questions are clear, actionable, and appropriate for the program's stage, while also considering ethical and resource constraints. The checklist is a useful tool for refining questions during evaluation planning to ensure they provide valuable insights.

Creative Ways to Solicit Feedback

https://www.publicprofit.net/Creative-Ways-To-Solicit-Stakeholder-Feedback/

Public Profit's "Creative Ways to Solicit Stakeholder Feedback" offers mission-driven organizations 15 innovative, non-traditional methods—such as selfie stations, candy surveys, and collages—to gather meaningful input from stakeholders, addressing common issues like survey fatigue and limited engagement. These approaches are organized into visual, kinesthetic, and verbal techniques, suitable for participants of all ages and adaptable to various settings, including virtual environments. Additionally, the guide provides quick start resources

tailored for specific audiences, such as children and youth, visitors, and strategies for equitable feedback collection.

Liberating Structures

Liberating Structures

Liberating Structures are 33+ adaptable structures designed to enhance group interactions by including and unleashing everyone, offering alternatives to conventional methods like presentations and managed discussions. These simple, easy-to-learn techniques foster lively participation, creativity, and trust within groups of any size. The website provides detailed descriptions of each structure, guidance on implementation, and resources to support individuals and organizations in transforming their collaborative processes

Measuring What Matters with Community-Led Monitoring

Measuring What Matters With Community-Led Monitoring - Collective Impact Forum

The article explores the importance of community-led monitoring in improving health systems, with the example of HIV treatment access. It highlights how community members gather data to identify issues and drive changes in health policy. By empowering affected communities, this approach helps ensure that health systems meet the needs of those who are often overlooked.

Participatory Asset Mapping

https://communityscience.com/wp-content/uploads/2021/04/AssetMappingToolkit.pdf

The Asset Mapping Toolkit is a resource designed to help communities identify and leverage their existing assets to drive development and problem-solving initiatives. It provides a structured approach to mapping resources, including physical, human, and organizational assets. The document outlines methodologies for asset-based community development (ABCD), emphasizing collaboration, local strengths, and sustainable growth.

Participatory Evaluation

Chapter 36., Section 6. Participatory Evaluation - Main Section | Community Tool Box

The Community Tool Box's Participatory Evaluation emphasizes the importance of involving stakeholders—such as participants, staff, and community members—in evaluating community projects. This collaborative approach ensures that multiple perspectives are considered, leading to more accurate assessments and fostering community buy-in. The section outlines steps for conducting participatory evaluations, including recruiting and training stakeholder teams, defining evaluation questions, collecting and analyzing data, and using findings to enhance the project. Additionally, it discusses when participatory evaluation is most appropriate and provides resources like checklists, tools, examples, and a PowerPoint presentation to support implementation

Participatory Methods

Participatory Methods Website

The Participatory Methods website, curated by the Institute of Development Studies, is a comprehensive resource dedicated to promoting inclusive development and social change

through participatory research methods. It offers detailed explanations of various methodologies, case studies, tools, and ethical considerations, aiming to empower individuals and communities to actively engage in decisions affecting their lives. Additionally, the site provides guidance for funders on supporting participatory approaches and features training opportunities, news, and blogs to keep users informed about the latest developments in the field.

Photovoice

https://www.countyhealthrankings.org/resources/facilitators-toolkit-for-a-photovoice-project

This toolkit (from United for Prevention in Passaic County) provides step-by-step guidance for community leaders to implement a photovoice project. It also examines ethical considerations, and includes sample timelines, photography tips, and additional examples and resources.

Ripple Effect Mapping

https://conservancy.umn.edu/items/6b190dd2-d66d-4c04-b76e-4b5d8a3784e8

Ripple Effects Mapping (REM) is a participatory evaluation technique that visually captures the impacts of complex programs and collaborations. Combining Appreciative Inquiry, mind mapping, facilitated discussion, and qualitative analysis, REM helps groups identify both intended and unintended outcomes. This field guide provides a step-by-step approach to implementing REM, with visuals, real-world examples, and practical guidance for community and organizational use.

Minnesota Data Sources:

SHIP Tableau Site

https://stats.web.health.state.mn.us/

This site hosts annual and multi-year data collected about SHIP through MDH. Talk to your CS if you want access to this site.

County Level Health Indicators:

https://www.health.mn.gov/communities/practice/assessplan/lph/countyindicators.html#download

The county-level health indicators spreadsheet provides links to county-level health data from various sources. MDH has gathered these indicators to assist Minnesota's local health departments and community health boards in their community health assessment and community health improvement planning processes.

Minnesota State Demographic Center

https://mn.gov/admin/demography/data-by-place/

The Minnesota State Demographic Center offers a variety of demographic, economic, and social data resources focused on different geographical areas within Minnesota. Users can explore data on cities, townships, counties, school districts, zip codes, and legislative districts. The site provides access to population estimates, projections, and historical census data, as well as data from the U.S. Census Bureau's American Community Survey. This resource is designed to help

users better understand and analyze local demographic trends and support informed decision-making for planning, policy, and research in Minnesota.

Minnesota Compass:

https://www.mncompass.org/

The website Minnesota Compass provides data about Minnesota. It tracks trends and measures progress in areas such as demographics, economy, education, health, and quality of life. The platform allows users to explore various statistics, custom profiles, and community-level data, with a focus on promoting equity and addressing social issues. It aims to support informed decision-making for individuals, organizations, and policymakers.

CDC Places data:

https://www.cdc.gov/places/index.html

The CDC's PLACES (Local Data for Better Health) website provides access to local public health data to support informed decision-making and improve health outcomes in communities. The site offers a range of data tools, including maps and reports, that allow users to explore key health metrics for various regions. These metrics help local organizations, policymakers, and public health professionals track trends, identify health disparities, and drive targeted interventions for better community health.

Health Equity and Community Engagement

Achieving health equity is important for all people and requires a systemic approach to making sure people and communities have access to what they need to be healthy. People and communities are often prevented from being as healthy as possible by unjust or unfair barriers, and these are called health inequities.

Community engagement is a process of intentionally connecting with community by working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting them. This is critical because the way the work is done with communities can advance or hinder health.

Health Equity/Community Engagement Guide

Relationship Building

Description

SHIP staff create and maintain holistic relationships with community partners at SHIP partner sites. These partnerships create pathways and methods for collaboration and SHIP PSE changes. SHIP staff have the skills and capabilities to acknowledge, leverage, and build upon project elements for implementing SHIP PSE changes.

How to

OSHII support to LPH to be successful:

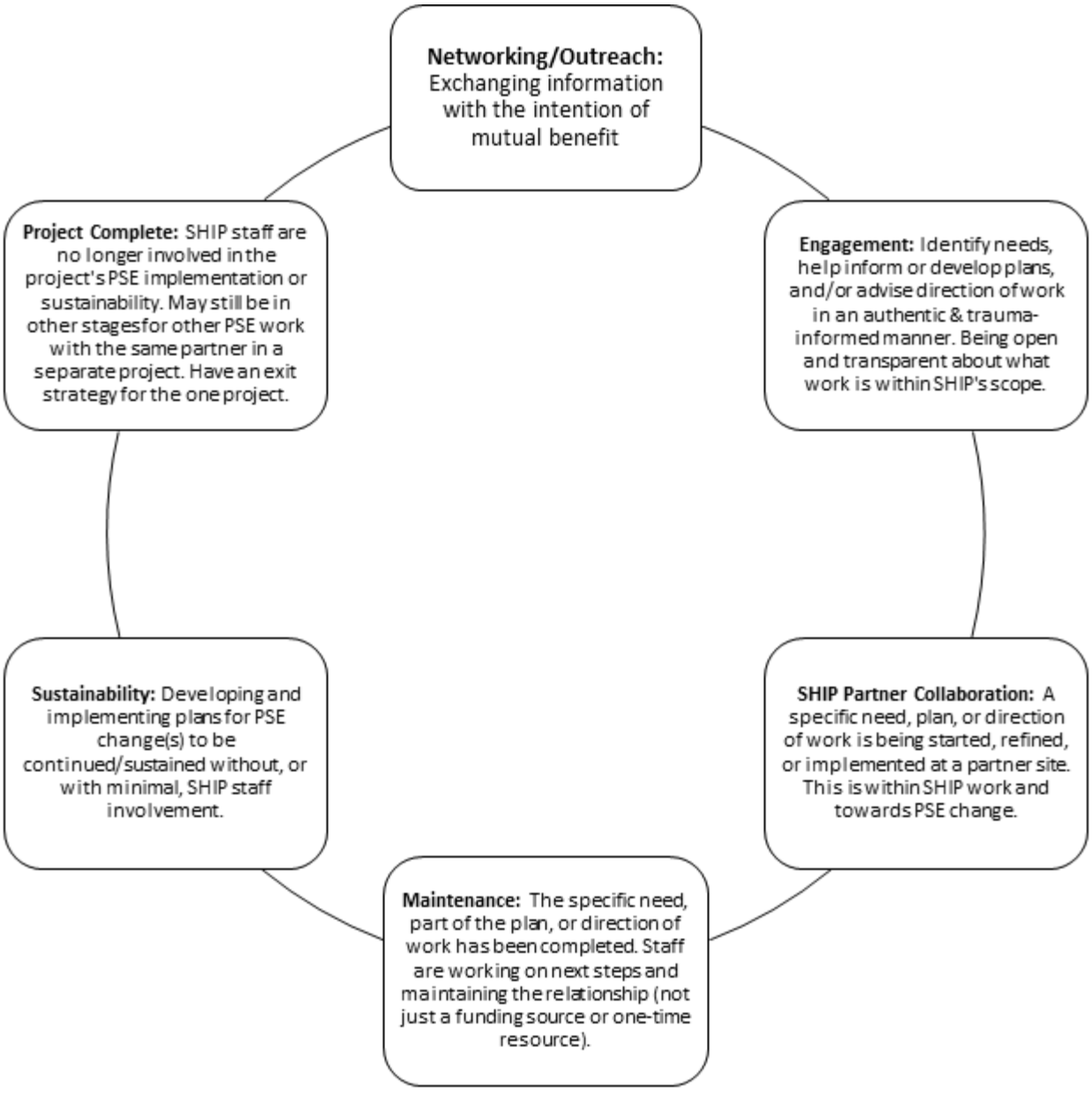
- Consistent use, definition, and guidance of the elements

- Clear requirements
- Training opportunities with refreshers
- “Job” shadow or peer learning opportunities
- TA and relevant tools, toolkits, templates, etc.
- Networking

LPH Skills needed:

- Building and maintaining trust
- Communication methods (e.g., long-term collaboration, active listening, transparency)
- Holistic relationship mindset
- Flexibility (e.g., different peoples’ abilities, practices, time, capacity, technology skills and access)
- Finding and sharing evidence-based resources
- Finding and sharing other grants
- Explaining and tying in evidence-based research and SHIP strategies to community anecdotes and empirical experiences
- Management skills (e.g., project, grant, people and personalities, meeting facilitation, coaching etc.)
- Cultural awareness
- Trauma-informed awareness
- Health Equity awareness

Elements of Relationship Building:



Relationship Building within Community Partner Awards:

- Funding Award must be connected to an approved project in the SHIP Information System.
- It is recommended that Community Partner Awards flow from assessment or proactive partnership. While not encouraged, an All-Call type Community Partner Award is allowable.
- In all cases, it is best practice to meet with a potential partner to share SHIP's purpose, eligible strategies, and expectations for potential applicants before a Community Partner Award Application is completed to ensure that the project aligns with SHIP PSE work.
    - All-Call Community Partner Award**:** This award recognizes a PSE (policy, systems, and environmental change) project that received SHIP funding through an open, publicly shared invitation issued by a LPH SHIP grantee. The invitation, shared through public

platforms such as newspapers, websites, or social media, welcomes organizations within the jurisdiction to submit a funding request without prior contact or consultation with LPH SHIP staff to confirm alignment with SHIP goals. LPH SHIP grantees are strongly encouraged to host a webinar or provide a publicly accessible FAQ to explain SHIP's purpose, eligible strategies, and expectations for potential applicants.

Technical Assistance and Training

Description

MDH's Office of Statewide Health Improvement Initiatives (OSHII) technical assistance (TA) and training system builds state and local capacity to successfully implement best practices in health improvement, community engagement and health equity strategies through policy, systems and environmental (PSE) changes.

Synopsis of TA & Training in SHIP State Statute

OSHII "shall provide content expertise, technical expertise, training to grant recipients, and advice on evidence-based strategies, including those based on populations and types of communities served." OSHII "shall ensure that the statewide health improvement program meets the outcomes…by conducting a comprehensive statewide evaluation and assisting grant recipients to modify or discontinue interventions found to be ineffective."

See Subd. 3.Technical assistance and oversight.

Goals

- OSHII is responsive to on-going and emerging LPH TA & Training needs.
- OSHII staff receive support (e.g., Training and Professional Development) to meet on-going and emerging LPH TA & Training needs. Professional development is a consciously designed, systematic process.
- Follows the TA & Training key elements, with an annual assessment at both LPH and OSHII levels of how these elements have been operationalized to identify improvements.
- Internal TA Tracking within OSHII (i.e., what OSHII is offering to LPH SHIP staff) is operationalized and applied across OSHII.
- On-going external support for the OSHII TA & Training program is provided by the LPH SHIP TA & Training Advisory Team.
- Internal support for the OSHII TA & Training program is provided by the OSHII TA & Training Advisory Team

Interrelationship of Core Terms for TA & Training:

Interrelationship of Core Terms for TA & Training (see the definitions of Professional Development, Technical Assistance, and Training in the definitions section: OSHII TA & Training Core Terms are interrelated. The operationalization of these core terms propels the continuous cycle of learning and improvement of the SHIP TA & Training program.

Key Elements

- **Continuous Learning and Improvement:** On-going design, delivery, and evaluation is centered on information gathered from the work through a structured process aiming for sustainability.
- **Audience-Centered:** Tailored to meet expectations, address requirements, and meet goals. Intentionally iterative, responsive, and grounded in adult learning principles to meet the needs of all partners (e.g., LPH SHIP staff, OSHII staff, SHIP Community Partners, TA Providers).
- **Clarity:** Expectations, requirements, processes, guidance, and information shared between and across all partners (e.g., LPH SHIP, OSHII Staff, SHIP Community Partners, TA Providers) is made as clear as possible through clear communications, shared through a variety of approaches and is accompanied by a mechanism for asking questions and engaging in discussion.
- **Timeliness:** Information, resources, evaluation, and design (TA & Training offerings) are as up to date as possible and are responsive to current and emerging needs of all partners (e.g., LPH SHIP staff, OSHII Staff, SHIP Community Partners, TA Providers).
- **Coordination:** Commitment to working collaboratively between OSHII and LPH SHIP across all levels of experience to align with programmatic goals.

TA & Training Methods (Active and Passive)

Active TA is TA that is available at specified times and includes human contact. Active TA includes:

- Local Public Health SHIP Staff Orientation – OSHII-led orientation to take place within the early weeks of employment with new LPH SHIP Staff. Check-in meetings are also scheduled 3 months, 6 months, and one year after the initial orientation. See Basecamp for the orientation outline.

- Individual, one-on-one TA – Phone, email and in-person responses to LPH SHIP individual requests and as part of the SHIP workplan review process
- Regional Meetings – In-person or virtual forums for peer learning, training, and networking on a rotating set of topics
- Statewide Meeting – In-person or virtual forum bringing together LPH SHIP, MDH staff and other partners to continue to network and strengthen our state – local public health partnerships
- TA Providers – organizations funded by MDH, provide technical assistance and training on foundational and setting and behavior specific skills
- Webinars and Conference Calls– Virtual training and TA opportunities on a variety of topics
- Workshops and Trainings – In-person or virtual workshops designed to meet the needs of LPH SHIP

Passive TA is TA that is available 24/7 with no direct human contact or is considered asynchronous or self-paced. Passive TA includes:

- Basecamp for peer-to-peer sharing - e.g., Message Board or Campfire Chat
- SHIP Implementation Guide - Documents that provide grant implementation guidance, located on Basecamp.
- SHIP 6 Strategy Guides - Guides to working in each of the seven SHIP 6 Settings. Each guide and related documents are available on Basecamp in the associated setting team.
- SHIP Information System – A form to request direct TA from OSHII Staff is available in Agile Apps.
- E-learning – Remote, virtual training and TA opportunities on a variety of topics (e.g., Minnesota Extension courses.) OSHII-developed e-learning modules are in development.

Other resources

- **Making It Better Newsletter** - E-newsletter for LPH SHIP that provides updates, upcoming trainings, success stories, resources, etc.
- MN Healthy Workplaces Newsletter – Quarterly E-newsletter for Minnesota employers to provide timely information from MDH. Also serves as a recruitment tool for LPH SHIP.
- Listing of grants that can help support SHIP projects or help support parts of projects that don't fall under the SHIP financial guide. A listing of annual seminars and conferences is also included in this resource.

External TA Providers

In addition to the delivery methods listed above, MDH staff work closely with several external partners to coordinate delivery of TA and training to support LPH SHIP and Commercial Tobacco Prevention grantees. Contact your Community Specialist with questions and requests for TA and training.

External TA Provider	Focus Area
American Lung Association	Commercial tobacco PSE change (ALA supports all counties outside of the 11-county metro area)
Association for Nonsmokers-MN	Commercial tobacco PSE change (ANSR supports the 11-county metro area)
BikeMN (ending 6/2026)	Improving access to active transportation and active living opportunities
Jason Bergstrand (ending 12/2025)	Workplace Wellness initiatives and Mental Wellbeing
Minnesota Department of Transportation	Safe Routes to School (SRTS) monthly call
Karen Nitzkorski (ending 12/2025)	Workplace Wellness initiatives
Public Health Law Center	Legal technical assistance on healthy eating and food access, active living, and commercial tobacco
Social Motion – Traci Warnberg-Lemm	Coach Training (All Settings); Food Rx Coach
Southeast Service Cooperative - Nicole LaChapelle-Strumski (ending 12/2025)	Workplace Wellness initiatives in Southeast MN

Support from MDH Staff

LPH SHIP may contact the MDH staff listed below for TA and training and to identify TA providers, partners, or peers who can be of assistance. **LPH SHIP staff are required to copy their Community Specialist in these communications.**

Topic	Contact
American Indian Community Initiatives	LaRaye Anderson, 218-368-0372 LaRaye.Anderson@state.mn.us Sarah Brokenleg, 612-394-6228 Sarah.Brokenleg@state.mn.us
Communications	Susan Thurston-Hamerski, 651-201-5433 Susan.Thurston-Hamerski@state.mn.us Commercial Tobacco-Free Communications: Parker Smith, 651-201-5496 Parker.Smith@state.mn.us
Community Specialists, Grants Management	health.ship.cs@state.mn.us Alice Englin, 507-508-0988 Alice.Englin@state.mn.us Anna Johnson, 651-201-5920 Anna.Johnson@state.mn.us Chelsea Tufts, 651-356-2190 Chelsea.Tufts@state.mn.us Jennifer Wald, 651-201-4485 Jennifer.Wald@state.mn.us
Child Care Settings	health.earlychildhood@state.mn.us Elizabeth Gardner, 651-201-3878 Elizabeth.Gardner@state.mn.us
Food Access in Community Settings	health.healthyeating@state.mn Sadie Gannett, 651-201-5680

Topic	Contact
	Sadie.Gannett@state.mn.us Hilary Gebauer, 651-201-3865 Hilary.Gebauer@state.mn.us
Evaluation	Health.ship.eval@state.mn.us Alexander Blidi, 651-201-6722 Kim Edelman, 651-201-5497 Liana Schreiber, 651-201-5441
Health Care Settings	health.healthysystems@state.mn.us Alex Dahlquist, 651-201-4099 Alex.Dahlquist@state.mn.us
Health Equity and Community Engagement	Tracy Ackman-Shaw, 651-201-3871 Tracy.Ackman-Shaw@state.mn.us
Active Living in Community Settings	health.activeliving@state.mn.us Ellen Pillsbury, 651-201-5493 Ellen.Pillsbury@state.mn.us
School Settings	health.healthyschools@state.mn.us Jeremy Vann, 651-201-5498 Jeremy.Vann@state.mn.us
TA and Training	ship.comTA@state.mn.us Brian Bluhm, 651-201-4663 Brian.Bluhm@state.mn.us Kim Engwer-Moylan, 651-201-5440 Kim.Engwer-Moylan@state.mn.us
Commercial Tobacco-Free in Community Settings	Emily Jones, 651-201-4752 Emily.Jones@state.mn.us
Commercial Tobacco Cessation	Heidi Larson, 651-201-3565

Topic	Contact
	heidi.larson@state.mn.us Michael Sheldon, 651-201-3663 Michael.sheldon@state.mn.us
Mental Wellbeing in Settings	Refer to each OSHII Setting Contact
Workplace Settings	health.workplace.wellness@state.mn.us Holly Glaubitz, 651-201-5432 Holly.Glaubitz@state.mn.us

Basecamp – On-line platform for peer-to-peer sharing

- Primary Teams: Communications, Community Engagement & Health Equity, Compass Calendar, Evaluation, Local SHIP Staff
- Each SHIP Setting has a Basecamp Team with Strategy Guides. Ask your Community Specialist for access to Basecamp Settings Teams.
- **Compass Calendar** – The Compass Calendar is a communication tool to help promote events to Local Public Health and others. It holds two main schedules:
- SHIP Schedules
  - Meetings
  - Webinars
  - Coffee Chats, co-learning, office hours, and small/peer groups
  - Trainings
  - Due dates
- Commercial Tobacco-Free Partner Meetings

Contact your Community Specialist to get access to the Local SHIP Staff and SHIP Compass Basecamp Teams.

Here is a tool on "How to find things on Basecamp".

Communications

Sharing the success of your SHIP work is an important part of your work. Through storytelling, we are able to present to our communities the value of SHIP in creating communities where making the healthy choice is the easy choice.

Approval Process

SHIP communications approval helps ensure that branding requirements are met, messaging is clear, and products reflect the best in SHIP communications and marketing efforts. This is important because as funders, OSHII has a responsibility to ensure that tax money is spent wisely and that its image is not damaged in the public eye.

- Communications items should be submitted via the SHIP Information System. When planning communications please include as much lead-time as possible (an ideal turn around would be five business days).
- All communications prepared by or for SHIP staff, service contractors and/or community partners must be approved by OSHII communications.
- Communications that need approval are all those that are funded by SHIP and seen by the public, including:
  - Advertisements
  - print and electronic materials (e.g., posters, fliers, direct mail, brochures, fact sheets, newsletters)
  - letters that are part of a larger outreach effort
  - scripts for radio spots/TV programming
  - media releases/media advisories/letters to the editor
  - permanent signs
  - purchased social media (e.g., boosts or ads)
- OSHII communications will try to turn requests around as soon as possible. The general guideline for approvals is a 48-hour turnaround. If your need is time sensitive, please state the response deadline in the request.

Outside contractor use

LPH SHIP may determine that their communications efforts could use some support from an outside contractor. LPH SHIP must get MDH approval for any communications contracts every fiscal year, no matter the amount. OSHII communications staff can help LPH SHIP determine project goals and what to expect when working with a contractor. Best practice is to include OSHII Communications Staff before proposals are released to contractors.

Plain Language

Our audiences are varied, and we strive to use language and channels that deliver our stories effectively—responsive to culture and community expectations—to inspire participation in and

awareness of SHIP. A key part of making that happen is the use of plain language. Refer to the MDH plain language guidance in Basecamp for best practices and preferred usage and style.

Required Communications

Acknowledgement and use of earned media

Communications created to advance SHIP and earned media—such as news stories, radio interviews, or other instances where media contact you about SHIP—are opportunities to increase the reach of SHIP work.

As LPH SHIP, you should

- Allow MDH to use any products and creative materials created with SHIP funds.
- Acknowledge SHIP funding in all publicity—including releases, informational brochures, public reports, publications, and other public information relating to approved projects. This can be accomplished by including the statewide SHIP logo on the communications piece or using the statement: Supported by the Minnesota Department of Health Statewide Health Improvement Partnership.

SHIP branding

Communicate with OSHII regarding product approval and ensure that communications pieces funded by SHIP conform to best practices and include a SHIP logo and appropriate messaging. You can find the SHIP approved logos in Basecamp.

Success Stories

Submit at least two success stories per year (one at six months – April 30 and one at year-end – November 30). Follow the guidance in Basecamp for a successful success story. The success stories are submitted via the Success Story Survey.

Social Media

- OSHII Communications Staff encourages use of social media to amplify SHIP visibility. To help elevate SHIP as a statewide brand, use the hashtag #MNSHIP in content.
- Tag all social media posts to the Minnesota Department of Health by including the tag @mnhealth. This makes the post visible to MDH communications and increases the likelihood of the post being liked and shared.
- Free social media posts do not require prior approval, only paid social media posts require prior approval via the SHIP Information System (see Approval Process above).

SHIP Settings

All Setting Strategies At A Glance:

All Settings, Strategies, Evidence Rankings, & Social Determinants of Health

Setting	Strategy	Evidence Rating	Social Determinant of Health Addressed
Active Living in the Community	Bicycle and Pedestrian Master Plans	Proven Effective	Neighborhood and Built environment
Active Living in the Community	Complete Streets Policies and Streetscape Design	Proven Effective	Neighborhood and Built environment
Active Living in the Community	Comprehensive Planning, Land Use and Zoning:	Proven Effective	Neighborhood and Built environment
Active Living in the Community	Public Transit Infrastructure and Access	Proven Effective	Neighborhood and Built environment
Active Living in the Community	Safe Routes to Schools	Proven Effective	Neighborhood and Built environment
Active Living in the Community	Vision Zero Policies	Proven Effective	Neighborhood and Built environment
Child Care	Breastfeeding Support	Proven Effective	Health care access & quality, Neighborhood & Built Environment, Social and Emotional Context, Economic Security
Child Care	CACFP	Proven Effective	Education Access & Quality, Neighborhood & Built Environment, Social and Community Context
Child Care	Farm to ECE (Nutrition Ed, Gardening, Local Procurement)	Proven Effective	Education Access & Quality, Neighborhood & Built Environment, Social and Community Context
Child Care	Movement throughout the Day	Proven Effective	Neighborhood & Built Environment
Child Care	Nutrition Guidelines	Proven Effective	Neighborhood & Built Environment
Child Care	Outdoor Classrooms	Theory-based	Education Access & Quality, Neighborhood & Built Environment, Social and Community Context
Child Care	Social Emotional Learning	Theory-based	Education Access and Quality, Social and Community Context, and Health Care Access and Quality
Commercial Tobacco Free in the Community	Point-of-Sale	Proven Effective	Neighborhood and built environment
Commercial Tobacco Free in the Community	Smoke and Commercial Tobacco-Free Outdoor Spaces	Proven Effective	Neighborhood and built environment
Commercial Tobacco Free in the Community	Smoke-Free Housing	Proven Effective	Neighborhood and built environment

Commercial Tobacco Free in the Community	Youth Engagement in Commercial Tobacco-Free Strategy	Proven Effective	Neighborhood and built environment, Education Access & Quality, Social & Community Context
Food Access in the Community	Breastfeeding Support	Proven Effective	Reduce household food insecurity & hunger
Food Access in the Community	Community-Based Agriculture	Promising	Improve health by promoting healthy eating and making nutritious foods available
Food Access in the Community	Farmers Markets	Promising	Improve health by promoting healthy eating and making nutritious foods available
Food Access in the Community	Food & Nutrition Security	Theory-based	Reduce household food insecurity & hunger Improve health by promoting healthy eating and making nutritious foods available
Food Access in the Community	Food Guidelines	Proven Effective	Improve health by promoting healthy eating and making nutritious foods available
Food Access in the Community	Food Rx	Promising	Reduce household food insecurity & hunger
Food Access in the Community	Food Shelves	Promising	Reduce household food insecurity & hunger
Food Access in the Community	Food Systems Policy & Planning		Reduce household food insecurity & hunger
Food Access in the Community	Hydration Access	Proven Effective	Improve health by promoting healthy eating and making nutritious foods available
Food Access in the Community	Local Food Procurement	Promising	Improve health by promoting healthy eating and making nutritious foods available
Healthcare	Age-Friendly Public Health Systems	Promising	Health Care Access & Quality; Social & Community Context
Healthcare	Baby Café- Breastfeeding Support in the Community	Proven Effective	Health Care Access & Quality; Neighborhood & Built Environment; Social & Community Context
Healthcare	Behavioral Health Settings - Commercial Tobacco Free	Proven Effective	Health Care Access & Quality; Neighborhood & Built Environment
Healthcare	Breastfeeding-Friendly Birth Center	Proven Effective	Health Care Access & Quality; Social & Community Context; Neighborhood & Built Environment; Economic Stability
Healthcare	Community-Clinical Linkages for Mental Health	Promising	Health Care Access & Quality; Social & Community Context
Healthcare	Community-Clinical Linkages for Social Determinants of Health	Promising	Health Care Access & Quality; Social & Community Context

Healthcare	Exercise is Medicine - Park Rx	Proven Effective	Health Care Access & Quality; Neighborhood & Built Environment; Social & Community Context
Healthcare	Food Rx	Proven Effective	Health Care Access & Quality; Social & Community Context
Healthcare	Health Care Homes	Proven Effective	Health Care Access & Quality
Healthcare	Organizational Health Literacy	Proven Effective	Health Care Access & Quality; Social & Community Context
Healthcare	Patient Self-Management with Clinical Support	Proven Effective	Health Care Access & Quality; Social & Community Context
Healthcare	Quit Partner Referrals	Proven Effective	Health Care Access & Quality
Healthcare	Supporting Students with Chronic Conditions	Promising	Health Care Access & Quality; Social & Community Context; Education Access & Quality
Healthcare	WIC Referrals	Proven Effective	Health Care Access & Quality
Schools	Comprehensive Commercial Tobacco-Free Schools	Proven Effective	Educational Access and Quality
Schools	Comprehensive Framework for School Nutrition Environment and Services	Proven Effective	Educational Access and Quality
Schools	Comprehensive Mental Health Systems	Proven Effective	Educational Access and Quality
Schools	Comprehensive School Physical Activity Program	Proven Effective	Educational Access and Quality
Workplace	Breastfeeding Support	Proven Effective	Economic stability, Neighborhood and built environment
Workplace	Commercial Tobacco Free Workplaces	Proven Effective	Neighborhood and built environment
Workplace	Healthy Eating in the Workplace	Proven Effective	Economic stability, Neighborhood and built environment
Workplace	Mental Wellbeing in the Workplace	Promising	Social and community context
Workplace	Supporting Movement throughout the Day	Promising Effective	Neighborhood and built environment

To support integrated, community-driven work, the following guidance outlines how to plan and implement SHIP Policy, Systems, and Environmental projects that span one or more settings. This next section provides a step-by-step approach for developing cohesive strategies anchored in local priorities and aligned with a shared SMARTIE goal.

Creating a Cohesive SHIP PSE Project

SHIP 6 is designed to support coordinated, community-driven work across multiple settings through PSE Projects. PSE projects are made up of community partners working on setting-specific strategies. A PSE project's make up can vary by number of settings, strategies, and partners. For example, a PSE project can be made up of:

- multiple settings, multiple strategies, and multiple partners
- one setting, multiple strategies, and multiple partners
- one setting, one strategy, and multiple partners
- one setting, one strategy, and one partner
- one setting, multiple strategies, and one partner

While the make-up of PSE projects may vary, **all** PSE projects will be driven by community priorities. A SMARTIE goal will define the scope of work. For example, if multiple settings and strategies are chosen for a project, all strategies within the PSE project must contribute to achieving the SMARTIE goal.

This section outlines how to develop community-driven PSE projects across SHIP settings for a more cohesive approach.

Action Steps

Step: 1: Review your SHIP Overall Assessment and Priorities (SOAP) and Opportunity/Problem Statements

The purpose of the SHIP Overall Assessment and Prioritization (SOAP) process is to ensure that SHIP 6 PSE projects and strategies are genuinely driven by community priorities and help determine where SHIP 6 resources should be allocated to address the greatest needs. With your CLT/CLT alternatives and/or other community partners, review the SOAP Assessment and Prioritization Summary and Opportunity/Problem statements and other data that is relevant to SHIP work. This information will assist in determining the focus of SHIP 6 PSE projects. This review will result in a list of potential PSE projects that the community has prioritized.

MDH acknowledges that not all PSE projects will address priorities as PSE projects are also developed based on emerging needs, momentum, and capacity.

Step 2: Develop SMARTIE goals with your CLT/CLT Alternatives (community and partners)

Step 1: All projects require a SMARTIE goal. SMARTIE stands for: Specific, Measurable, Achievable, Relevant, Time Bound, Inclusive and Equitable.

A goal is an aspirational statement about what you want to achieve and a concrete way to drive results, but without an explicit equity and inclusion component, goals will not produce better outcomes for marginalized communities, address disparities, or create belonging. Use community input and data to identify key health priorities. Center their voices in your planning

and build from their priorities. Use SHIP's core components, such as community engagement, equity, and trauma-responsiveness, to guide collaboration.

An example of a SMARTIE goal around healthy eating would be "Increase access to and consumption of nourishing, affordable, and culturally relevant foods for families with young children in example County by reviewing data from key interest holders and documents to implement at least one SHIP strategy in two or more SHIP Settings over the next year."

Step 3: Identify strategies across SHIP settings that support the shared goal(s) by reviewing the SHIP Implementation Guide

Take your priorities and goals and review the Setting and Strategy information in the Implementation guide. Look for similar themes and areas that overlap. There are specific Strategy Guides that outline the action steps and implementation expectations for each strategy. Some Foundational Settings Projects may need to be done before the work on the PSE Project and the specific strategies can begin. Additional resources, examples, and inspiration can be found in Basecamp. Contact your CS and OSHII Setting staff for any additional questions or planning support at any point in your work.

For the healthy eating goal above, here is how strategies could be aligned:

- **Child Care Settings**
  The Farm to Early Care strategy - source local foods, integrate nutrition education, and engage families in culturally meaningful food-related activities.
- **School Settings**
- **The Comprehensive Framework for School Nutrition Environment and Services strategy** - conducting activities that increase the establishment or implementation of evidence-based school nutrition and food security policies and practices, such as but not limited to establishing school gardens, updating the wellness policy to reflect smart snack guidelines, providing learning opportunities for healthy eating, or creating the policy, system, and environment for school-based food shelves.
- **Food Access in the Community Settings**
  The Food Shelves strategy - increase the availability of fresh produce and/or culturally relevant foods by prioritizing a client-choice based model.
- **The Community Based Agriculture strategy** - support improved food access or donation policies to local hunger relief organizations by implementing policy and systems changes at community gardens.
- **Healthcare Settings**
  Community-Clinical Linkages for Social Determinants of Health - integrate food insecurity screening during well-child visits and refer families to SHIP-supported local food resources (e.g., food shelves, farmers markets, community-supported agriculture). Could include WIC Referrals strategy and promoting produce prescription programs when feasible (Food Rx).
- **Workplace Settings**
  Healthy Eating in the Workplace strategy - partner with employers and local businesses to

improve food environments (e.g., healthy vending, nutritious staff meeting policies). Provide wellness education and promote connections to local food systems such as farmers markets, CSA shares, or community gardens.

Step 4: Enter the PSE project into the SHIP Information System (SIS) for OSHII Review and Approval before implementation

Now that you have the data, the community voice, and the SHIP strategies that support the PSE project, SHIP staff need to enter that information into the SHIP Information System (SIS). This is where you will manage and report on the project within your workplan. For SHIP 6, all projects need to be entered by LPH SHIP staff and then marked as approved by OSHII staff before work may begin and expenses incurred. This includes using staff time and/or granting community partner awards. Some PSE Projects may flow from Core Component or Foundational Settings Projects that were already approved by OSHII staff, but the PSE Project will also need to be marked as approved.

Step 5: Implement the PSE Project

The implementation method(s) may follow the strategy guide(s), or they may not. Every community, partner, and SHIP staff are different in how they work together on SHIP PSE projects within the allowed strategies.

Step 6: Report, reflect, evaluate, and adapt

As your team implements the action steps for each PSE Project, the SHIP information System (SIS) will have you document actions, monitor progress, and report results. Reporting on your work is very important! Every 6 months, you will also be asked to write what has happened in the last 6 months, think about the status of projects and strategies, reflecting on how they are progressing (or not), and the factors contributing to the status. Feel free to add notes or report more frequently in SIS within the 6-month update areas. Don't try to remember 6 months' worth of work all at once but use SIS to help you manage the project and report all in one, as much as possible and as often as needed for yourself. Together, these tools support learning and accountability across all settings. Celebrate progress, learn from challenges, and adjust your project as needed. Discuss and share with colleagues across the state too. Writing project notes and reports is one way to help ensure project continuity and sustainability but so does talking and listening with others. The process is as important as the SHIP PSE accomplished.

Evaluation is always encouraged, and some is required for every project. Feel free to track and share outcomes across settings to assess how your integrated approach is working. Collect both qualitative and quantitative feedback from community members and partners.

Examples

Each of these examples illustrate how PSE changes within strategies can align across Settings to reinforce behavior change and build a culture of health in communities.

Example 1: School Settings + Food Access in Community Settings + Healthcare Settings

SMARTIE Goal:

By June 2026, increase access to healthy, affordable food for low-income families by implementing at least three coordinated initiatives across school, community, and healthcare settings in partnership with local interest-holders, ensuring culturally relevant food options and input from populations most impacted by food insecurity.

Strategies:

School Settings - Comprehensive Framework for School Nutrition Environment and Services Strategy:

PSE Changes:

- **Policy:** School wellness policy updated to require locally sourced produce in meals.
- **System:** Institutionalized farm-to-school procurement system with local food hub.
- **Environment:** Salad bar installed and maintained in cafeteria.

Food Access in Community Settings – Local Food Procurement and Farmers Markets Strategies:

PSE Changes:

- **Policy:** Create or update a policy around local food procurement in any SHIP setting [Local Food Procurement Strategy] to support purchase agreements between local farmers and the school district
- **System:** Establish a system to connect local producers with organizations to support local food procurement [Local Food Procurement Strategy] via a local food hub
- **Environment:** Start a new Farmers Market [Farmers Market Strategy} that will sell locally grown, culturally relevant produce to the community

Healthcare Settings - Community-Clinical Linkages for Social Determinants of Health Strategy:

PSE Changes:

- **Policy:** Screening protocols for food insecurity integrated into patient intake.
- **System:** Referral system embedded into EHR linking patients to school and community food programs.
- **Environment:** Nutrition materials made visible and accessible in waiting rooms and clinics.

Example 2: Child Care Settings + Workplace Settings + Food Access in the Community Settings

SMARTIE Goal:

By June 2026, support early childhood nutrition by partnering with at least five early care providers to implement healthy eating activities and connect 100 working families to healthy

food supports (e.g., WIC, food shelves, produce boxes), with outreach efforts designed in collaboration with culturally diverse families to ensure inclusivity and equity.

Child Care Settings PSE changes:

- **Policy:** Nutrition standards adopted for meals/snacks based on CACFP or state guidance.
- **System:** Family engagement process updated to include nutrition education at enrollment.
- **Environment:** Child-friendly visuals promoting healthy eating displayed in eating areas.

Workplace Settings PSE changes:

- **Policy:** Healthy food procurement policy for meetings, events, and vending.
- **System:** Regular lunchtime wellness education series scheduled as part of HR benefits.
- **Environment:** Improved access to fruits/vegetables in breakrooms and vending machines.

Food Access in Community Settings PSE changes:

- **Policy:** Establish / update food guidelines for concessions at a community location [Food Guidelines Strategy] – specifically for concessions sold to youth and provided a youth programs.
- **Systems:** Establish / support a system for food distribution to priority population(s) [Food and Nutrition security Strategy] – specifically integrate referrals to local SNAP-Ed coordinator into library & parks & rec platforms.
- **Environment:** Expand existing community garden to serve priority population [Community Based Agriculture Strategy] – by providing children's gardening tools and educational materials to local community garden.

Example 3: Workplace Settings+ Healthcare Settings + Food Access in Community Settings

SMARTIE Goal:

By December 2025, increase access to locally grown foods for working adults and families by establishing three collaborative initiatives with clinics, employers, and neighborhood organizations, prioritizing partnerships that serve under-resourced communities and reflect input from diverse populations.

Workplace Settings PSE:

- **Policy:** CSA participation reimbursed through wellness benefits.
- **System:** Annual workplace wellness calendar includes local food activities and vendors.
- **Environment:** Produce pick-up site located on-site or nearby for convenience.

Healthcare Settings PSE:

- **Policy:** Nutrition counseling referrals and messaging embedded in provider workflow.
- **System:** Partnership agreements established with local farms and employers.

- **Environment:** Farmers' market pop-ups at clinics or shared spaces with local employers.

Food Access in the Community Settings PSE:

- **Policy:** Create or update garden policies (maintenance, volunteer policy, donation policy, rules for participants, etc.) [Community Support Agriculture Strategy] – specifically related to ongoing garden maintenance by volunteers
- **System:** Establish a system for garden produce to be donated or used locally [Community Based Agriculture Strategy]
- **Environment:** Upgrade garden to improve accessibility (for seniors, disability community etc.) [Community Based Agriculture Strategy]

Active Living in Community Settings

Purpose

Active Living in Community Settings is focused on policy, system and environmental changes at the community level (i.e., county, city, neighborhood) to improve daily routine physical activity or active living in this setting. Through partnerships, SHIP supports planning, adoption, and implementation of PSE changes which support an increase in routine physical activity opportunities.

Health equity and community engagement for this setting

Where people live play a role in their health and opportunities for daily routine physical activity. Safe routes to destinations, active transportation options and street design influence prominent health factors related to safety and physical activity. This setting's strategies work to make communities safer and more accessible for SHIP priority populations to walk, bike, use transit and utilize public parks, trails and green space. Community engagement in this setting involves connecting with three distinct local partner groups, 1) community members/organizations with lived experience and perspectives on the opportunities for active living, 2) local units of government (e.g., city, county, state) staff who plan and implement policies, system and environmental changes and 3) local decision-makers (elected or appointed officials) who determine the policy priorities. Partnership and ongoing engagement with each group is important for the identification of the issues and PSE change solutions that can be sustained and maintained by the community.

Getting started

Relationship building/recruiting

Active living in community settings strategies focus on PSE changes at the local unit of government level. This work is accomplished in two ways with partners 1) by joining and supporting existing community efforts related to the SHIP active living strategies or 2)

determining with local partners through assessment and engagement what issues need to be addressed and working with them to get started.

Partner relationship building begins with the SHIP overall assessment process (SOAP) and then utilizing the SOAP data to review of any existing local plans/policies and/or local efforts underway impacting active living for identified prioritized populations. After completing a local plan and effort review, identify the local staff responsible for implementation of existing plans or efforts and meet with them to learn about their role, upcoming projects and begin to establish mutual goals. Identify and meet with local community organizations serving SHIP priority populations to understand their experience with active living in the community.

Foundational Practices

Start with the foundational practices steps to determine with partners the Active Living in community settings strategy to implement. The scope of the foundation practices conducted will vary depending on the extent of previous work done in communities.

- Assessment and Prioritization - Assess with local partners the active living barriers faced by the priority populations and communities. The assessment could include the review of public health and demographic data, existing plans and active transportation and park policies or efforts in place which impact active living. Information can be collected through one –on-one meetings, policy document review and engagement activities to understand lived experience and needs and potential opportunities. Utilize assessment tool(s) such as a walkable community assessment, bicycle friendly community assessment, equitable park assessment to assist in determining issues and opportunities. With partners develop an action plan to prioritize and address the assessment findings.
- Equity and Community Engagement – Begin engagement work with partnering community organizations and agencies which serve priority populations experiencing the greatest barriers to safe and accessible active living opportunities in the community. With partners consider developing an engagement plan to collect and incorporate community member input. Engagement and assessment work can be done simultaneously to inform what issues to prioritize through strategy PSE change. Example: work with a local community action organization to conduct a walk audit to assess the current environment for walking. Partner with organization to engage community members on identified issues (i.e., Vehicle speeds, long crossing distances) related to upcoming transportation planning projects.
- Communication- Communication for this setting's strategies focus on the importance of a community build environment policies and transportation systems to facilitate routine physical activity and the ability for people to safely walk, bicycle, use transit and access public parks/greenspace. Studies have shown the numerous community benefits when places are walkable and bikeable. Resource: CDC Active People Healthy Nation.
- Technical Assistance/Training- Training resources on each strategy are available on SHIP Active Living Basecamp. Monthly technical assistance calls provide timely information, best practices and peer sharing opportunities are various topics related to active living strategies.

The 6 "E" Approach to Active Living in Community Settings Implementation

A comprehensive approach to implementing the Active Living in community settings strategies include efforts within the 6 E's, described below. The "6 E" approach, when strategically planned and implemented with partners, sustains incremental PSE change.

Equity: Nearly half of Minnesota adults do not meet physical activity recommendations. The prevalence of inactivity is greatest in rural areas, among people of color, older adults, and persons with disabilities, women, recent immigrants, members of LGBTQ+ communities, those with lower educational attainment, and those in lower income groups. Efforts should be focused to support access to walking, biking, transit use and physical activity in public park spaces for these populations. The equity approach should be incorporated into the other "E"s listed below.

Engagement: Continually listening to the needs, assets, and proposed solutions of local partners and community members. Engagement efforts should be inclusive and accessible and build capacity of local partners to play instrumental roles in the work. This approach can also create opportunities for community social connectedness.

Evaluation: Identify the underlying issues and use the evaluation results to understand how the projects and programs of the other five "E"s can be most effective in communities to support active transportation and physical activity in public park spaces.

Engineering: Infrastructure or facility improvements that make a community's build environment safety and more accessible to people walking, bicycling, taking transit or being physically active in public park spaces.

Education: Decision-makers and partners have appropriate information and resources to understand how access to physical activity opportunities, walking and bicycling and transit use affect their community and value its role in decision-making; general public has increased awareness of how policies and practices facilitate and inhibit their choice to walk and/or bicycle or utilize a park thereby affecting their health and quality of life.

Encouragement: Strategic events or opportunities to increase interest, engage partners and the general public to build support and buy-in for active living PSE changes. Events can highlight the infrastructure or facility improvements and provide resources on the benefits of increased access to parks and active transportation for the community.

Implementation Approaches Based on Funding Availability

Without funds: LPH SHIP staff can use their time and expertise to support various local partner efforts. Efforts such as: participating on ad hoc or standing advisory committees related to active living policy, planning or projects at the city, county, regional or state level; Assist with the coordination and submission of grant applications (external to SHIP), Assist with local partner project coordination; Connect partners to resources (i.e., technical assistance or external grant programs); Provide technical assistance to community partners.

With funds: Local Public Health SHIP can support: professional planning, engineering design, landscape architect, engagement or other technical service contracts to provide the professional services needed for planning processes to create, update active transportation plans, Park Master plans or other policy or system development efforts. SHIP funds can be used for existing plan implementation leading to PSE change, and small environmental changes such as benches, bike parking, way-finding signage, demonstration/pilot project materials.

Active Living in Community Settings Potential Partners

Active Living work necessitates collaboration with many different partners such as local community members/organizations with lived experience and perspectives on the opportunities and barriers for active living, local units of government (e.g., city, county, state) staff who plan and implement policies, system and environmental changes and local decision-makers (elected or appointed officials) who determine the policy priorities. The list below outlines some of the most common partners in the Active Living in Community Setting. The specific partners involved will depend on the community and work being done.

Local units of government

- City and County parks and recreation departments
- Community development staff
- County and city planning staff
- County, city public works and engineering staff
- Department of Natural Resources
- Economic development staff
- Emergency preparedness coordinators
- Department of Transportation District staff
- Public safety staff
- Regional development commission/organization planning staff
- School District staff
- School staff and faculty
- Three Rivers Park District

Elected officials

- City council members
- Comprehensive planning advisory committees
- County board members
- Planning and zoning commissions
- School boards
- State representatives

Community Organizations

- AARP or the Area Agency on Aging
- Chambers of Commerce and Visitor Bureaus
- Community members or neighbors
- Community organizations and local non-profits serving prioritized populations
- Cross guard staff
- Driver's education training organizations
- Extension at the University of Minnesota
- Faith communities
- Parents and caregivers
- Parks and Trails Council of Minnesota
- Parks, trails or green space advocacy organizations
- Regional/local Towards Zero Death coalitions
- Related advocacy groups
- Youth

Active Living in Community Settings Strategies

Bicycle & Pedestrian Master Plan:

Bicycle, pedestrian and active transportation plans set local unit of government (i.e., County, City) vision, goals and policy direction for bicycle and/or pedestrian travel utilizing a public planning process. Through plan implementation, over time, the policy, systems and environment are established and changed to support safe and accessible walking and bicycling in community. **Strategy Guide**

Examples of SHIP PSE

Policy Change: Completion/Adoption of a new or updated plan, Implementation of existing plan recommendations (e.g., establishing a pedestrian or bicycle advisory committee, establishing a policy for crosswalk re-painting.)

System Change: Implementation of existing plan recommendations (e.g., snow removal system, local government coordination activities, evaluation plan, communication or engagement system.)

Environment Change: Implementation of existing plan recommendations related to physical infrastructure improvements (e.g., street intersection, sidewalk or trail improvements.)

Activities

- Build support for local active transportation planning, utilizing engagement, encouragement, education and evaluation/data collection activities.

- Engage with local partners to identify safety and access barriers to walking and bicycling especially for prioritized populations. For example: could include one on one and partner meetings in collaboration with local community organizations, walk audits (Inclusive Walk Audit Facilitators) guide bicycle audits, community gatherings.
- Education for community, elected officials, community organizations and internal organization-Example: Bicycle friendly or walk friendly community certification
- Encouragement to build awareness and buy-in for strategy. This can include planning for events such as National Bicycle Month or Week Without Driving.
- Assessment of local community plans and policies, systems and the build environment to determine the existing PSE barriers to walking and bicycling. Example: Bicycle friendly or walk friendly community, AARP -Walkable Streets for all ages .
- With key partners develop a plan (i.e., strategic, action and/or work plan) to address identified PSE barriers include 6-month, 1 year and 5 year and beyond goals.
- Participate in city, county, regional, or statewide bicycle or pedestrian, active transportation related planning processes.
- Implementation of existing bicycle, pedestrian, or active transportation plans.
- Local community has established a maintenance sustainability plan for continued implementation. (e.g. local partners have created a work group/committee responsible for plan implementation.)

Complete Streets Policies and Streetscape Design

The Complete streets approach to planning, designing and building streets enables safe access for all users, including pedestrians, bicyclists, transit riders and motorists of all ages and abilities. Complete street policies put this approach into practice as a system for transportation planning. Local communities can try a complete street approach before creating a local policy by piloting a streetscape design, as part of a demonstration project. A demonstration project uses temporary material to show what future changes to a street might look like. A Complete Streets approach to streetscape or roadway design recognizes the varying needs of priority populations across rural, suburban, and urban settings and designs will differ as a result. Projects could be planned and implemented for short time and or long-term timeframes. **Strategy Guide**

Activities

- Engage with local partners to identify safety and access barriers to walking and bicycling along local street network. Example: conduct a walk audit with partners.
- Assessment of local plans, policies, practice, systems or upcoming street projects impacting the local street network to determine the existing policy and system barriers or opportunities. Example: utilize AARP livable community, bicycle friendly community or green steps cities assessment tools.

- Encouragement to build support for complete streets and streetscape design projects, this could include participation in local active transportation planning efforts. Example: open streets events, public art, demonstration projects.
- Participate in streetscape or roadway geometry design planning studies or processes, city, county or state transportation planning processes.
- Support implementation of complete street and streetscape initiative projects at Minnesota Employment and Economic Development, county or local level. Demonstration projects, seek external resources.
- Work is maintained and sustained by local community to prioritize complete street design, Safer Streets Stronger Economies.

Potential strategy integration opportunities with other SHIP settings

This strategy could be paired with the Schools setting-Comprehensive Physical Activity Program strategy as it relates to Safe Routes to School and improving safety and access to school or surrounding community destinations.

Vision Zero Policies:

Vision Zero policy work acknowledges that traffic deaths and severe injuries are preventable and sets the goal to eliminating both through multidisciplinary approach prioritizing the safety of people walking, bicycling, or taking transit to eliminate traffic fatalities and severe injuries among all road users. Vision Zero efforts utilize a safe system approach and emphasizes policy, system and environmental changes in the way a road system in to reduce human error and protect humans from death and severe injury when they make mistakes. This strategy and systems approach reiterates road safety is a shared responsibility among all stakeholders and proactive approaches can be taken to improve road safety. The strategy can be utilized when participating on or partnering with an existing local Minnesota's Toward Zero Death (TZD) coalition. Minnesota TZD program is the State's traffic safety program, employing an interdisciplinary approach to reducing traffic crashes, injuries and deaths on Minnesota roads. Integration of the Vision Zero strategy into TZD program can elevate the needs vulnerable road users and identify PSE changes. This strategy can also be implemented with partners by supporting Vision Zero action planning, policy development and implementation activities. **Strategy Guide**

Examples of SHIP PSE

Policy Change: Participate on local Vision Zero action planning process. Participate in the adoption or implementation of complete street policy.

System Change: Create and/or monitor existing data collection system related to road system safety to inform Vision Zero projects.

Environment Change: Infrastructure changes that limit speeds of motor vehicles and provide protection for pedestrians and other road users.

Activities

- Engage with community organizations, older adults, youth, families, people with disabilities, local unit of government staff, elected officials. Vision Zero Toolkit (dot.gov)
- Assess, analyze, and use data to identify safe issues or trends and potential disproportionate impacts of traffic deaths on vulnerable populations Vision Zero Toolkit (dot.gov)
- Participate in planning Vision Zero efforts to improve safety along roadways and lower speeds to safe levels Minnesota Toward Zero Death Case Study
- Participate in implementation of Vision Zero efforts VZN_ActionPlan_FINAL.pdf (visionzeronetwork.org)
- Provide education on Vision Zero and safe systems approach.
- Work with local partners to sustain local Vision Zero efforts. (e.g., a work group/committee is in established to continue to build local support for vision zero priorities of managing speed through a systems approach, centering equity and community engagement.

Potential strategy integration opportunities with other SHIP settings

This strategy could be paired with the Schools setting-Comprehensive Physical Activity Program strategy as it relates to Safe Routes to School and improving safety and access to school or surrounding community destinations.

Public Transit Infrastructure and Access

Public transit infrastructure and access focuses on planning and PSE changes to support improvements to public transit access for communities with a focus on prioritized populations. Efforts within this strategy include partnering with regional transportation coordinating councils, local transit agencies (greater MN) or metro transit services (metro area) staff. Activities can include community engagement support to identify existing barriers, or participation on or working with a transit policy advisory committee to improve access through PSE change. **Strategy Guide**

Activities

- Assessment to understand the benefits, barriers and issues to local public transit in the community or region. MDH Community Health Assessment, MnDOT Greater MN Transit, Metropolitan Council
- Communicate, educate, share or combine resources with internal LPH staff also working on transit access efforts.
- Participation on local and/or regional committees or coalitions that identify and try to reduce barriers and increase access to transit.
- With city, county, stakeholders and community members participate in planning activities to address identified PSE barriers include 6-month, 1 year, 5 year and long-term goals.
- Participate in transit plan implementation efforts with local partners.

- Work with local partners to maintain and sustain PSE changes to address public transit infrastructure and access. (e.g., local partners maintain a new transit stop at local community college or other policies or system changes identified in local transit plan.)

Potential strategy integration opportunities with other SHIP settings

This strategy could pair with:

- Food Access in the Community–Community Food assessments and planning strategy as it relates to transportation and local food access.
- Worksites-Supporting movement throughout the day strategy as it relates to supporting worksite active transportation commuting policies.

Safe Routes to Parks:

The Safe Routes to Parks (SRTP) strategy focus on safe and accessible connections to parks, trails, greenways and open spaces to increase opportunities for physical activity especially for priority populations to increase park usage through a multidisciplinary approach and PSE change. SRTP involves work with diverse partners to identify the barriers to access and partner with park system partners to address the needs through planning and sustained implementation. **Strategy Guide.**

Examples of SHIP PSE

Policy Change: Completion/Adoption of a new or updated park, greenspace or trail plan, Implementation of existing plan recommendations.

System Change: Expanded park hours of operation to better accommodate park users' needs.

Environment Change: Update or creation of wayfinding signage, including signage in additional languages.

Activities

- Engage with community members, park boards, and community leaders, community organizations to identify and assess the safety barriers to walking and biking to parks within community.
- With partners create action plan based on data and community input to address issues within a one to three-year timeframes.
- Participate in creation or updating of long-term plans such as park master plans, trails master plans, park system plans, and community park improvement plans.
- Participate in the changing of policies and practices that limit access to parks and trails. – Equitable Access to Parks and Greenspace
- Participate in the implementation of park improvements with an identified need from community engagement.
- Work with local partners to create maintenance and sustainability plans for parks.
- Evaluate SRTP efforts to measure success in supporting equitable outcomes.

Potential strategy integration opportunities with other SHIP settings

This strategy could pair with:

- Schools -Comprehensive Physical Activity Program strategy as it relates to Safe Routes to School and improving safety and access to school or surrounding community destinations.
- Healthcare - Exercise is Medicine/Parks Rx
- Food Access in Community - Farmers Markets

Comprehensive Planning, Land Use and Zoning:

Comprehensive plans are a specific type of long-range plans used by local governments to create a shared vision, community goals, policies and action steps for guiding the physical (i.e. land use, transportation, and parks) social and economic development (both public and private) of a municipality and its environment. Local zoning, building, subdivision and other codes regulate land use as defined by the comprehensive plan and impact the form of buildings and therefore the access and opportunities for active living. This strategy can involve partnerships with community and local partners on support for plan development or existing plan implementation. Plan implementation could include land use and zoning regulation changes to improve safety and access for people walking, bicycling, taking transit. Zoning regulations impact environmental design, street connectivity, residential density and proximity to destinations. All of which result in improved access and safety for people walking, bicycling or taking transit. **Strategy Guide.**

Activities

- Engage and assess with local partners existing local comprehensive plan goals and policies, practices and systems. – Assessment resource
- Work with partners to determine existing comprehensive plan priorities to address active living access barriers. Determine the incremental steps needed to see progress on PSE changes. – Changelab Healthy Neighborhoods
- Build support for comprehensive planning or zoning efforts if local plan or zoning regulations are non-existent or no-longer relevant to the community. E.g. Create fact sheets or utilize an assessment tool such as AARP livable community toolkits
- Participate in comprehensive planning or zoning regulation processes. – Healthy community policy guide
- Support implementation of existing comprehensive plan policies that are related to SHIP Active Living in Community settings.

Potential strategy integration opportunities with other SHIP settings

Food Access in the Community–Community Food assessments and planning strategy as it relates to transportation and local food access.

Safe Routes to School:

The Safe Routes to School (SRTS) strategy in Active Living in Community Settings includes activities that lead to SRTS PSE changes. These activities are led by community partners and include changes such as but not limited to local SRTS program planning, or pedestrian infrastructure improvements along a walking route to a school or slowing down traffic speeds outside of a school. These examples support students and others walking, biking, and rolling to school, and occur in the community, thus making them part of the Active Living in the Community Settings. SRTS is not identified as a specific strategy in School Settings, but instead falls under the Comprehensive School Physical Activity Program (CSPAP) strategy (see School Settings Strategies section). These activities are led by school staff and included changes such as but not limited to implementing the Walk, Bike, Fun curriculum in Physical Education classes or developing pick-up and drop off maps and procedures. In these examples, the changes occur at a school and thus are part of School Settings. Please contact the School Health Systems Coordinator or the Active Transportation Coordinator if you have questions determining what strategy(s) to select.

Strategy Guide

Activities

- Engage with youth, families, school and community leaders, community organizations to identify and assess the safety barriers to walking and biking to school and within the community. Equity Approach and Engagement tools.
- Education -provide opportunities for students, caregivers and community members to learn pedestrian and bicycle safety skills. The activity could be done both in community and school settings. For example: Education resources.
- Encouragement- supporting encouragement activities to build support for SRTS. Encouragement examples.
- Participate in a Safe Routes to School Planning process and grant application process – Planning 101 & MNDOT SRTS planning assistance.
- Participate in the implementation of an existing SRTS plan.
- Participate in planning for engineering projects identified in SRTS plans. - Engineering resources.
- Evaluate SRTS programs and efforts to measure the success in supporting equitable outcomes. - Evaluation tools
- Work with local partners to sustain local SRTS programs.

Potential strategy integration opportunities with other SHIP settings

The Safe Routes to School strategy can be paired with the School setting's Comprehensive School Physical Activity Program Strategy

Child Care Settings

Purpose

Healthy behaviors are being developed and formed during childhood. In addition, healthy nutrition is critical for healthy brain development and school readiness. The implementation of policies, systems, and environmental (PSE) changes can support healthy child development (birth through 5 years) within early child care and community settings and in the areas of Healthy Eating (including Breastfeeding), Physical Activity, and Mental Wellbeing.

Health Equity and Community Engagement for this Setting

The Statewide Health Improvement Partnership (SHIP) is committed to advancing health equity in Minnesota's child care settings—a strategy strongly supported by academic research. For example, a 2020 study published in the *Journal of Pediatrics* emphasizes that documenting health disparities among children is essential, as these disparities can have long-term impacts on adult health, educational attainment, and economic success.

One of SHIP's six key child care strategies—Farm to Early Care—promotes nutrition while also addressing health inequities through a systemic approach. Farm to Early Care increases access to healthy, affordable, and culturally relevant local foods for all populations. It also supports local economies by encouraging early care programs to purchase from Minnesota farmers, producers, and distributors.

Research highlights the effectiveness of implementing all three pillars of the farm to school model: local food procurement, gardening, and nutrition education. Together, these elements help children and families make sustainable, healthy eating choices and improve access to local foods. By focusing on priority populations experiencing health inequities—and by co-designing culturally relevant Farm to Early Care programs in partnership with those communities—SHIP aims to further health equity across the state.

Community engagement is also a powerful catalyst for positive change, especially when it comes to improving children's health outcomes. According to *Child Care Aware* and the *National Association of County and City Health Officials (NACCHO)*, family and community engagement provides at least seven key benefits for local health departments, including improved health outcomes for children, stronger partnerships, more effective programs, and enhanced public health surveillance.

SHIP 6 will integrate community engagement strategies by building provider capacity, centering the voices of Local Public Health (LPH), and honoring the diversity of all stakeholders. Experts in early childhood care emphasize that when families, providers, and communities work together in mutual support and understanding, everyone benefits—especially young children.

Getting Started

Relationship Building

This child care strategy focuses on activities and interventions in family-based child cares, Family, Friend and Neighbor (FFN) caregivers, child care centers, preschool and early care environments such as Head Start and Early Head Start. In addition, before and after-school programs, offered in the community and not affiliated with a school district, fall under the auspices of the child care setting.

Child care providers have the enormous responsibility of caring for our children and preparing for their future. And local health departments help children have the tools they need to thrive. In Minnesota, the partnerships between these two entities have been mutually beneficial. Local SHIP staff have already strategically partnered with child care providers to enhance child care providers' practices.

When approaching a child care director, a home provider or non-profit organization, for collaboration, consider the provider's priorities, strengths, and operational needs. It's important to strive for crafting a mutually supportive and beneficial partnership. Consider writing a draft purpose or mission statement before your first meeting with a potential partner; this helps to organize potential, new ideas. The Child Care of America and the National Association of County and City Health Officials (NAACHO) published a report highlighting the importance of relationships between local public health agencies and organizations that serve children. It has helpful ideas about community engagement.

While approaching providers, keep in mind that research has shown that racial/ethnic and socioeconomic disparities exist across risk factors for physical inactivity, poor nutrition, breastfeeding and mental wellbeing. Specific priority populations include:

- Children from low-income households and/or communities
- Children with special health needs
- Children who are members of minority cultural groups

All children can benefit from improved nutrition, breastfeeding, mental wellbeing and physical activity practices and policies. A special effort to provide resources and opportunities to programs for children in priority groups can contribute to health equity. In some cases, the child care providers and parents will also benefit from the changes in program practices, but the focus is the children in care.

There are several ways to identify child care programs that serve priority populations. Communicating with providers and programs that are income-eligible for various child care assistance programs is a proven method of collaboration.

Identifying and Recruiting Child Care Programs

There are several ways to identify child care programs that serve priority populations—regardless of their size. LPH SHIP has used a variety of methods for building relationships with child care providers, including but not limited to:

1. Coordinate with local County child care licensing to send personalized letters of recruitment.
2. Contact non-profit organizations for collaboration such as Child Care Aware or the Minnesota Head Start Association. Local school districts can also be contacted.
3. Request a referral from a Family Services Collaborative as its their mission to assist with community outreach and coordination.
4. To recruit Family, Friends and Neighbor providers, consider reaching out to their Program Navigators. The Navigators are considered agency resource hubs and are willing to share information.
5. To recruit smaller-sized providers, attend community events (e.g., bookmobiles, family resource centers, etc.) and develop creative ways to facilitate communication with providers.

In addition, targeting providers and programs that are income-eligible for various child care assistance programs is another way. Here are some descriptions of programs with whom to consider coordination or collaboration to recruit child care providers.

Child and Adult Care Food Program (CACFP)
The Child and Adult Care Food Program (CACFP) is a federally-funded initiative administered by the U.S. Department of Agriculture (USDA). This program offers financial assistance for eligible meals and snacks served to children aged 0-12 who are enrolled in participating child care centers, licensed family child care homes, emergency shelters, and to children up to age 18 in at-risk afterschool care programs, and to adults aged 62 and over enrolled in licensed adult day care programs. CACFP plays a vital role in promoting nutrition security, local food purchases, fostering healthy development, and encouraging the establishment of good eating habits.

Meals and snacks provided by institutions participating in CACFP are well-balanced and are required to meet the minimum nutrition guidelines established by the USDA Food and Nutrition Service (FNS), in alignment with the Dietary Guidelines for Americans (DGA). Additionally, Minnesota's child care licensing statutes stipulate that any food offered by the license holder must conform to the nutritional requirements set by the USDA Food and Nutrition Service. CACFP assists institutions with the purchasing of healthy food options. By providing nutritious meals and snacks, CACFP contributes significantly to the wellness, healthy growth, and overall development of young children. Visit the Minnesota Department of Education to learn more about CACFP applications and CACFP meal reimbursements. Refer to this page to learn more about family child care home eligibility for CACFP. For purpose of SHIP, the MDH recommends that LPH SHIP refer local, interested child care providers to MDE for registration in CACFP. Please note, LPH SHIP do not have to administer or manage the CACFP's program's requirements.

Family, Friend and Neighbor (FFN) Caregivers
Family, Friend and Neighbor (FFN) caregivers are home-based caregivers working outside the formal child care system. Relatives, friends, and other community members serve as FFN caregivers. These child care arrangements vary in terms of unpaid and paid, part time and full-time, and hours of care. FFN caregivers often cover non-traditional work shifts. FFN child care is a frequent choice of many families, and arrangements are designed to meet the needs and

preferences of those involved. Parents who choose FFN care often do so to preserve a cultural, ethnic or religious heritage and for the trust that comes with care by a family member. There are no restrictions for FFN caregivers unless they register with the Child Care Assistance Program as a Legal Non-licensed (LNL) child care provider. LNLs must meet various criteria, including completion of a background study and health and safety training. For more information about Family, Friend and Neighbor caregivers, this website may be of interest. A report describing community-based networks of FFN caregivers is also available.

School-Based Care (e.g., School Readiness Programs, Early Childhood Special Education) These programs tend to serve priority populations. School Readiness Programs typically serve low-income children, and Early Childhood Special Education serves children with special needs. Consider collaborations with early childhood programs in schools with a high (over 50%) free-reduced lunch percentage.

Early Childhood Family Education (ECFE)
These programs, for parents/grandparents and their children younger than school age, serve families of all income levels. Contact your local school district for more information about ECFE in your area.

Private Preschools
These part-time programs serve a broad spectrum of children and families. To learn more about each program, a personal contact may be made. Be aware that since they are part-time, they may not serve meals or spend time in active/outdoor play.

Action Planning

Engaging with Child Care Providers

Community engagement comes in a variety of techniques. For example, by using:

- Emails
- Phone calls
- Phone calls followed by emails containing relevant resources
- Conference call(s) to provide information and coaching to a group of providers
- In-person gathering(s) of a group of child care providers for coaching and peer learning
- The cohort model, with regular trainings and meetings, for the same group of providers
- Onsite visits to offer individualized, customized coaching and resources

Foundational practices

Capacity Building and Its Significance

For reference, the Public Health Institute provides a practical definition of capacity building. The PHI says by building the capacity of communities, nonprofit organizations, local governments

and individuals can be more effective in achieving their mission and creating lasting change. This definition and its interpretation can be applied to child care providers and SHIP.

Capacity building for child care providers can include developing and strengthening their skills and abilities to implement health promotion best practices. This Implementation Guide is designed to provide ideas and tools for LPH to build their local capacity to implement child care interventions. Additional tools related to building capacity are located in BASECAMP.

Assessment and Training for Implementation

Assessing the policies, systems and environments of child care settings is an important foundational practice. Assist child care providers to assess their current healthy eating, physical activity, and breastfeeding support practices and policies using the SHIP Child care Self-Assessment. After the Assessment is complete, participate in an approved training (see list below) that focuses on the highest needs uncovered through the assessment form.

After or at the end of each training, LPH SHIP staff or trainers will assist child care providers to create an Action Plan for improving their practices in the focus area of the training. The best practices for healthy eating, supporting breastfeeding and physical activity are linked below, as well as optional action planning worksheets. An optional action planning worksheet for mental wellbeing initiatives is being developed.

- Nutrition, Breastfeeding Support and Physical Activity Best Practices for Early Care and Education Programs (PDF)
- Healthy Eating Action Planning Worksheet (PDF)
- Supporting Breastfeeding Action Planning Worksheet (PDF)
- Active Child Care Action Planning Worksheet (PDF)

One copy of each action plan should stay with the provider and one should be retained by SHIP staff, to be used in planning the resources and technical assistance that will be offered to child care providers over the following 6 months to one year.

1. Technical assistance and/or coaching (for a period of at least 6 months after a training)
2. A post-assessment to measure progress

Child care providers should complete the same Self-Assessment at the end of the designated timeframe, at least 6 months after each training, as they completed before they participated in each training. You may choose to have them complete the entire assessment, even if they have not taken trainings in all three areas, since the self-assessment also serves as an informational tool, reminding providers of the best practices in all areas.

The post-assessments will demonstrate to the providers their own progress toward best practices and serve as a guide to continuous quality improvement in their individual programs. They can also serve as the basis for planning child care work in future rounds of SHIP.

Success is achieved when healthier foods are offered for meals and snacks, and fewer competitive foods are available. This means more fruits and vegetables, and fewer foods high in sodium, saturated fats, and added sugars are served. Integration of culturally-relevant fruits and vegetables is another healthy change. Mealtimes are relaxed and without pressure. Food is

not used as a reward or punishment. Children are developing healthy eating habits, such as eating only until they are full and being willing to try new foods. Child care providers can increase the likelihood of their new practices being sustained by including them in their written policies or parent handbooks. These changes will have an even greater impact in programs serving a high number of children with barriers to accessing healthy foods, such as those from low-income families.

LPH SHIP are required to offer training (virtual or live) to child care providers in these areas: healthy eating, support for breastfeeding, and physical activity, using programs that are approved for SHIP. Trainings for mental wellbeing are being sourced and verified and will be available, soon. LPH SHIP may choose one or more options to provide these trainings.

The Minnesota Center for Professional Development (MNCPD) is the official child care professional development system and dictates requirements for SHIP staff who wish to train child care providers. In order to guarantee that child care providers will receive credit for their hours of training, trainers and trainings must be approved by the MNCPD and listed in their online registry called Develop.

- Option 1: Become an approved trainer: Approved Trainers can participate in Trainings of Trainers and then be qualified to offer these trainings. Categories of trainers and the requirements for each are available in the Trainer Approval Process Guide (PDF) (https:/www.mncpd.org/wp-content/uploads/2018/01/Trainer_Approval_Process.pdf) on the MNCPD website (www.mncpd.org/).
- Option 2: Contracting with an approved MNCPD trainer. Approved trainers and the classes they are approved to teach are listed on the MNCPD site called DEVELOP (https://www.developtoolmn.org/).
- Some trainings are also available in an online class format through Eager-to-Learn (www.eagertolearn.org).

Additional trainings that meet SHIP goals may be added as they become available. LPH SHIP must attend any training that they do not have MNCPD approval to teach. This is required in order to be able to provide appropriate technical assistance and coaching.

Approved Trainings:

- HealthyKids, HealthyFuture: Nutrition, Beverages and Infant Feeding (Formerly called Let's Move-Nutrition, Beverages and Infant Feeding)
- Let's Move - Physical Activity and Screen Time
- Moderate to Vigorous Physical Activity (MVPA)- I am Moving, I am Learning
- Opportunity Knocks: Reversing Current Obesity Trends: I am Moving I am Learning
- Moving with the Brain in Mind - I am Moving, I am Learning
- Body Language; I am Moving I am Learning
- Learning about Nutrition Through Activities (LANA)

- Physical Activity Learning Session (PALS) Virtual Training
- Physical Activity Learning Session (PALS)
- Virtual Learning about Nutrition Through Activities (LANA)
- CATCH Early Childhood - Healthy Eating
- Virtual CATCH Early Childhood - Healthy Eating
- Learning About Nutrition through Activities (LANA) Training of Trainers

Child Care Settings Strategies

Because many young children in Minnesota spend at least part of their day in care outside of their homes, child care settings provide an ideal environment to promote and support the development of healthy eating, physical activity and social/emotional learning skills. Since children's choices are limited to those provided by adults, it is necessary to influence their caregivers. Through training and coaching, child care providers can learn best practices to improve the eating, physical activity and mental wellbeing for the children in their care, including modeling their own healthy habits.

LPH SHIP working on this comprehensive child care strategy will work with caregivers, decision-makers and educators of young children, from birth to school entry, to improve the nutrition, physical activity breastfeeding and social emotional skills' environments in their child care programs. Using a policy, systems and environmental (PSE) approach, LPH SHIP will recruit and train child care providers to increase their knowledge of best practices, provide coaching and resources to support the implementation of these practices in their programs, and assist in embedding these new practices into programs' policies. Work can occur simultaneously or sequentially to improve menus and eating environments; to improve the quantity and quality of physical activity offered; and, to support breastfeeding mothers to increase the duration of breastfeeding for infants.

New to this grant period, emphasis is also placed on educating child care providers about mental health best practices in child care settings and trauma-informed practices. This Guide provides a framework for an inclusive approach using PSE changes.

Note: While there are no commercial tobacco-free strategies for the child care setting, it is important to be aware of the Minnesota Clean Indoor Air Act and how it applies to this setting. Smoking or using electronic delivery devices is not permitted indoors in Minnesota licensed daycare centers, family home child cares or group family child cares during hours of operation. If indoor smoking is permitted in a home used for a child care outside of business hours, the child care provider must disclose after-hours smoking by:

1. Posting written notice on or immediately inside of all entrances to the child care area, and
2. Verbally inform parents or guardians that smoking is allowed in the home outside the hours of operation.

More information can be found here:
https://www.health.state.mn.us/communities/environment/air/mciaa/daycare.html

Breastfeeding Background Information and SHIP PSE Examples

Research shows that breastfeeding supports optimal growth and development in infants and provides lifelong health benefits. However, mothers who wish to continue breastfeeding after returning to work or placing their child in care often face significant barriers. A knowledgeable, supportive caregiver can make a meaningful difference by encouraging breastfeeding and ensuring proper handling, storage, and feeding of breast milk—allowing babies to continue receiving breast milk even when separated from their mothers.

The American Academy of Pediatrics, the World Health Organization, and other leading health organizations recommend exclusive breastfeeding for the first six months, followed by continued breastfeeding alongside complementary foods for at least the first two years. Breastfed infants benefit from a reduced risk of Sudden Infant Death Syndrome (SIDS), fewer instances of diarrhea, ear infections, and other illnesses. The longer a child is breastfed, the greater the health benefits.

Through training, technical assistance, and coaching, child care providers will learn about the health advantages of breastfeeding for both babies and mothers, as well as the state and federal laws that protect a parent's right to breastfeed. They will also develop the skills needed to safely store, handle, and feed expressed breast milk. Providers will be equipped to talk confidently with families about breastfeeding, and they will be able to offer both local and online resources for parents seeking additional support.

Their program policies will reflect supportive attitudes and practices, creating an environment that empowers mothers to continue breastfeeding their infants while in child care.

Strategy: Breastfeeding

Policy: The child care provider will have a written policy stating their support for breastfeeding families that can include safe handling and storing of breastmilk and providing a space for breastfeeding on site.

System: The child care provider will provide local and online resources for parents who need more assistance with breastfeeding and infant feeding. Allowable expense includes child care provider’s time to identify online resources.

Environmental: The child care provider will provide an appropriate place for mothers to breastfeed (or pump) and children’s materials such as books and posters that show breastfeeding as a normal way to feed babies. Allowable expenses include books and posters.

Physical Activity/Active Play Background Information and SHIP PSE Examples

Physical activity is a vital part of a healthy lifestyle for people of all ages. Because many young children spend significant time in out-of-home care each day, child care providers play a critical role in shaping their physical activity habits, skills, and preferences.

Through training, technical assistance, and coaching, child care providers will learn how to enhance both the quantity and quality of physical activity opportunities for the children in their

care. This includes daily structured and unstructured physical activity, offered both indoors and outdoors, as well as limiting screen time and other sedentary behaviors.

In addition to the many health benefits of being active, regular physical activity helps young children build essential movement skills they will use throughout their lives. Knowledgeable caregivers can also promote walking and biking as not only fun, but practical forms of transportation—such as for trips to the park. Given the amount of time children and caregivers spend together in child care settings, incorporating movement into the daily routine can help establish lifelong habits of physical activity.

As a result of LPH SHIP's work, child care systems and environments will be transformed to ensure children have multiple opportunities to be active every day—indoors or outdoors, regardless of the weather. Providers will offer both structured and unstructured activity periods that promote moderate to vigorous physical activity (MVPA) and support child-led movement. The physical environment will be safe and equipped to nurture age-appropriate motor skill development. Caregivers will actively participate in and enjoy physical activities alongside the children, fostering a shared enthusiasm for movement. Sedentary time will be limited, with minimal screen use and few sedentary group activities.

Strategy: Physical Activity/Active Play

Policy: The child care provider will create and implement policies that improve the quantity and quality of physical activity and movement opportunities. Written policies regarding indoor and outdoor play can be written into the parents' handbook using providers' time.

System: The child care provider will lead physical activities with the children. Allowable expense includes books and toolkits that teach the caregiver how to lead activities. Playground equipment is not an allowable expense.

Environmental: The child care provider will create a physical environment to provide children with multiple opportunities to be active every day, outdoors, and/or indoors, regardless of the weather. Caregivers will offer both structured and unstructured activity times to encourage Moderate to Vigorous Physical Activity (MVPA). (For more information on MVPA, visit the Centers for Disease Control and Prevention website.) This physical environment will be equipped to promote the development of age-appropriate motor skills. Allowable expenses include limited number of books and toolkits that help providers facilitate physical activity. Playground equipment is not an allowable expense.

Healthy Eating Background Information and SHIP PSE Examples

Young children rely entirely on their caregivers for food. By changing menus to include more fruits and vegetables, and reducing sodium, saturated fats, and added sugars, we can directly influence what children eat. Improving the eating and feeding environment also helps children become familiar with a wider variety of foods.

LPH SHIP will partner with child care providers to improve both menu offerings and the overall eating environment in their programs. Sourcing food locally can increase both access to and the affordability of healthy options—especially fresh fruits and vegetables.

Initiatives like Farm to Early Care and Education, cooperative food purchasing, and growing food onsite to introduce and serve to children can further expand access to nutritious foods.

Better feeding practices—including the way solid foods are introduced to infants—can set even the youngest children on a lifelong path toward healthy eating.

Healthy eating initiatives in child care settings have the potential to shift systems and environments in ways that support SHIP's desired outcomes.

Strategy: Healthy Eating

Policy: Add a policy to the parents' handbook about providing well-balanced meals and snacks. Food is not an allowable expense. Tools for meal-planning are allowable expenses.

System: Farm to Early Care and Education (also known as Farm to ECE) is an evidence-based nutrition strategy. LPH can decide if they would like to focus on procurement, gardening, or nutrition education. A systems' approach would involve using food grown in the gardening activity in several child care centers for meals or snacks. Or, in addition to growing and serving the food, incorporating the grown food with a teaching lesson (i.e., gardening education). An allowable expense is purchasing small amounts of food at farmers' markets for taste-testing activities.

Environmental: Utilizing indoor or outdoor gardening structures (e.g., hydroponic tomato-growing kits; raised gardening beds) and nutrition education.

Strategy: Mental Wellbeing: Social Emotional Skills

Policy: Choose and use a curriculum that teaches child care staff about best practices for supporting mental health and emotional development in children. Funds may be used to purchase the curriculum and to pay for staff training.

System: Plan innovative mental wellbeing child care activities such as utilizing mental health assessments to evaluate the child care climate and determine gaps in care. Allowable expenses include purchase of mental health assessment tools.

Environment: Support the creation and use of calm spaces where children can self-regulate or take breaks. Train staff on how to use calm rooms appropriately. Funds may be used to purchase training or curriculum that outlines the use the benefits of calm spaces. Construction or building costs are not allowed.

Criteria for Selecting Curriculum

- Aligned with age-appropriate developmental standards
- Evidence-based or supported by research
- Includes culturally-responsive and inclusive practices
- Provides practical strategies for emotional regulation, relationship building and behavior management

Criteria for Selecting Curriculum/Tools

- Validated for early childhood or child care settings
- Provides clear guidance on interpretation and use of assessment results
- Aligns with state and national child mental health guidelines

Criteria for Selecting Curriculum/Training

- Focuses on trauma-informed and supportive care practices
- Offers practical strategies for setting up and managing calm spaces
- Includes staff guidance on how and when to use calm rooms

Strategy: Mental Wellbeing: Outdoor Classrooms

The American Psychiatric Association (2024) documents the benefits of providing children with regular access to green space. Improved mental well-being and overall health have been associated with access to green space. Consequently, SHIP 6 includes child care interventions that can occur in the outdoors.

Policy: Create a policy for parents' handbook about outdoor classrooms for use in the child care home or child care center. Allowable expenses include curricula describing the value of outdoor play and time for staff to plan and walk to the designated outdoor classroom space. Transportation costs are not allowed.

System: Professional training for teachers and staff, offered in-person or online, can introduce or reinforce skills and techniques for promoting physical activity in an outdoor learning setting. For child care organizations with multiple sites, ensure changes are consistent across locations to build a coordinated system of support. Allowable expenses include updating parent communication materials or handbooks and purchasing digital communication tools.

Environment: Organize outdoor walking field trips that encourage physical activity and exploration of natural environments. Destinations may include local parks, farms, gardens, or nature centers. Ensure proper supervision and safety protocols are in place.

Criteria for Selecting Curriculum/Training

- Promotes outdoor play as part of mental wellbeing and healthy development
- Includes guidance for integrating outdoor learning into daily routines
- Supports safe and inclusive outdoor play practices
- Aligns with national and state early childhood standards

Criteria for Selecting Curriculum/Training

- Includes interactive or experiential learning
- Demonstrates strategies for outdoor engagement
- Focuses on nature-based play and learning

- Encourages family and community engagement

How to implement this setting with and without funds to grant out to local partners.

If your LPH SHIP is not able to grant sub-awards to local child care providers to implement interventions, you can continue to use your staff time to coach and mentor these providers. Help child care providers complete the Self-Assessment **and** Action Planning Forms (refer to the ***Assessment and Training for Implementation*** section above) to maximize your relationship with the providers and to design steps forward for making changes without costs to LPH or the child care provider. At the heart of this coaching technique, is the relationship you form and maintain with child care providers. When possible, provide follow-up coaching and technical assistance based on the needs highlighted in the forms.

Don't forget to maintain the relationship by conducting the post-assessment of their healthy eating, breastfeeding, mental wellbeing practices and policies, using the SHIP Child Care Self-Assessment Tool. In addition, there are many websites devoted to providing resources and technical assistance about coaching for performance. For additional resources, contact the Early Childhood Education Coordinator.

In addition to coaching, look for local collaboratives or coalitions that are addressing the priorities of healthy eating, breastfeeding, mental wellbeing and physical activity for children. Carefully examine the mission or purpose of these collaboratives or coalitions and determine if your participation is a good match for your LPH SHIP staff time. You may be able to create social change and impact policy, systems and environments by participation in these type of groups.

For a complete list of strategies, visit the strategy guides:

- CC CACFP Strategy Guide.docx
- CC Farm to ECE local procurement Strategy Guide.docx
- CC Farm to ECE Gardening Strategy Guide.docx
- CC Farm to ECE Nutrition Education Strategy Guide.docx
- CC Promote Food Guidelines Strategy Guide.docx
- CC Movement All Day Guide.docx
- CC Breastfeeding Strategy Guide.docx
- CC Outdoor Learning Strategy Guide.docx
- CC SEL Training Strategy Guide.docx (Mental Well-being)

Potential strategy integration opportunities with other SHIP settings

Before- and after-school programs, offered in the community and not affiliated with a school district, are full under the auspices of the child care setting.

Early Childhood/Child Care General Resources, Programs and Organizations

Child Care Aware of Minnesota child careawaremn.org Child Care Aware of Minnesota serves as a statewide early childhood leader driving change through partnerships to

build an equitable, high-quality early care and education system that meets the needs of Minnesota's families and children. They offer grants and scholarships, professional development support, advocacy tools, and other resources to help early educators and families in the state.

Eager-to-learn eagertolearn.org Eager-to-Learn is the innovative, e-learning program of Child Care Aware of Minnesota. They offer high-quality, online training to help early educators meet requirements and expand their knowledge. Eager-to-Learn offers both self-paced and instructor-led training options.

Parent Aware – Minnesota's Quality Rating and Improvement System parentaware.org Parent Aware offers free tools and resources to help families find the quality care their children need to succeed in school and life. They also help child care and early education programs find opportunities to improve their quality, support them with the tools and resources they need to succeed, and celebrate the work they are doing to create better lives for children in Minnesota.

- Minnesota Association of Child Care Professionals (http://www.maccp.org/) Statewide professional organization for licensed family child care providers
- Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs (http://nrckids.org/CFOC/)
- Supporting Minnesota Families, Friends & Neighbors Caring for Children https://mn.gov/dhs/ffn-minnesota/
- Minnesota Department of Education, Early Childhood Outdoor Learning Ideas Guide, What can I do outside today? (https://education.mn.gov/MDE/dse/early/highqualel/out)

Policy Resources

Go NAPSACC makes it easier to give children in our communities start. https://gonapsacc.org

GoNAP SACC Self-Assessments (https://gonapsacc.org/self-assessment-materials)

The policy question(s) at the end of each self-assessment lists possible topics for a policy in that area.

Centers for Disease Control and Prevention, Early Care and Education. Strategies for Early Care and Education https://www.cdc.gov/early-care-education/php/public-health-strategy/index.html

Mental Wellbeing

- **Trauma Informed Care for Young Children:** Helping Young Children Who Have Experienced Trauma: Policies and Strategies for Early Care and Education. Child Trends. https://childtrends.org/publications/ecetrauma
- **Head Start Heals Campaign:** Head Start Early Childhood & Knowledge Center (ECLKC) https://eclkc.ohs.acf.hhs.gov/mental-health/article/head-start-heals-campaign
- **Attachment, Trauma, and Reality: Creating Trauma-Informed Systems for Infants, Toddlers, and Their Families.** (Video). ZERO TO THREE

https://www.zerotothree.org/resource/virtual-event/attachment-trauma-and-reality-creating-trauma-informed-systems-for-infants-toddlers-and-their-families/)

- 80X3 is a systems change initiative that requires everyone to work together to address the effects of childhood.
- Home - Minnesota Association for Children's Mental Health

Additional Resources

- Let's Move! Child Care Technical Assistance Manual (PDF) HKHF_TA_Manual_Final.pdf
- Eat Well Play Hard in Child Care Settings
- Eat-Well-Play-Hard-ine-Child-Care-Setting-Overview-PDF.pdf
- Nutrition and Wellness Tips for Young Children: Provider Handbook for the Child and Adult Care Food Program b50ad221-0238-4a46-8304-7468b245e6f4
- Let's Go Toolkits Toolkit | letsgo
- eXtension Alliance for Better Child Care Hands-on Activities Database Hands-On Activities for Child Care – eXtension Alliance for Better Child Care
- Minnesota Food Charter Minnesota Food Charter
- Preschoolers: Health and Nutrition Information www.choosemyplate.gov/health-and-nutritioninformation
- Cooking Matters Cooking Matters
- Farm to Early Care in Minnesota Farm to Early Care MN

Commercial Tobacco-Free (CTF) in Community Settings

Purpose

To use evidence-based policy, systems, and environmental change (PSE) strategies to:

1. Prevent initiation of commercial tobacco product use (including emerging products and e-cigarettes) among youth and young adults
2. Promote quitting among adults and youth
3. Eliminate exposure to secondhand smoke
4. Advance health equity by identifying and eliminating commercial tobacco product–related inequities and disparities to improve the health of all Minnesotans.

Health equity and community engagement

Health equity and community engagement should be integrated into commercial tobacco-free strategies in the community setting. Local public health SHIP partners should identify communities or populations to prioritize in this work by looking at commercial tobacco use rates, disease and death rates, or historic (and continued) targeting by the tobacco industry.

The CDC Best Practices User Guide for Health Equity in Tobacco Prevention and Control (https://3.basecamp.com/3777019/buckets/4020798/uploads/8442690236) guide provides context on commercial tobacco-related disparities and considerations for integrating equity into your work.

Examples of equity considerations in this setting:

- If you are working on ending the sale of flavored commercial tobacco products, avoid exempting specific products or flavors such as menthol or mint. The tobacco industry has heavily targeted marketing of menthol cigarettes to Black Americans for decades. Work with TA providers to ensure the use of the model policy language when updating local tobacco retail license ordinances.
- When working on smoke-free housing, the goal is to maximize smoke-free air and housing stability (avoid evictions). Use graduated (involve a range of strategies that get progressively stricter), equitable enforcement strategies and provide resources to help people quit.
- Remove purchase, use or possession penalties (PUP) in policy language to avoid youth from being penalized for nicotine addiction. Learn more about PUP: Youth Purchase, Use, or Possession Penalties (PUP) (https://www.publichealthlawcenter.org/sites/default/files/resources/Youth-Purchase-Use-Possession-Penalties.pdf)

Getting started

If you are new to working on commercial tobacco-free strategies in the community setting, below are a few suggested steps to start with to help you identify which strategies to work on:

- Meet with your commercial tobacco technical assistance (TA) provider, American Lung Association (ALA) for Greater Minnesota and Association for Nonsmokers-Minnesota (ANSR) for the 11-county metro area.
- Identify local coalitions, organizations, or partners who are working on commercial tobacco prevention or similar issues.
- Determine which commercial tobacco-free community strategies your Community Health Board (CHB) leadership will support.
- Review Implementation Guide for commercial tobacco-free in community strategies (below and on Basecamp for expanded detail on strategies: https://3.basecamp.com/3777019/buckets/4020798/vaults/8442684574).
- Review local data and policies related to the commercial tobacco-free community strategies such as store audit data, environmental scans, local tobacco retail license ordinance language, smoke-free housing policies, local smoke or commercial tobacco-free policies for parks and recreational areas
- Review the Minnesota Comprehensive Commercial Tobacco Control Framework, 2022-2026 (https://www.health.state.mn.us/communities/tobacco/initiatives/docs/mnframework2022.pdf) which includes seven guiding principles, four bold goals and 40 bold actions that build on best practices established by the CDC. The bold actions include price related policies, commercial tobacco retail sales restrictions and end game policies.

Commercial Tobacco-Free (CTF) in Community Settings Strategies

Point-of-Sale

The Point-of-Sale (POS) strategy reduces youth and other targeted groups' exposure to commercial tobacco products and marketing through local ordinance changes. LPH SHIP will pursue and implement evidence-based approaches that will lead to decreased youth access and overall exposure to marketing practices.

The goals of this strategy are to:

- Decrease commercial tobacco exposure and use.
- Reduce commercial tobacco-related health disparities.
- Increase community awareness of commercial tobacco industry marketing practices.
- Improve implementation, compliance, and enforcement with retail licensing laws.
- In this strategy, LPH SHIP will educate and mobilize community partners to educate the public and decision makers about public health concerns related to the commercial tobacco retail environment.
- At a minimum, LPH SHIP will update and strengthen local licensing, compliance, and enforcement laws and best practices to ensure they meet state requirements, provide clear and comprehensive definitions, and include robust and self-sustaining compliance programs. LPH SHIP also has the option to work on advanced approaches to improve the retail environment through local ordinance changes.

Policy change examples for POS:

- Updating city or county tobacco retail license ordinances to align with state and federal laws, including raising the minimum sales age to 21 (T21) and removing PUP penalties
- Updating city or county tobacco retail license ordinances to include advanced POS approaches. This could include restricting the sale of menthol and flavored commercial tobacco products, prohibiting coupon redemption or price discounting, or restricting the number, location, or density of retail outlets.

Point-of-Sale Implementation Guide:

https://3.basecamp.com/3777019/buckets/4020798/vaults/8442684574

Smoke-Free Housing

The Smoke-Free Housing strategy decreases Minnesotans' exposure to secondhand smoke in their homes by increasing access to smoke-free housing options. People who live in multi-unit housing may be involuntarily exposed to secondhand smoke if other people are smoking in the building. Studies have shown that despite attempts to seal and ventilate individual units, air movement from one unit to another, or throughout an entire multi-unit building, can be significant.

Local SHIP partners will work with the renters, property managers or owners, representatives of the housing industry, common interest communities, and local decision makers. Smoke-Free

Housing activities may include conducting assessments, educating partners on the benefits of smoke-free housing, informing them of evidence-based strategies, providing model smoke-free policy language, and assisting with the implementation and evaluation of such protections.

Policy change examples for Smoke-Free Housing:

- Working with renters, property managers or owners to pass smoke-free building or grounds policies
- Working with cities or counties to pass a smoke-free multi-unit housing ordinance or a smoking policy disclosure ordinance

Smoke-Free Housing Implementation Guide:

https://3.basecamp.com/3777019/buckets/4020798/vaults/8442684574

Smoke- and Commercial Tobacco-Free Outdoor Spaces

This strategy includes the implementation of policies to reduce exposure to commercial tobacco products, as well as secondhand smoke and aerosol. Commercial tobacco-free spaces provide health protection from commercial tobacco product use and exposure. Commercial tobacco-free spaces change community norms by promoting commercial tobacco-free living, and they help protect the environment from the commercial tobacco product waste, like cigarette butts or used vapes. This strategy could include policies or ordinances for parks, beaches, and other outdoor spaces or events.

Policy change example for Smoke- and Commercial Tobacco-Free Outdoor Spaces:

- Passing a smoke- or commercial tobacco-free policy or ordinance for local parks, beaches, fairgrounds, campgrounds, or outdoor events

Smoke- and Commercial Tobacco-Free Outdoor Spaces Implementation Guide:

https://3.basecamp.com/3777019/buckets/4020798/vaults/8442684574

Youth Engagement within Commercial Tobacco-Free (CTF) Strategies

Youth engagement is the involvement of young people in decision making to create positive social change. Youth engagement efforts give young people the ability and authority to make decisions that improve the policy environment, change social norms, and reduce commercial tobacco initiation and use in their communities.

This strategy is an add-on to any existing CTF strategy. LPH SHIP Partners working on this strategy will engage youth in the activities listed below, or from the CDC Best Practices User Guide for Youth Engagement in Tobacco Prevention and Control (https://bpb-us-w2.wpmucdn.com/sites.wustl.edu/dist/e/1037/files/2011/11/UG_YouthEngagement_2019.pdf), with the goal of having youth support a PSE change in another commercial tobacco-free strategy such as point-of-sale, smoke-free housing, smoke- and commercial tobacco-free outdoor spaces, or commercial tobacco-free schools (policy, curriculum, or cessation activities).

PSE activities should align with CDC Best Practices and may include:

- Raising awareness about the importance of commercial tobacco-free environments.
- Educating about the impact of commercial tobacco product prices.
- Reducing tobacco industry influence in retail stores.
- Communicating the dangers of youth commercial tobacco use and secondhand smoke exposure.
- Building community awareness of commercial tobacco control efforts.
- CDC Best Practices for Youth Engagement in Tobacco Control: https://3.basecamp.com/3777019/buckets/4020798/vaults/8442684574

Commercial Tobacco-Free in Community Settings Strategy Guide:

https://3.basecamp.com/3777019/buckets/4020798/vaults/8270806020

Potential partners for strategies in this setting

- MDH grantees from the following programs:
  - Commercial Tobacco-Free Communities
    - Youth E-cigarette Prevention and Cessation Initiation
    - Tribal SHIP and Tribal Tobacco
    - Eliminating Health Disparities Initiatives
- Blue Cross and Blue Shield of Minnesota's Center for Racial and Health Equity
- Minnesota Regional ATOD Prevention Coordinators
- Drug Free Community Coalitions
- Other existing local commercial tobacco, alcohol, or other drug prevention coalitions
- SHIP Community Leadership Teams (CLT)
- Organizations or groups with similar missions, such as youth organizations and clubs, community-based organizations, health and wellness organizations, neighborhood associations, social service organizations, faith-based organizations, health systems
- Individuals with unique perspectives and a vested interest in the health and wellbeing of their community. This could include physicians, educators, elders, parents, and youth advocates.

How to implement this setting without funds to grant to local partners.

Most of the CTF in community strategies will not require funds to go to outside partners, but funds could be offered for signage for new policies. LPH SHIP partners are encouraged to work with the commercial tobacco technical assistance providers to receive support on commercial tobacco-free strategies and to share their public health expertise with external partners to move local PSE work forward.

Commercial Tobacco Technical Assistance (TA) Providers

MDH funds several technical assistance providers to support LPH SHIP and other commercial tobacco grant programs. Grantees are encouraged to connect with their TA provider for support.

Find more information on about TA providers on Basecamp: https://3.basecamp.com/3777019/buckets/4020798/vaults/5907975815

- American Lung Association (ALA) provides policy, systems and environmental change (PSE) TA to local SHIP partners in Greater Minnesota (all counties outside of the 11-county metro area).
- Association for Nonsmokers - Minnesota (ANSR) provides policy, systems, and environmental change (PSE) TA to local SHIP partners in the 11-county metro area (Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Scott, Sherburne, Ramsey, Washington, and Wright counties).
- Public Health Law Center (PHLC) provides legal technical assistance for commercial tobacco point of sale regulations, and smoke-free and commercial tobacco-free strategies statewide, including model policy language tailored to the needs of the community.

Cessation Resources

When passing local policies that may encourage people who use commercial tobacco products to cut back or quit, it is important to provide support by offering cessation resources. Quit Partner™ (https://www.quitpartnermn.com/) is one free resource available to Minnesota communities to provide cessation support. More information can also be found below in the healthcare section of the Implementation Guide under the *Quit Partner Referral Strategy*.

Free support from Quit Partner - Minnesota's free way to quit nicotine, including smoking, vaping, and chewing:

- One-on-one phone coaching, text, and email support available 24/7
- Free quit medications including patches, gum, or lozenges
- Specialized support programs for pregnant and post-partum individuals, people living with mental illness or substance use disorder
- My Life, My Quit program for youth ages 13-17
- American Indian Quitline provides culturally appropriate support for the AI community: https://www.quitpartnermn.com/american-indian-quitline/
- Quit Partner and My Life, My Quit materials can be downloaded or ordered from here: https://www.quitpartnermn.com/toolkit-materials/

Food Access in Community Settings

The SHIP 6 planning process informed the decision to change the name of this body of work from 'Healthy Eating in the Community' to 'Food Access in Community Settings'. While healthy eating is still a primary behavior that SHIP works to address, effectively promoting and supporting healthy eating behaviors is dependent on the policies, systems, and environmental factors that impact food access within communities and overall food security. Ensuring sufficient, equitable, affordable, and culturally relevant access to food is at the root of food security and reinforces healthy eating behaviors.

The Food Access in Community Settings Strategies are designed to improve food and nutrition security and make healthier foods accessible to all, especially for those who have the greatest barriers to accessing them.

All SHIP efforts must be informed by data and evidence, and be focused on sustainable policy, systems, and environmental (PSE) changes that will improve food access and in turn, result in healthier eating behaviors. A comprehensive and coordinated approach is vital to improving food access. Assessment, community engagement, capacity building, and relationship building are all necessary to make policy, systems, and environmental changes that strengthen the food system and benefits all Minnesotans. Collaborations, such as food access networks (also called food policy councils) and diverse community work groups, are vital in order to plan and integrate food access strategies into existing systems and policies.

Food insecurity can lead to or exacerbate chronic health conditions and occurs when access to nutritionally adequate and safe food is limited or uncertain. The Minnesota Statewide Health Assessment, published in April 2024, highlighted eating behaviors and food security statistics for Minnesotans:

- Significantly fewer Minnesotans reported eating at least one vegetable and at least one fruit a day in 2021 compared to 2017. Significantly more adults consumed three or fewer sugary beverages per week in 2021 compared to 2018.
- Minnesota has experienced dramatic changes in food security since the outset of the COVID-19 pandemic in early 2020, with food insecurity surging by as much as 40%.
- In 2020, Black and Latine people in Minnesota are more than twice as likely to report food insecurity than white people in Minnesota.
- The number of people visiting food shelves in Minnesota has increased to 5.5 million in 2022, from 3.4 million in 2017, likely because of rising food costs due the COVID-19 pandemic and inflation impacting the supply chain.

Purpose

Food Access in Community Settings strategies are designed to support to SHIP's overall goal to Reduce incidence of preventable chronic disease and death in MN. The 10 strategies, combined with recommended foundational practices, seek to strengthen access to healthier foods for all Minnesotans. Improved access to healthier foods and beverages translates into healthier dietary behaviors, which in turn translates into reduced risk for nutrition related chronic disease and death.

Health equity and community engagement for this setting

Health equity is at the heart of SHIP's food access efforts. Addressing food access in the community requires acknowledging the structural and social determinants that shape who has access to nutritious, affordable, and culturally relevant food and who does not. SHIP's role is to center those most impacted by food insecurity and co-create solutions *with* community members, not *for* them.

LPH SHIP staff are encouraged to build trusting relationships with community members, cultural leaders, and grassroots organizations early and often. Engagement strategies should emphasize shared decision-making, trust-building, and transparency. This includes offering various ways for community members to participate (e.g., surveys, focus groups, leadership roles) and compensating them for their time and insights whenever possible.

Meaningful engagement goes beyond outreach; it means ensuring voices from historically excluded populations influence the design, implementation, and evaluation of food access strategies. This also includes honoring lived experience as expertise and creating feedback loops that show how community input shaped the work.

Getting started

SHIP healthy eating and food access work has a long history in Minnesota, and likely in your community too. As you get started with your SHIP Food Access in Community Settings work consider the following themes. Also, remember that in the past, "Food Access in Community Settings" was called "Healthy Eating in the Community", so you may see it referenced in both ways as you review past documents and training.

SHIP and Food Access in Community Settings 101

Across all SHIP settings, a great place to start your SHIP training is with the Implementation Guide and the core training offered by MDH. Your employer may or may not have additional formal training related to current and past SHIP work.

Looking back is also a good way to inform how you'll move forward in your work. Review past work plans, communications pieces, success stories and other documents that exist for the Food Access in Community Settings work in your area. You may also want to set up some time with your supervisor and colleagues to get their thoughts and history on SHIP healthy eating and food access work, almost like an informational interview. Consider questions such as:

- What have been some of the most successful SHIP projects related to healthy eating and food access?
- What have been some of the less successful projects? What were the lessons learned?
- What do you think I should consider as I start to get involved in this work?
- Who have been key community partners?
- Are there any community partners that I should be talking to, that maybe haven't been involved in the past?
- Who else should I be talking to about the history, and the future, of SHIP in our community?

Partners & Relationship Building

After doing some initial internal research and conversations, it is important to look outside of your agency to nurture existing partner relationships and develop new ones. There are a wide variety of partners in the Food Access in Community Settings space, so think broadly as you start to consider this network. The list below outlines some of the most common types of partners, but your list will depend on the work you are doing, and the key players in your community.

- Food Policy Councils and other food network members
- Local and regional community and economic development organizations
- Hunger relief organizations such as food shelves, food pantries and backpack programs
- Community service-based organizations and groups such as Rotary Clubs, Lion's Club, Boys & Girls Club, FFA, 4H, Community Action Partnership agencies, etc.
- Farmers markets, farmers, and other food producers
- Local businesses that serve priority populations
- Health equity champions, cultural organization, faith-based organizations
- Community members representing the priority population
- Local churches that focus on hunger relief and/or social justice
- U of M Regional Health and Nutrition Extension Educators and SNAP-Educators
- Local health care systems/hospital leaders
    - *Partnering with health care settings presents an opportunity to layer with healthy eating through such efforts as screening for food insecurity, or the SHIP Food Rx strategy. Please see the Healthcare section of this Guide for more information.*
- City and county officials (e.g., city planners and zoning officials, transportation planners, environmental health and public works staff, food inspectors, etc.)
- Community Leadership Team or other community partner organizations
- Local government advisory commissions and boards

Connect & Re-Connect with MDH OSHII Staff

As you orient yourself to the Food Access in Community Settings work, do not hesitate to reach out to MDH OSHII staff with questions, concerns, ideas or moral support. That's what we are here for. Reach out to your Community Specialist (CS) to schedule time to meet with the OSHII Food Systems Coordinator and/or Nutrition Policy Coordinator at any time.

Foundational Practices

In previous SHIP cycles, Community Food Assessments and Food Access Networks loosely fit under the activity of Community Food Assessments & Planning. The SHIP 6 Planning process helped identify how to better organize the work and revealed that Community Food Assessments and Food Access Networks are truly foundational practices that support the breadth of Food Access in Community Settings strategies and needed to be called out as independent bodies of work.

Using Data to Inform Decisions

It can be hard to know where to start when you're making decisions and prioritizing limited resources. Using data to inform your decisions will help ensure you're moving forward in a way that will support the goals and priorities of SHIP, and your community. Below are a few resources to help you get started, but this is by no means a complete list, and not everything on this list may be relevant for your work. Additional strategy specific resources are also included below, under each strategy heading.

Reach out to your CS and Food Access in Community Settings OSHII staff for more support with grounding your work in data.

- Hunger & Poverty in the United States | Map the Meal Gap
- Minnesota | County Health Rankings & Roadmaps
- Food Access Research Atlas | Economic Research Service
- Grocery Gap Atlas
- SNAP Data by Congressional District - Food Research & Action Center
- Rural Health Mapping Tool
- Minnesota Statewide Food Shelf Survey
- Census Bureau Data

Community Food Assessments

Community Food Assessments (CFAs) are essential for supporting and strengthening local food systems and improving food and nutrition security. A CFA can help communities understand specific issues like local food insecurity or provide a broader picture of the food system-including components like community gardens, farmers markets, food shelves, and other access points.

CFAs can identify:

- Opportunities for collaboration across the local food system
- Gaps in services or infrastructure
- Strategies to prioritize, such as launching a community garden or improving partnerships with local food retailers or food shelves

The findings can also help inform local decision-makers about areas needing investment or support. In many cases, CFAs also highlight action items that can shape the work of a Food Access Network or Food Policy Council.

A CFA is a collaborative process involving data collection and analysis with local and regional partners. The scope of a CFA will depend on the unique needs and characteristics of the community and geographic area. Strong assessments use both quantitative data (e.g., demographics, zoning, transportation, land use) and qualitative data (e.g., interviews, focus groups, community storytelling) to provide a complete and accurate picture.

Engaging community members and partners throughout the process builds ownership, strengthens trust, and ensures the assessment reflects lived experience and local assets.

The Role of LPH SHIP

LPH SHIP's role in a CFA may vary depending on the needs of the community:

- Lead or support coordination of the assessment
- Provide staff time or technical assistance
- Serve in an advisory or connector role
- Use findings to identify and support SHIP-aligned strategies

Ultimately, SHIP's involvement should aim to build local capacity, so communities are empowered to sustain and grow this work overtime.

Additional Resources

There are many examples of how to conduct a Community Food Assessment. Here are a few toolkits and guides to help you get started:

- **Local Foods, Local Places Toolkit: A Guide to Help Communities Revitalize Using Local Food Systems:** This Environmental Protection Agency (EPA) resource helps create action plans that chart a course for using local foods to help meet a broad range of community goals. It provides step-by-step instruction for planning and hosting a community workshop that produces an action plan laying out next steps for implementation. A facilitator, either from the community or hired from outside, could use this toolkit to help articulate goals, engage stakeholders, and prioritize achievable actions.
- **Making Food Systems Part of Your Community Health Needs Assessment:** This resource is aimed at providing hospitals guidance on how to work with external stakeholders, like local public health, to integrate food security and local food system capacity into the Community Health Needs Assessment (CHNA) process.
- USDA Community Food Security Assessment Toolkit: This report provides a toolkit of standardized measurement tools for assessing various aspects of community food security.

For additional resources, including examples of SHIP supported Community Food Assessments, please see the Basecamp Folder Community Food Assessments in the Foundational Activities Folder.

Food Access Networks

A Food Access Network (FAN) can strengthen and support the growth of a community's local food system and positively impact local food and nutrition security. FANs are community-based, cross-sector groups that work collectively to identify and solve complex issues within their food systems.

These networks, through mutual learning and collaboration, can identify the best strategies to improve food security, prevent diet-related chronic diseases and implement food access strategies in the community. They can take many forms, ranging from food security coalitions to food policy councils with lots of variations in between, and can influence policy at the local

and state level. The scope and geography of each network is shaped by the goals and the needs of the community and can occur at the neighborhood, city, county, or multi-county regional level.

LPH SHIP's role can vary depending on the structure and scope of the FAN. For instance, SHIP staff may take a lead role in convening partners and facilitating meetings, acting as the backbone organization to support the FAN. Or SHIP staff may participate in the FAN, but not take on a leadership role, providing support and technical assistance as needed. A primary goal LPH SHIP's involvement in a FAN is to develop capacity and partnerships within the community to identify and respond to opportunities and barriers to community food access and food security. An outcome of SHIP's involvement in a FAN could lead to identifying partnerships and projects that align with SHIP strategies to carry the work forward.

Food Access Networks can be complimented by a Community Food Assessment (see above). In some cases, a CFA may occur first, with an identified need to form some type of FAN. Or an FAN may identify that their work would be strengthened by conducting a CFA. Either way, a CFA can act as a guiding document for a FAN, which identifies goals and action items to work towards.

Additional Resources

- Johns Hopkins Center for a Livable Future: Food Policy Networks Resource Clearinghouse
- UMN Extension: Facilitation Materials and Methods
- Food Justice Facilitation Article
- The Art and Science of Networking Extension Article
- Cultivating Collective Action Statewide Food Network Report
- Food Resilience Planning Guide for Local Government
- For additional resources, please see the Basecamp Folder Food Access Networks in the Foundational Activities Folder.

Implementation Approaches Based on Funding Availability for Community Partner Awards

The Food Access in Community Settings Strategies may done with or without funding for community partner awards. Some examples of how to do a no funds option include:

- Offer consulting/technical assistance
- Connect partners with other resources such as the SuperShelf consultants, or FFEN for tools and resources
- Support partners with meeting facilitation and planning for longer term and/or community wide projects

Food Access in Community Settings Strategies

Breastfeeding Support

Description

Breastfeeding promotion and support programs are proven effective to increase breastfeeding rates which lead to improved health outcomes for infants and parents. This SHIP strategy supports the creation of supportive environments and promotes policies that normalize and sustain breastfeeding practices.

Health Equity Considerations

Ensure spaces are welcoming and accessible for all breastfeeding parents. Prioritize communities where breastfeeding disparities exist due to structural racism or lack of infrastructure. Cultural stigma, access to private spaces, and language barriers should be addressed with the community. Consider sites in the community where people with young children spend time, which can include libraries, community centers, park & recreation centers, community events, local businesses, etc.

As you develop your PSE strategies, keep health equity in mind. Each PSE change should be developed in consideration of the priority population(s) identified during your assessment phase. These are some of the most common PSE changes that LPH SHIP accomplish in this strategy.

Some examples of PSE changes for this strategy include:

Policy: Develop a lactation policy

System: Implement a system to receive/provide donor milk

Environment: Create Lactation Room or Lactation Tent to support lactating parents

There may be other PSE changes that support this work in your community

Additional Resources

Additional information on this strategy can be found in the Strategy Guide on Basecamp:

- Breastfeeding Support
- Ramsey County Guide to Becoming a Breastfeeding Friendly Public Space
- CDC Public Health Strategies for Breastfeeding
- Minnesota Infant Feeding Practices Survey
- MN WIC: Benefits of Breastfeeding

Community Based Agriculture

Community based agriculture is a proven effective strategy to increase access to and consumption of fruits & vegetables, increase physical activity, improve mental health and

wellbeing, and contribute to an improved sense of community. This strategy is commonly implemented using the traditional community garden model, but there are variations on this strategy, depending on the characteristics and needs of your community.

Implementing this strategy will need to take into consideration the location and infrastructure needs of the project. Work with your city and/or county officials to determine locations where growing produce is allowed in the community. Locations with access to water that are within walking distance of your primary audience are ideal. Consider co-locating with partners that are already prominent in the community such as schools, after-school program sites, faith-based organizations, libraries, food shelves, worksites, and other locations where key partners may be able to assist with sustainability.

Health Equity Considerations

Consider partners in local government, local businesses and funders, non-profits, food shelves, faith-based organizations, schools, community members and community leaders, farmers, UMN Master Gardeners and more.

Choose sites that serve communities with limited access to fresh produce. Ensure accessibility for people with disabilities and consider language, cultural practices, and intergenerational involvement in gardening.

As you develop your PSE strategies, keep health equity in mind. Each PSE change should be developed in consideration of the priority population(s) identified during your assessment phase. These are some of the most common PSE changes that LPH SHIP accomplish in this strategy. Some examples of PSE changes for this strategy include:

Policy: Create or update garden policies (maintenance, volunteer policy, donation policy, rules for participants, etc.)

System:

- Establish a system for garden produce to be donated or used locally
- Establish a system for using the garden to educate a priority population (local school, low-income residents, etc.)

Environment:

- Create new community garden to serve priority population
- Expand existing community garden to serve priority population
- Upgrade garden to improve accessibility (for seniors, disability community etc.)
- There may be other PSE changes that support this work in your community

Additional Resources

- The Minnesota Department of Agriculture: AGRI Urban Agriculture Grant
- The Public Health Law Center, Community Gardening Policy Reference Guide
- Webinar: The Public Health Law Center, Get Ready for Spring! Supporting the Success of Local Community Gardens through Local Laws and Policies

- UMN Extension: Master Gardeners Make a Difference in your Community
- UMN Extension: Growing Safe Food
- UMN Regional Sustainable Development Partnership (RSDP): Consider Submitting an Idea to RSDP
- The University of Minnesota Extension SNAP-Ed team can partner with your agency on educational offerings, or on a project for changing practices and systems to create an environment conducive to healthier living.
- American Planning Association: Urban Agriculture
- APA: Growing Food Connections

Planning & Policy Brief: Community Food Production; The Role of Local Government in Increasing Community Food Production for Local Markets

Farmers Markets

Description

The Farmers Market strategy is a promising practice to increase access to and availability of fruits & vegetables. Fruit &vegetable incentive programs such as Market Bucks, that are offered at Farmers Markets are proven effective to increase access to and consumption of healthy food and increase healthy food purchases.

Health Equity Considerations

Focus efforts on areas with the greatest need, for example, communities where:

- Access to affordable fruits and vegetables is limited
- Chronic disease rates are high
- People most impacted by structural racism, bias, and inequity

Markets can also implement measures to be economically accessible and affordable to all customers by accepting SNAP (Supplemental Nutrition Assistance Program) and other programs such as Market Bucks and Power of Produce (PoP).

Below is an overview of the most common nutrition benefits that SHIP has supported in the past. Additional information and TA on how to implement these programs at your market can be found in Basecamp.

Supplemental Nutrition Assistance Program (SNAP): SNAP benefits can be used at participating farmers markets. Once a farmers' market can accept SNAP benefits, it opens the doors for offering other nutrition incentive programs such as Market Bucks.

Farmers Markets that want to accept SNAP must first be approved by the USDA Food and Nutrition Services (FNS). Information can be found on the Department of Children, Youth and Families webpage: Electronic Benefit Transfer for Retailers, Farmers Markets and Direct Marketing Farmers.

Electronic Benefits Transfer (EBT): EBT is a card, much like a credit card, which is used to disburse funds from a variety of assistance programs, including SNAP.

Minnesota offers free wireless point of sale (POS) equipment for Farmers Markets and Direct Marketing Farmers in Minnesota that have been approved by the USDA FNS. The equipment processes EBT benefits only and must be within range of an AT&T cell tower. How to request equipment is covered in Step 5 on the Department of Children, Youth and Families webpage: Electronic Benefit Transfer for Retailers, Farmers Markets and Direct Marketing Farmers.

These guides can help understand the process of setting up SNAP/EBT access at a farmers' market:

- University of Minnesota Extension – Supporting Farmers Markets in Accepting SNAP Benefits
- Farmers Market Coalition – SNAP Guide for Farmers Markets

Market Bucks

Market Bucks is a state funded program that provides a dollar-for-dollar match up to $10 worth of SNAP benefits to be used at farmers markets. Market Bucks increases purchasing power for SNAP-eligible foods at each visit. As a bonus, SNAP and Market Bucks used at the market put more money into the pockets of local farmers, who may have low incomes themselves.

You can learn more about Market Bucks on the Hunger Solutions webpage.

Power of Produce (PoP) Club

The Power of Produce (PoP) program helps engage children at the farmers market with fun educational activities and provides them with a $2 token each visit to spend on fresh produce. PoP is another way that farmers markets can make fresh produce more affordable for families. Some markets have also started to offer "PoP Plus," which is a similar program designed to benefit senior citizens. These programs operate independently from SNAP and Market Bucks and a market does not need to accept SNAP to operate a PoP program.

For more information on starting or supporting PoP, check out the PoP Club information and toolkit from the University of Minnesota Extension

WIC Farmers' Market Nutrition Program (FMNP) and Seniors Farmers' Market Nutrition Program (SFMNP)

The Farmers' Market Nutrition Program (FMNP) and the Senior Farmers' Market Nutrition Program (SFMNP) are federal programs administered by the Minnesota Department of Agriculture (together known as FMNP). More information can be found on MDA's webpage: Senior/Farmers' Market Nutrition Program

WIC participants can find out if they are eligible for the FMNP program by contacting their local WIC agency. Seniors can find out if they are eligible to receive SFMNP by contacting their local Commodity Supplemental Food Program (CSFP) agency.

To find out if your local market can accept FNMP or SFMNP visit the MN Department of Agriculture's list of Authorized Farmers' Markets.

Farmers markets that intentionally create an inclusive and accessible environment can be more impactful in increasing access to fruits and vegetables and contribute to the well-being of

communities and individuals. It takes intentional and ongoing efforts to make a farmers market a fully inclusive and welcoming space, creating a sense of belonging for all. Some examples of this work that SHIP has supported are:

- **Safe and equitable access to the market**: Consider a location for the market that is accessible by multiple modes of transportation to ensure equitable access.
- **Accessible spaces at the market**: Consider creating shaded areas for people to gather and rest. Be sure to consider accommodations such as clear, level pathways, accessible restrooms, transportation options, room for strollers, wheelchairs, etc.
- **Community resource booth and market navigators**. A resource booth can be the connection hub between market visitors and the wider community. Organizations such as nonprofits, health care providers, city or county departments, libraries, and other organizations that serve the community can be great partners for contributing to and staffing a resource booth. Market navigators can welcome and orient new customers and can also assist in implementing SNAP-EBT and other market programs.
- **Clear and accessible communication**: Ensure market signs, promotional and informational materials can be easily understood by anyone in the community.
- **Use a multi-media approach to connect with the community**. Consider multiple communication outlets such as social media, newspapers, radio, flyers and other print media. Local newspapers and radio stations are often looking for content and might welcome public-interest pieces centered around the market.

As you develop your PSE strategies, keep health equity in mind. Each PSE change should be developed in consideration of the priority population(s) identified during your assessment phase. These are some of the most common PSE changes that LPH SHIP accomplish in this strategy. Some examples of PSE changes for this strategy include:

Policy: Create or update market policies related to food access (SNAP acceptance, vendor training on nutrition programs, etc.)

System:

- Support market to start/sustain accepting nutrition benefits (SNAP, WIC-FMNP, Senior-FMNP)
- Support market to implement/sustain nutrition incentive program (Market Bucks, PoP, etc.)
- Establish a Community Resource Booth with community partners to share resources and implement SNAP-EBT and other market programs.

Environment:

- Support market with signage or supplies to promote access for priority populations
- Create accessible seating area to accommodate all community members, including seniors and families.
- Start a new Farmers Market
- There may be other PSE changes that support this work in your community

Additional Resources

- Hunger Solutions Minnesota: Market Bucks Informational video
- The Minnesota Farmers Market Association (MFMA) provides services, programs and leadership that support and promote farmers markets across Minnesota.
- FM360 is a collaborative metrics service for farmers markets that was developed through a partnership between market advocates, market managers, and researchers from the University of Minnesota.
- The Farmers Market Coalition works nationally to strengthen farmers markets.
- The Minnesota Grown Directory, supported by the Minnesota Department of Agriculture, is available online and in print to help consumers find farmers markets near them.
- USDA Local Food Compass Map Shows locations of farmer's markets, and food hubs across the country, in addition to federal investments in local and regional food systems.
- The University of Minnesota Extension SNAP-Ed team can partner with your agency on educational offerings, or on a project for changing practices and systems to create an environment conducive to healthier living.
- University of Minnesota Extension, Safe Food Product Sampling for Demonstrations
- The Anti-Racist Farmers Market Toolkit - Farmers Market Coalition. This toolkit was created to help farmers market managers take action against systemic racism and create a safe space at farmers markets nationwide.

Food & Nutrition Security

Description

This strategy aims to ensure that all community members have consistent access to affordable, nutritious, and culturally appropriate food. It addresses food insecurity through a range of flexible approaches that do not fit neatly into other SHIP strategies. The goal is to reduce hunger and improve dietary quality among underserved populations.

Food & Nutrition Security means having reliable access to enough high-quality food to avoid hunger and stay healthy. Improving access to nutritious food and beverages supports overall health, reduces chronic diseases, and helps people avoid unnecessary health care. For more information, visit the USDA's webpage on Food and Nutrition Security.

In previous cycles of SHIP, this strategy included a broad range of work in food shelfs, as well as other community settings. For SHIP 6, all food shelf work should be included in the "Food Shelf" strategy, rather than the "Food & Nutrition Security" strategy. Activities included in this strategy should support efforts to ensure reliable access to enough high-quality food to avoid hunger and stay healthy, and that do not fit under other Food Access in Community Settings strategies.

LPH SHIP's role can vary depending on the needs of the food and nutrition security partners involved. Consider how your efforts will support two key elements of food and nutrition security:

- Making sure people have access to *enough* food: Sometimes this can look like simply making sure people have enough food to eat to make sure they are not going hungry
- Making sure that people have access to the *affordable, nutritious, and culturally appropriate* foods that is healthy and right for themselves and their families

While we know that a wide variety of foods make up a nutritious and enjoyable meal pattern, a primary focus for SHIP's involvement in Food and Nutrition Security is to increase access to fruits and vegetables and reduce access to sodium, added sugar, and saturated fat.

Health Equity Considerations

Focus efforts on populations often underrepresented in food access initiatives, including seniors, youth in detention, and individuals in congregate or institutional settings. Be mindful of the cultural, linguistic, and physical accessibility needs of these groups and involve them in planning and feedback.

As you develop your PSE strategies, keep health equity in mind. Each PSE change should be developed in consideration of the priority population(s) identified during your assessment phase. These are some of the most common PSE changes that LPH SHIP accomplish in this strategy. Some examples of PSE changes for this strategy include:

Policy: Establish or update organizational policy related to food and nutrition security

System: Establish/support a system for food distribution to priority population(s)

Environment: Changes to support or expand community meals or food distribution for priority populations (e.g., seniors, low-income residents, etc.)

There may be other PSE changes that support this work in your community

Additional Resources

- Minnesota Department of Agriculture: Temporary Food Establishments

Food Guidelines

Description

Food Guidelines (FG), or Food Service Guidelines (FSG), are guidelines or standards to support healthier food and beverage options in a wide range of community settings. These many include vending machines, concession stands, grab-and-go coolers, cafeterias, and other accessible food service environments. Common sites for implementation include public properties such as parks, community centers, public housing, and school athletic venues.

Food Guidelines are also applicable to small food retail outlets like corner stores, convenience stores, dollar stores, and gas stations. For SHIP purposes, "small retail" is considered a small independent or chain store with three or fewer cash registers. Because small retailers often face sourcing challenges, SHIP can combine Food Guidelines with other strategies to address distribution barriers.

Basic steps SHIP can support include:

- Identifying partners and forming a planning team

- Assessing the food environment
- Exploring policy options and contract language
- Selecting product, pricing, placement, and promotion strategies
- Creating an evaluation plan

LHP SHIP staff or partners can conduct assessments (e.g. NEMS), communicate with vendors, support marketing efforts, and engage communities to choose preferred healthier items. A successful approach involves working with retailers to understand business needs and co-create sustainable solutions aligned with shared community goals.

Health Equity Considerations

Food access varies widely by geography, race, income, and disability status. SHIP staff should identify communities with limited access to healthy food and work with them to tailor guidelines that reflect their preferences and realities. This may include:

- Providing multilingual materials
- Partnering with BIPOC-owned or culturally specific food retailers
- Promoting options relevant to cultural dietary practices
- Ensuring signage and displays are accessible for all ages and abilities

As you develop your PSE strategies, keep health equity in mind. Each PSE change should be developed in consideration of the priority population(s) identified during your assessment phase. These are some of the most common PSE changes that LPH SHIP accomplish in this strategy. Some examples of PSE changes for this strategy include:

Policy: Establish/update food guidelines for concessions at a community location

- Establish/update vending guidelines at a community location

Systems: Develop system for communicating new/updated food guidelines to consumers

Environment: Improvements to retail locations to support new food guidelines (e.g., displays, signage, coolers, etc.).

Additional Resources

- Additional information, including local SHIP examples, can be found in the Basecamp Folder: Food Guidelines
- Minnesota Department of Agriculture: Good Food Access Program (GFAP)
- Minnesota Department of Agriculture: Retail Food Program
- Minnesota Department of Agriculture: Starting a Food Business Roadmap
- UMN Extension: Shelf Life: Rural grocery webinar series
- Food Service Guidelines Implementation Toolkit
- CDC: Smart Food Choices: How to Implement Food Service Guidelines in Public Facilities
- The Food Trust: What we do in Corner Stores

    - Healthy Corner Store Initiative Overview
- America's Healthy Food Financing Initiative, Reinvestment Fund
- Regional Sustainable Development Partnerships Rural Grocery Store
- Tracking Healthy Food Sales
- Nutritional Environment Measures Survey (NEMS) Tools

Food Rx

Description

Food Rx (also known as Produce Rx or Veggie Rx) is a Food is Medicine intervention that links health care providers and food system partners to address food insecurity and chronic disease. It allows providers to "prescribe" nutritious foods, often fruits and vegetables, that can be redeemed at food shelves, farmers markets, or grocery stores. SHIP supports these community-clinic partnerships to improve health outcomes and food access.

SHIP Food Rx activities are intended to be a partnership between a healthcare setting (e.g., primary care clinic, hospital) and the food system (e.g., farmers market, food shelf). This combination of partners is unique since these two systems don't typically talk to each other.

The hallmark of a Food Rx project is that patients are screened for food insecurity and other possible chronic disease risk factors, such as high blood pressure or diabetes risk factors. Based on their screening, they receive a food "prescription" that can be redeemed at a community or clinic location. Food Rx programs, and the screening questions used, are focused on food insecurity and/or chronic disease risk factors or symptoms, depending on the population.

Food Rx is a relatively new concept for healthcare and food systems, and for this reason the research and best practices around program develop are still evolving and emerging. The specifics of your program will depend on the availability of resources within your community and priorities of your partners. It's best to design a program that capitalizes on local assets (such as an established food hub, farmers market, or grocery store) and builds on momentum behind existing health needs assessments and shared priorities.

Consider identifying two champions for this work: someone from healthcare and someone from the food system. Having two equally vested partners can lead to confusion about "who is in charge" so be sure to clarify, and reclarify, roles as the partnerships develop.

Early on, be sure to consider the logistics how participants will redeem their Food Rx. Some options include a CSA-style produce box that is picked up at the clinic location or delivered to the participants home. Other programs use a voucher that can be redeemed at a grocery store or farmers market. As mentioned above, local assets and existing momentum will be important considerations as you develop the system for how to "fill" the Food Rx.

Health Equity Considerations

Focus on patients and communities disproportionately affected by chronic disease and food insecurity. Ensure materials and processes are linguistically and culturally appropriate. Work

with trusted partners in both the clinical and food access settings to reduce stigma and promote accessibility.

As you develop your PSE strategies, keep health equity in mind. Each PSE change should be developed in consideration of the priority population(s) identified during your assessment phase.

Some examples of PSE changes for this strategy include:

- Clinic staff and partners have defined roles, documented duties, have received training, and the workflow is documented
- Clinic has developed or updated standardized screening protocol to determine program eligibility
- Food systems partner has developed a system and relevant policies to accept Food Rx vouchers/payments/implement the exchange of food as issued by the clinic partner
- Food Rx participants are actively redeeming their food prescriptions
- Develop a system for redemption data to be shared between the food system partner and the clinic.
- Clinic collects patient perspective on health behavior change and/or program satisfaction

Additional Resources

- Produce Prescription (PPR) Project Readiness Checklist
- Getting Started | Nutrition Incentive Hub
- Rooting Food as Medicine in Healthcare Toolkit_May 2019
- Food Is Medicine | odphp.health.gov

Food Shelves

Description

In previous SHIP cycles, food shelf work occurred within the activity of Food and Nutrition Security or SuperShelf. The SHIP 6 Planning process helped identify how to better organize the work and revealed that food shelf work needed to be called out as an independent strategy. SHIP's goal for working with food shelves is to increase access, availability, and selection of healthier and culturally relevant food, prioritizing a client-choice based model as a means to increase access to fruits and vegetables and reduce access to sodium, added sugar, and saturated fat.

Food shelves are a key food access point for individuals and families that are food insecure. The 2024 Food Shelf Visits Report indicated that Minnesotans made nearly 9 million visits to food shelves in 2024 compared to over 3.5 million visits to food shelves in 2020. Additionally, the 2022 Minnesota Food Shelf Survey found that one of the most important experiences of food shelf shoppers is to be able to choose their own food but only 64% of shoppers reported that they were always able to select their own food. This survey also found that fresh fruits and

vegetables were one of the most important foods that shoppers want at each visit, however only 51% of responders indicated that this was always an option.

Supporting healthy food initiatives in food shelves is a promising practice to increase fruit and vegetable consumption and increase food security. The SuperShelf model is a best practice for working with food shelves since it is a comprehensive PSE approach that transforms food shelves to create a welcoming environment in which to access healthy foods using a values-based approach. The SuperShelf approach is rooted in evidence-based practices and relies on collaborative partnerships between food shelves, University of Minnesota Extension SNAP-Ed, and hunger relief organizations. LPH SHIP can work in partnership with the SuperShelf Team at the University of Minnesota Extension to provide support and technical assistance to food shelves throughout the SuperShelf transformation process.

It is important to meet community partners where they are at. Some food shelves may not feel ready for a SuperShelf transformation. This work is most commonly supported by community-based and faith-based organizations that provide a range of services to their communities around Minnesota. While some food shelves have paid staff, almost all rely heavily on volunteers. There are growing numbers of institutions such as schools, hospitals, and colleges that are delivering some type of hunger relief. SHIP support of food shelf work can take various forms including food and donation guidelines, increasing access, availability, and selection of healthier and culturally relevant food, prioritizing a client-choice based model, policies or agreements that support the gleaning, transport, light processing, or storage of healthier food choices. LPH SHIP's role can vary depending on the needs of the food shelf and the partners involved and the level of involvement will likely change over time depending on the phase of the project. As always, a primary goal of SHIP's involvement and support is to develop leadership within the community to sustain the work.

As you develop your PSE strategies, keep health equity in mind. Each PSE change should be developed in consideration of the priority population(s) identified during your assessment phase. These are some of the most common PSE changes that LPH SHIP accomplish in this strategy. Some examples of PSE changes for this strategy include:

Policy: Establish or update organizational policy related to supporting a client choice shopping model.

System: Establish/support a system for a client choice model.

Environment: Physical changes to support or expand the client choice shopping model.

Additional Resources

- Additional resources can be found on the Basecamp Folder: Food Shelves
- SuperShelf; SuperShelf is a food shelf best practice and is supported in partnership with the UMN Extension SuperShelf team. Connecting with the local SNAP-ed SuperShelf Consultant in your area can help you approach the food shelf with the best knowledge and resources of what is involved for a SuperShelf transformation. To begin the process, please submit a SuperShelf Transformation Interest Form.
- Foundation for Essential Needs (FFEN)

  - FFEN offers a multi-level approach for food shelf leaders to engage in ways that work best for their needs. From one-on-one tailored support to professional development to broader systems work, FFEN services focus on improving the experience for the food shelf shopper by offering more predictable, fresh food through welcoming and dignified experiences. Visit their Services Page for more information on no-cost consultations and additional resources.
  - FFEN provides a Food Sourcing Analysis (FSA) as part of their no-cost consulting for food shelves. This is an important step toward improving overall food shelf operations. Consider discussing this with your food shelf partners as you start to build your relationship and identify goals. Find out more and request an FSA on FFEN's webpage.
- Hunger Solutions of Minnesota; Supporting Minnesota's food shelves and connect them with resources to serve their clients.
- Food and Nutrition: Programs and Services; Department of Children, Youth, and Families (DCYF)

Food Systems Planning and Policy

Description

This strategy supports the creation or revision of local government policies, plans, and systems that improve community food environments. By influencing zoning, land use, procurement, and long-term planning, SHIP helps communities embed food access into decision-making structures that shape daily life. The goal is to institutionalize food systems thinking through community-driven public policy.

There is a growing body of evidence that local public policies can positively impact the food system and food security on a range of issues such as rural and urban food production, farmland protection, infrastructure for food aggregation and distribution, local food purchasing and procurement, healthy food access, food policy councils, food policy coordination, and much more.

Health Equity Considerations

Ensure those most affected by food insecurity are meaningfully involved in the planning and policy process. Address historical exclusion from decision-making tables and actively partner with cultural organizations, BIPOC-led groups, and grassroots coalitions to co-create solutions.

As you develop your PSE strategies, keep health equity in mind. Each PSE change should be developed in consideration of the priority population(s) identified during your assessment phase. These are some of the most common PSE changes that LPH SHIP accomplish in this strategy. Some examples of PSE changes for this strategy include:

Policy: Create a policy change at the local government level that removes land use and zoning barriers to support food access and food systems.

Systems:

- Establish a system for convening key stakeholders to work on policy and planning priorities.

- Establish a system for communicate policy changes and planning activities to key partners and those most affected by the policy and planning activities.
- There may be other PSE changes that support this work in your community.

Additional Resources

- Additional resources can be found in the Basecamp Folder: Food Systems Planning & Policy
- American Planning Association: Growing Food Connections: Growing Food Connections (GFC) is an effort to build local government capacity to enhance food security for all. GFC had three main tasks: assess communities to understand how they improved their local food systems, provide technical assistance to Communities of Opportunity, and develop applied planning tools.
- Growing Food Connections: Community Food Systems and Economic Development
- Growing Food Connections: Community Food Production; The Role of Local Government in Increasing Community Food Production for Local Markets
- Local Government Food Policy Database: a searchable collection of local public policies that explicitly support community food systems.
- The Healthy Food Policy Project This resource includes a policy database, food systems framework, case studies, and more.

Hydration Access

Description

This strategy increases community access to safe, appealing, and free drinking water. By making water readily available in public settings, Hydration Access helps improve dietary behaviors, reduce sugary drink consumption, and support cognitive and physical health. SHIP supports this work through PSE changes that encourage water as the default beverage.

The strategy of Hydration Access is proven effective to increase water consumption, which improves health outcomes, dietary choices, and cognitive function. This strategy covers a range of policy, systems and environmental changes that support access to hydration and healthy beverages. This could be anything from an organizational policy change for beverages available, installing a hydration station to make clean drinking water available at a community location or changing city or county policy regarding beverages.

Health Equity Considerations

Focus on ensuring hydration infrastructure reaches communities disproportionately burdened by sugary beverage marketing and limited water access. Prioritize accessible locations (e.g., parks, libraries, shelters) and consider cultural, language, and physical accessibility barriers. Engage the community in site selection and education campaigns.

As you develop your PSE strategies, keep health equity in mind. Each PSE change should be developed in consideration of the priority population(s) identified during your assessment

phase. These are some of the most common PSE changes that LPH SHIP accomplish in this strategy. Some examples of PSE changes for this strategy include:

Policy: Develop/update policies related to beverages (at the organizational, city or county level).

System: Establish a policy or agreement related to maintaining hydration access infrastructure (e.g. Park board will winterize outdoor hydration station).

Environment: Install hydration station/drinking fountain that is accessible by the community.

There may be other PSE changes that support this work in your community.

Additional Resources

- CDC landing page About Water and Healthier Drinks
- National CACFP Association Water First: A Toolkit for Promoting Water in Community Settings (toolkit is linked at the bottom of this landing page)
- National Drinking Water Alliance Healthy Hydration report
- National Drinking Water Alliance Fact Sheets
- Healthy Eating Research AQWA: Assessing Quality of Water Access Photo-Evidence Toolkit
- Change Lab Solutions Sugary Drink Strategy Playbook (doesn't explicitly mention drinking water access but it's implied as part of the SSB reduction strategies)
- Change Lab Solutions Approaches to Reduce Sugary Drink Consumption (the infographic that you can download mentions drinking water access as part of a larger SSB strategy)

Local Food Procurement

Description

This strategy supports the purchase of locally grown food by community partners such as schools, child care, hospitals, correctional facilities, and food shelves. It complements other strategies by building sustainable links between local producers and institutions that serve priority populations. SHIP's role is to help facilitate partnerships, align procurement policies, and support systems that make local purchasing feasible.

Health Equity Considerations

Prioritize institutions and populations that experience limited access to fresh, nutritious food. Consider culturally relevant procurement practices and ensure that local sourcing reflects the diversity of the community. Engage local producers from underserved communities and address barriers like distribution logistics and pricing.

Local Food Procurement is a strategy intended to compliment other strategies, including in other settings, that are promising or proven effective, such as Farm to School, Food Rx, or healthy food initiatives at food shelves. When selecting the strategy of Local Food Procurement, you will be required to select a corresponding strategy that this supports. This additional strategy could be in the Food Access in Community Settings, such as a Food Shelf, or it could be

in another setting such as Schools. For example, the corresponding strategy in School settings would be the Comprehensive Framework for School Nutrition Environment and Services.

In previous SHIP cycles, Local Food Procurement occurred within the Farm to School, ECE, and/or Institution activity. The SHIP 6 Planning process identified how this work is unique within the community setting and identified an opportunity to broaden the settings and strategies that could integrate Local Food Procurement. There are a wide variety of settings, organizations, and programs who reach priority populations that present an opportunity to incorporate purchasing local foods. Consider partners such as hospitals, assisted-living facilities, correctional facilities, colleges, cafeterias, or government facilities. Similar to Farm to School and ECE, these activities give local producers the opportunity to develop new markets and sell to local institutions, organizations, and community partners.

Local Food Procurement often involves many partners and LPH SHIP's role can vary depending on the needs and capacity of the partners involved. Activities under this strategy could include establishing a system to connect local producers with community partners who want to incorporate local food procurement or establishing a policy within an institution to purchase a certain percentage from local producers. The level of involvement with the project will likely evolve over time as partnerships are established and skills and knowledge grow. For instance, staff may be highly involved at the beginning of a SHIP strategy that wants to incorporate local food procurement as you establish relationships, gauge readiness and capacity, and convene the necessary partners. Once these activities are established, you may serve in an advisory capacity, providing technical support as needed.

As you develop your PSE strategies, keep health equity in mind. Each PSE change should be developed in consideration of the priority population(s) identified during your assessment phase. These are some of the most common PSE changes that LPH SHIP accomplish in this strategy. Some examples of PSE changes for this strategy include:

Policy:

- Create or update a policy around local food procurement in any SHIP setting.
- Establish a system to connect local producers with organizations to support local food procurement.

System: Establish or expand a system to facilitate local food procurement within the SHIP settings.

Environment: Support a communications campaign to promote the policy and systems changes for local food procurement.

Additional Resources

- Minnesota Farm to School
- Minnesota Farm to Early Care
- Minnesota Farm to Kids Strategic Plan
- Minnesota Department of Agriculture: Farm to School and Early Care Programs
- Minnesota Department of Education: Farm to School and Early Care

- Procurement
- Minnesota Grown: Wholesale Directory
- Minnesota Institute for Sustainable Agriculture (MISA): Food from Farms: Toolkit for Direct Purchasing of Local Food
- Renewing the Countryside: Minnesota Farmers Market Food Hubs
- Growing Food Connections Planning and Policy Briefs
- Local, Healthy Food Procurement Policies: Local governments can augment demand for locally produced, healthy food, and improve the availability of healthy foods through the adoption of innovative food procurement policies.
- Incentivizing the Sale of Healthy and Local Food: Policies, programs, and projects developed by local governments can help overcome economic barriers to the consumption of healthy, local food by incentivizing the sale of healthy and local food for all residents.
- Food Aggregation, Processing, and Distribution: Food hubs play an important role in connecting farmers to larger, more diverse markets, and local governments can support the development of such comprehensive food system infrastructure.
- Additional information can be found in the Basecamp Folder: Local Food Procurement

Healthcare Setting (aka Community-Clinical Linkages)

Purpose

Facilitating connection between two population health management models: public health and clinical care. The theory of change states that health outcomes improve when clinical services and linked with community-based services, through partnerships developed and maintained by local public health. This work can be summarized by the term: Community-Clinical Linkages (CCLs).

Health equity and community engagement

The *Healthy People 2030* initiative defines health equity as the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities. Disparities can prevent people from receiving or even seeking healthcare services. This can come from uncomfortable past experiences of patients in clinical settings, or something as simple as providers not taking time to understand patients' perspectives on their own health. The ability to address equity and reduce disparities is not any one organization's responsibility, but everyone's. Every SHIP strategy is defined by specific, equity-focused activities. The cumulation of multi-setting strategy initiatives in this Implementation Guide represents a community-wide and community-specific PSE response to health disparities that impact quality of life.

Health equity examples that are unique to this setting include:

- Training clinic staff and providers on cultural competency and implicit bias to change systems and policies on how they engage and share health information with patients.
- Developing population-specific interventions that address not only quality of care, but environmental drivers of health as well (SDoH).
- Expanding screening of patients that identify and address the needs of the whole person, not just their disease or diagnosis.
- Improving access to and enrollment in programs that support vulnerable populations (i.e. Supplemental Nutrition Assistance Programs).

Action Steps for Equity-Focused CCLs

- Make sure the CCL includes community members most affected by health inequities.
- Verify that community members and partners have a shared understanding of key health equity terms and concepts.
- Build systematic and formal processes that encourage partners in both sectors to learn how changes in community and health care landscapes may affect people.
- Check that the CCL builds on the strengths of the priority populations and SDoH-related assets of the organizations in both sectors.
- Set up structures that balance perceptions of power among community members most affected by health inequities and partners from distinct sectors.

Getting started

All SHIP work should start with a landscape analysis and equity assessment. Learn about, reach out to, and engage with populations that are experiencing health inequities where they live. Where do people seek care? Where do they go or who do they talk with to get health-related information? In addition, reach out to the organizations that are tasked with serving these populations. Groups that may be experiencing health inequities can include, but are not limited to low income, uninsured or underinsured, older adults, racial or ethnic minorities, etc. Resources to help you assess and identify opportunities include:

- SHIP Locally Led Evaluation (LLEs) and Health Equity Data Analysis (HEDA) projects
- Local Public Health Strategic Plan, Community Health Improvement Plan, and Quality Improvement (Performance Management) Plans
- Hospital Community Health Needs Assessment (CHNA) and their Patient/Family Advisory Councils (PFACs)
- Ensure you always solicit feedback from community partners to make sure proposed solutions meet a defined need, and most importantly, do not cause harm. Community driven solutions play a large role in sustainability of projects as health and well-being can look different depending on the population served. It's important to understand that health and well-being is not a universal standard and can mean different things to different people.
- In addition to assessing needs around health equity, developing strong partnerships to move work forward is essential to creating sustainable PSE change. Think beyond traditional

healthcare partners to address needs for those at greatest risk for health disparities. Keep in mind, the best partners might be those whom you haven't yet met.

Foundational practices

Community-clinical linkages represent a formal connection between community, public health, and clinical sectors. By themselves, these individual sectors do not possess all the necessary skills or capacity to address complex community-wide challenges. However, when these 3 sectors align efforts, they can improve care and support patients better than an uncoordinated approach. Ultimately, they should depend on each other to be successful in their missions.

Each sector's population health model is based in evidence, but that doesn't imply they're the same or similar in services. In fact, they may operate quite differently, and each has its own culture and perspective on what works. Even within one sector, there will be differences in perspectives between administration roles whose focus is financial obligations, and provider roles who prioritize clinical quality.

Community-Clinical Linkage Sectors

Relationship Building is a Core Element of Successful PSE Change

All SHIP work is based on relationships and the quality of the outcome correlates to the quality of the partnership. As with other settings, building relationships is slow and sometimes arduous. It's important to spend the necessary time establishing trust before jumping into change-related roles and responsibilities.

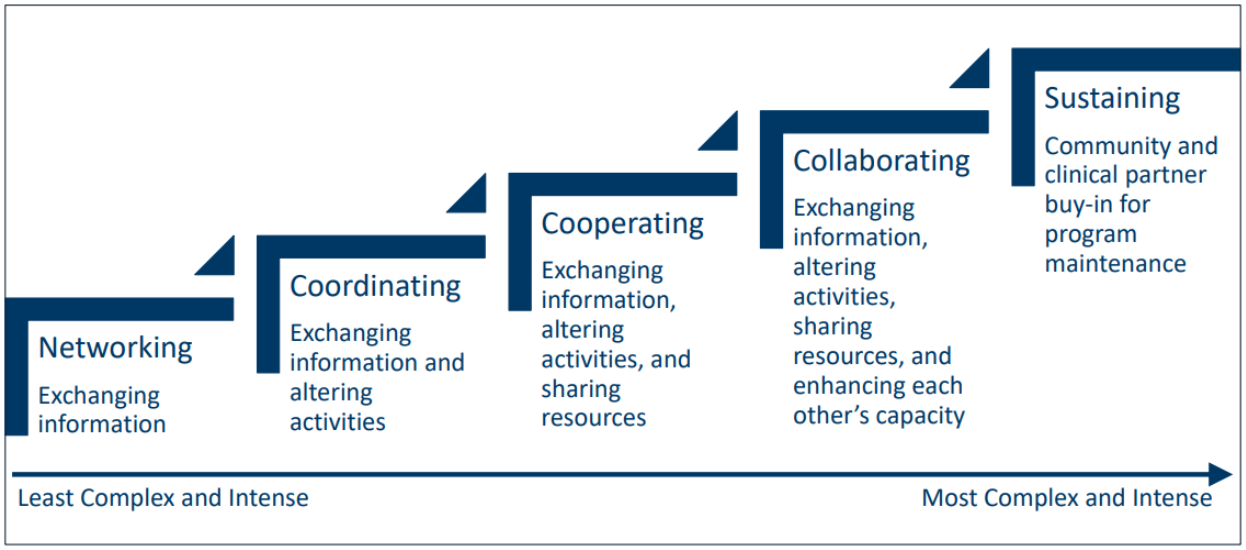
If you want to go fast, go alone. If you want to go far, go together.

-Proverb of unknown origin

If partnerships advance along a continuum of maturity, the initial stage after introduction would be networking – or simply sharing information. As you advance toward a sustainable partnership, each subsequent stage will introduce a new opportunity to add contributions and

receive benefits for all involved parties. The kinds of projects you may pursue with different partners will likely start, stop, or otherwise evolve over time. But what will remain constant is the commitment to coordination of work. SHIP is project-oriented, which means that projects, made up of strategies, will have start and end dates. Partnerships and PSE changes should remain constant. The final stage of the CCL continuum implies sustaining coordination. From a project perspective, this stage represents a changeover from something started and funded by SHIP, to be transitioned into something that's not project-limited. Since SHIP projects aren't funded indefinitely, they're all intended to transition out of SHIP, at a mutually agreed upon future date. And thus, the end of one project makes room for the start of another.

Community-Clinical Linkage Continuum



SHIP's Role in Developing and Facilitating CCLs

Since local public health plays an important role in bridging community and clinical resources toward a common goal of healthier communities, what are some of the assets that your agency brings to a clinical practice? Consider how you would approach a partnership opportunity so you're perceived as a contributor rather than a burden (i.e., someone who can help with the work, not just someone whose request adds to my workload).

- Why would a clinic want to collaborate with you?
- What are the health priorities according to your community health assessment?
- What resources can you bring to bear?
- What do you want out of the relationship / what does success look like?

The following are guiding questions used for an in-person conversation with a clinic champion, usually someone in a leadership position like an executive director or medical officer, clinic manager or nurse supervisor. These are not meant as a script, but should provide a framework for learning about clinic priorities, efforts already underway, and where your agency would fit in.

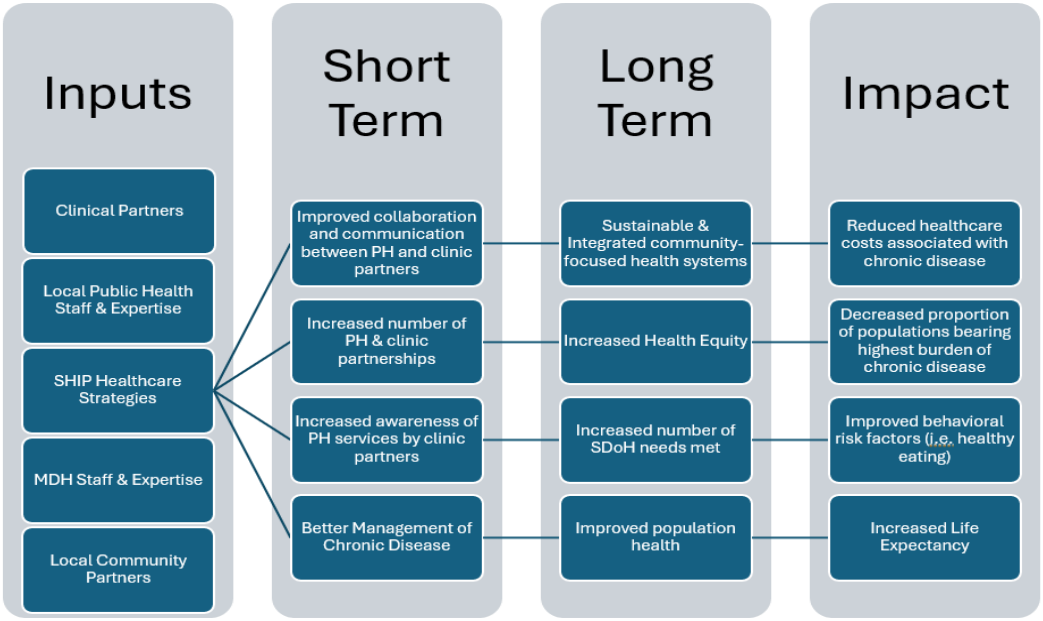
- Are there specific clinic priorities you have identified that fit with SHIP?

- How was this identified as a priority? What kind of data is collected to monitor this?
- Are there champions; who are they? (What roles do they have in the clinic?)
- Who within the clinic is responsible for conducting quality improvement activities?
- Tell us about any community resources or agencies you see as your partners?
- How do you see LPH contributing to clinic priorities?

CCL Logic Model and Theory of Change

Similar to the SHIP 6 Theory of Change outlined earlier in this Implementation Guide, where health care is identified as a setting, the specific strategies selected for this setting also follow a logic model. Before getting into the details of individual strategies, take a moment to review the expected goals and impact of this work, collectively. Strategies vary by topic but consider them as different roads to the same destination.

Community-Clinical Linkage Logic Model



Despite the variety of strategies outlined below, they're all designed for LPH to implement using a combination of Community-Clinical Linkages and Implementation Science Frameworks.

Snapshot of Healthcare Strategies

Strategy	Evidence Rating	Focus Area	HP 2030 SDoH Domain(s)
Organizational Health Literacy	Proven Effective	All	Health Care Access & Quality; Social & Community Context
Breastfeeding-Friendly Birth Center	Proven Effective	Healthy Eating	Health Care Access & Quality; Neighborhood & Built Environment; Economic Stability;

Strategy	Evidence Rating	Focus Area	HP 2030 SDoH Domain(s)
			Social & Community Context
Health Care Homes	Proven Effective	All	Health Care Access & Quality
Age-Friendly Public Health Systems	Promising Practice	Mental Well Being	Health Care Access & Quality; Social & Community Context
Community-Clinical Linkages for Mental Health	Promising Practice	Mental Well Being	Health Care Access & Quality; Social & Community Context
Community-Clinical Linkages for Social Determinants of Health	Proven Effective	All	Health Care Access & Quality; Social & Community Context
Supporting Students with Chronic Conditions	Proven Effective	All	Health Care Access & Quality; Social & Community Context; Education Access & Quality
Baby Café	Proven Effective	Healthy Eating	Health Care Access & Quality; Neighborhood & Built Environment; Social & Community Context
Food Rx	Proven Effective	Healthy Eating	Health Care Access & Quality; Social & Community Context
Park Rx / Exercise is Medicine	Promising Practice	Physical Activity	Health Care Access & Quality; Neighborhood & Built Environment; Social & Community Context
Patient Self-Management with Clinical Support	Proven Effective	All	Health Care Access & Quality; Social & Community Context
WIC Referrals	Proven Effective	Healthy Eating	Health Care Access & Quality
Behavioral Health Settings – Commercial Tobacco	Proven Effective	Commercial Tobacco	Health Care Access & Quality; Neighborhood & Built Environment
Quit Partner Referral	Proven Effective	Commercial Tobacco	Health Care Access & Quality

Think of SHIP as a bridge between efficacy and effectiveness. The better the SHIP strategy, the smaller the gap between the two. Strategy Guides and the data points collected through SHIP Information System will allow us to continuously evaluate effectiveness of implementation through an ongoing feedback cycle between fidelity (accurately defining the strategy) and impact (looking at the perceived result of the strategy). As you review the individual strategy guides, they should more clearly articulate the progression of activities as well as the measurable indicators we'll be asking you all to report on.

Below you'll find brief descriptions of Healthcare Strategy purpose, goals, and resources. Each resource section also includes a link to the corresponding strategy guide located in Basecamp.

Healthcare Setting (aka Community-Clinical Linkages) Strategies

Organizational Health Literacy

Health literate organizations allow individuals to find, understand and use health information for themselves and others. The specific activities for this type of work start with an organizational assessment of current practices around communicating information to patients. Organizations can then take what they learn from the assessment and create an action plan to move work forward around creating an organization that better serves individuals through health literacy goals.

Strategy Goals

- Within the 1st year, (a) Leadership champion identified, and team is assembled, (b) Plan kick-off event and initiate assessment.
- Within 5 years, (a) Complete post-assessment, (b) All organizational staff have received training on health literacy (c) Implement or enhance health literacy practices with at least one partner site.

Strategy Resources

- Strategy Guide for Implementation (Basecamp) SHIP 6 Health Care Strategy Guides
- https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030
- Primary Care Health Literacy Assessment
- Building-Health-Literate-Organizations.pdf (dfwhcfoundation.org)
- 10 Attributes of Health Literate Health Care Organizations
- A Proposed 'Health Literate Care Model' Would Constitute A Systems Approach To Improving Patients' Engagement In Care - PMC (nih.gov)

Breastfeeding – Friendly Birth Center Recognition

The Minnesota Breastfeeding Friendly Birth Center (BFFBC) Recognition Program recognizes Birth Centers statewide that have taken steps toward implementing the Ten Steps to Successful Breastfeeding. The journey to accomplishing the Ten Steps to Successful Breastfeeding, as defined by the World Health Organization and Baby-Friendly USA, is a unique and incremental process for each Birth Center to promote and support best infant feeding practices. Work will focus on supporting birth centers around the steps to become Breastfeeding-Friendly. We will also consider creating a new clinic recognition program in the future.

Strategy Goals

- Within 1st Year, (a) Birth center and staff champion are identified, (b) Intent to apply is submitted and assessment is completed of current policies/procedures.
- Within 5 years, (a) Birth Center has received a star rating from MDH BFFBC, (b) Data collection method is identified and functioning (i.e. exclusive breastfeeding rates), (c)

Policy/recognition is shared and available to all staff who care for mothers, infants and families.

Strategy Resources

- Strategy Guide for Implementation (Basecamp) SHIP 6 Health Care Strategy Guides
- https://www.health.state.mn.us/people/breastfeeding/recognition/birthcenters.html

MN Health Care Homes/Patient-Centered Medical Home

A Health Care Home refers to a primary care clinic or clinician certified by the Minnesota Department of Health to coordinate care among the primary care team, specialists and community partners to ensure patient-centered whole person care and improve total health and well-being. This strategy is intended to promote further partnership between state and local partners through the introduction of practice improvement specialist (HCH) staff as a resource. This provides an opportunity for LPH to connect to HCH/PCMH certified clinical partners, which in turn supports improved patient outcomes.

Strategy Goals

- Within 1st Year, (a) LPH completes assessment of existing certified HCHs within an LPH/CHB region, and (b) review existing opportunities with HCH staff to expand reach of LPH into clinical environment.
- Within 5 years, patients are connected to resources that address social determinants of health through established changes in protocols (gap closure).

Strategy Resources

- Strategy Guide for Implementation (Basecamp) SHIP 6 Health Care Strategy Guides
- https://www.health.state.mn.us/facilities/hchomes/index.html
- https://www.health.state.mn.us/facilities/hchomes/collaborative/lms.html

Age-Friendly Public Health Systems

Age-Friendly Public Health Systems looks to address healthy aging across LPH by supporting departments to make healthy aging a core function in their work. This includes leading change around policy, systems and environment, connecting and convening multi-sector partnerships, implementing healthy aging strategies and coordinating with other age-friendly initiatives to advance healthy aging policies.

Strategy Goals

- Within 1st Year, Established partnership and coordination of services between LPH and Area Agencies on Aging or other Title III funded organizations.
- Within 5 Years, (a) Coalition/Task Force is created or expanded and must include i)multi-sector partners, ii) older adults, iii) as well as caregivers, and (b) Coalition members, the public, and care providers are educated on Ageism, practices that overtly or implicitly

discriminate against older adults, and (c) Other SHIP and County work becomes aligned with Age-Friendly Public Health System (i.e. core SHIP work is linked to dementia risk reduction).

Strategy Resources

- SHIP 6 Health Care Strategy Guides
- https://afphs.org/afphs-recognition-program/
- https://afphs.org/wp-content/uploads/2022/03/Action-Plan-Template-Final-1.docx
- https://afphs.org/wp-content/uploads/2022/03/6Cs-Examples-Description-Final-1.pdf
- https://www.youtube.com/playlist?list=PL7u1bLiBGRfZ-Rb6nkfsbaQPaUMte1_jC

Community-Clinical Linkages for Mental Health

Primary care and behavioral health clinics play a crucial role in addressing mental health and improving overall health outcomes. By implementing system changes that connect patients and families to local resources, these settings can foster a community-based approach to mental well-being. Integrating mental health screenings and linking individuals to evidence-based programs and community resources can significantly enhance the health and resilience of individuals and families.

Strategy Goals

- Within 1st Year, (a) Identify local and regional partners who serve and represent the priority population; (b) Map existing community assets and service gaps; (c) Conduct a strategic planning process to prioritize and set goals; (d) Create an action plan with a timeline and identify fiscal and non-fiscal resources; (e) Develop pilot programs for small-scale testing.
- Within 5 Years, (a) Enhance access to suicide prevention and mental health services; (b) Implement stigma-reduction campaigns in schools, workplaces, and healthcare settings; (c) Engage community health workers and peer support specialists; (d) Expand mental health literacy through outreach, training, and technical assistance for healthcare providers, educators, and community leaders; (e) Implement culturally responsive education/training programs.

Strategy Resources

- Strategy Guide for Implementation (Basecamp) SHIP 6 Health Care Strategy Guides
- Centers for Disease Control and Prevention (CDC). (2021, 2022). Community-Based Interventions for Mental Health.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2020, 2021, 2022). National Guidelines for Behavioral Health Integration.
- National Alliance on Mental Illness (NAMI). (2022). Stigma Reduction and Mental Health Literacy Programs.
- U.S. Department of Health & Human Services (HHS). (2022). Social Determinants of Health and Mental Health Access.

- Robert Wood Johnson Foundation (RWJF). (2020, 2021). Community Health and Mental Well-being Strategies.
- Health Resources and Services Administration (HRSA). (2021). Community-Clinical Linkages for Behavioral Health.
- National Academy of Medicine. (2021, 2022). Improving Care Coordination in Mental Health Services.
- World Health Organization (WHO). (2021, 2022). Global Mental Health Action Plan.

Community-Clinical Linkages for Social Determinants of Health

Based on Patient-Centered Medical Home best practices, this strategy focuses on creating or enhancing non-physician team-based care teams that will coordinate (between the clinic care team and community partners) patient access to non-clinical resources to ensure patient-centered whole person care and improve total health and well-being.

Strategy Goals

- Within 1st Year, (a) Assessment of existing clinical/community setting roles, registries, and standardized screening tools or standardized assessments to identify non-clinical factors affecting patient health and well-being, (b) Assessment of primary social, cultural, and linguistic needs of patient population.
- Within 5 years, (a) Provider buy-in for enhanced care delivery strategies in place to respond to social, cultural, and linguistic needs of the patient population, (b) Expanded registry data elements that facilitate management of patient needs related to social determinants of health and other whole person care factors.

Strategy Resources

- Strategy Guide for Implementation (Basecamp) SHIP 6_Health Care Strategy Guides
- https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2019/09/20190926_PCMH_Evidence_Report.pdf
- https://pmc.ncbi.nlm.nih.gov/articles/PMC8240195/
- https://www.health.state.mn.us/facilities/hchomes/yrendreport/index.html

Supporting Students with Chronic Conditions

Children and adolescents with chronic health conditions spend many hours in school and depend on trained school staff and a healthy school environment to help them manage these conditions. A good working partnership between students, school nurses, health care providers, school staff, and administrators, can help reduce absenteeism and improve academic achievement. In this strategy, public health will convene and facilitate a project between clinics and school health services to assess current guidelines and look for opportunities to improve communications between school and community-based providers who provide health services to children.

Strategy Goals

- Within 1st Year, Assess the priorities and scope of practice of community-based health care providers such as family practice, pediatrics, or mental health, to review potential communication/coordination opportunities with school health services.
- Within 3 years, (a) Establish shared guidelines and practices related to communication between health services settings (i.e., school-based and community-based), and (b) Shared evaluation approach of guidelines and practices, including qualitative measures for identified gaps to be improved by shared guidelines.

Strategy Resources

- Strategy Guide for Implementation (Basecamp) SHIP 6 Health Care Strategy Guides
- Research Brief: Addressing the Needs of Students with Chronic Health Conditions: Strategies for Schools (cdc.gov)
- School Health (aap.org) HATS Assessment
- Whole School, Whole Community, Whole Child (WSCC) | Healthy Schools | CDC

Baby Café

Baby Café is a recognized program that provides free support opportunities to parents to gain education and support around breastfeeding. Many Baby Cafés focus on the early months to address any concerns mothers are having around breastfeeding and to determine breastfeeding goals. This can look different based on the population and partners involved. These groups also increase social connections around participants to connect and learn from each other.

Strategy Goals

- Within 1st Year, Breastfeeding Coalition and other community partners (i.e., health care, WIC, early childhood organizations) are engaged in planning.
- Within 5 Years, referrals are being made to Baby Café from clinic and/or community partners and the Baby Café is actively serving mothers who breastfeed, or who are wanting breastfeeding support.

Strategy Resources

- Strategy Guide for Implementation (Basecamp) SHIP 6 Health Care Strategy Guides
- Baby Cafes in Minnesota Resource List Baby Cafe USA - Help Me Connect
- Baby Café in Chisago County, MN Baby Cafe | Chisago County, MN - Official Website
- Baby Café in Wright County, MN Breastfeeding | Wright County, MN - Official Website
- Baby Café News Report- Wright County 'Baby Cafe' Supports Moms Struggling With Breastfeeding - CBS Minnesota

Food Rx

See Food Access in the Community Settings section.

Park Rx – Exercise is Medicine

Park Rx is a park prescription program that is designed in collaboration with a health care partner and park/public land agencies or other community partner, with the overall goal of improving patient/client health and wellbeing by prescribing time outdoors. This can include screening for physical activity or other health related conditions, such as mental health, counseling them as to why spending time in nature can benefit their health and referring/connecting them to a local, regional, or state park.

Strategy Goals

- Within 1st Year, (a) Health care and park partner identified; provider champion identified, (b) Identify resources/parks for referral system; Park System champion identified.
- Within 5 years, (a) Clinic staff and partners have defined roles, have received training, and their workflow is documented, (b) Park Rx program is launched and prescriptions are being made to parks, or other public green spaces.

Strategy Resources

- SHIP 6 Health Care Strategy Guides
- https://www.exerciseismedicine.org/wp-content/uploads/2021/04/EIM-Physical-Activity-Vital-Sign.pdf
- https://www.exerciseismedicine.org/eim-in-action/health-care/health-care-providers/

Patient Self-Management with Clinical Support

Purpose: This strategy supports work around self-management programs within a health care setting or in collaboration with a community partner. This includes programs such as the Diabetes Prevention Program, Arthritis Appropriate Evidence-Based Interventions (AAEBIs), self-measured blood pressure monitoring, falls prevention, and other lifestyle change evidence-based programs.

Strategy Goals

- Within 1st Year, (a) Clinical partner identified & provider champion(s) identified, and (b) Assessment and documentation of existing clinical practices for screening, counseling, referring, and follow-up for identified high risk patients (c) Community assessment of current evidence-based programs available internally and/or externally
- Within 5 years, (a) Clinic staff and partners have defined roles, their workflow is documented and impacted staff have received training on updated workflow, (b) Patients are being referred to either internal program, or community partner offering external program

Strategy Resources

- SHIP 6 Health Care Strategy Guides

WIC Referrals

The Special Supplemental Nutrition Program for Women, Infants & Children (WIC) is a nutrition and breastfeeding program that helps eligible pregnant women, new mothers, babies and young children. WIC referrals will look at partnering with health care organizations (i.e., Obstetrics, Pediatrics, Family Practice, or others who work with pregnant women, families with children 0-5) to screen and identify WIC-eligible patients and create a process around screening and referrals to your local WIC agency- this also can include a component of follow up to close the loop on the referral.

Strategy Goals

- Within 1st Year, (a) health care partner is identified, and (b) WIC partnership is secured.
- Within 5 years, (a) Referrals (closed loop, if possible) are happening between health care partner and WIC, and (b) Screening/referrals to WIC are expanded to other areas within organization, if applicable (Obstetrics, Pediatrics, Family Practice, or others who work with pregnant women, families with children 0-5).

Strategy Resources

- SHIP 6 Health Care Strategy Guides
- How to Establish Referral and Data Sharing Processes with Healthcare Providers Healthcare Provider Toolkit: Establishing Referral and Data Sharing Processes with Healthcare Providers – WIC Research, Policy and Practice Hub
- Streamlining WIC Referral and Data Sharing Systems Streamlining WIC Referral and Data Sharing Systems | National WIC Association
- Referrals to Community Partners Toolkit Toolkit-Referrals.pdf

Behavioral Health Settings – Commercial Tobacco

This strategy intends to address commercial tobacco use in the behavioral health (mental health and substance use treatment providers) settings and includes steps to implement commercial tobacco-free grounds policies and integrate nicotine dependence treatment into existing services and processes. The approach is to connect and engage behavioral health organizations and staff who are providing services to implement policy, systems, and environmental changes to address commercial tobacco use in behavioral health. The goal of this strategy is to increase access to commercial tobacco treatment services.

Strategy Goals

- Within 1st Year, (a) Complete needs assessment, (b) Partner site and partner site champion are identified at new or existing partner site(s).

- Within 5 years, (a) Identify systems changes (e.g. workflows for identifying people who use commercial tobacco and providing commercial tobacco treatment, commercial tobacco-free grounds), (b) Partner site(s) evaluate effectiveness of systems changes made.

Implementing PSE change

Conducting a needs assessment to gather information from mental health and substance use treatment provider partners is an important step to connecting and engaging behavioral health organizations and staff in the community you are serving. Below are some examples of this work leading to PSE change.

- Conduct a needs assessment to determine behavioral health organizations and staff who are providing services in your community. Identify partner sites and partner site champions.
- Conduct an introductory one-on-one with a manager or director at the behavioral health organization and complete a readiness assessment. A Toolkit to Address Tobacco Use in Behavioral Health Settings provides a sample readiness assessment that can be used with behavioral health partners.
- Assess if the behavioral health organization has a comprehensive commercial tobacco-free grounds policy. If they have a policy, is it a written or verbal policy?
- Assess if the behavioral health organization has integrated commercial tobacco treatment protocol. Assess if they offer individual counseling, group counseling, NRT or medications.
- Connect with the American Lung Association and Lung Mind Alliance for technical assistance and free resources at www.lungmindalliance.org.
- Review existing resources on incorporating commercial tobacco dependence treatment and commercial tobacco-free grounds policies in behavioral health settings
- A Toolkit to Address Tobacco Use in Behavioral Health Settings
- How to Address Tobacco Use in Minnesota's Mental Health and Substance Use Disorder Services: Tips from the Field Manual
- Implementing Tobacco Cessation Programs in Substance Use Disorder Treatment Settings
- Integrating Tobacco Use Disorder Interventions in Addiction Treatment

Strategy Resources

- SHIP 6 Health Care Strategy Guides

Quit Partner Referral

This strategy works to increase clinical and community integration for referral to Quit Partner, including policy, systems and environmental changes. Options include embedding Quit Partner information into your organization's communications, developing new partnerships for promotion, such as outreach to providers (including eReferral implementation), pharmacies,

WIC, schools, community organizations and priority populations. The goal of this strategy is to increase access to Quit Partner services.

Strategy Goals

- Within 1st Year, (a) Complete needs assessment, (b) Partner site and partner site champion are identified at new or existing partner site(s)
- Within 5 years, (a) Quit Partner information is included in LPH official communications, (b) Quit Partner information is included in partner site communications, (c) Partner sites are referring patients to Quit Partner

Quit Partner is Minnesota's family of programs to help people who want to quit smoking, vaping, chewing or using other commercial tobacco products. Quit Partner offers a suite of free treatment programs that include phone counseling, text and email support, web-based tools, and access to nicotine replacement therapy (NRT).

Quit Partner also offers specialized programs for people living with mental illnesses or substance use disorders, American Indian communities (American Indian Quitline), pregnant and post-partum women, and teens ages 13-17 (My Life, My Quit). To learn more about Quit Partner programs, including specialized programs, view Quit Partner™ and My Life, My Quit™ Trainings.

Referring Individuals to Quit Partner

The following are two ways to connect individuals interested addressing their commercial tobacco use with Quit Partner.

- Give them Quit Partner information so they can sign themselves up through 1-800-QUIT-NOW or QuitPartnerMN.com.
- Refer to Quit Partner and Quit Partner will reach out to them.

Planning for promotion and referral

Conducting a needs assessment to gather information from community members and partners should drive what Quit Partner promotion and referral looks like within the community you are serving. Incorporating assessment throughout your work plan will help you identify messaging that resonates with community members, community-appropriate methods of promotion and referral, and new opportunities for building knowledge and trust of Quit Partner programs within the community.

Quit Partner promotion activities should be based on your needs assessment. Identify specific outreach and messaging strategies that will work best in the community you are serving. Some questions to consider when developing your plan for promotion:

- What messages resonate with the community?
- How do people want to receive information?
- What methods work well for outreach and education?

- How can you integrate Quit Partner promotional activities into your organization's existing activities?

Please note the MDH Commercial Tobacco Cessation Communications Coordinator is available to assist you.

Promotion/communication resources, such as a style guide and Quit Partner flyers, are available in the Quit Partner Promotion Resources section of Basecamp.

Use the How to Promote Quit Partner Programs Guide.pdf guide for ideas on earned media (for example, submitting an op-ed to your local newspaper) and paid media ideas. If you are interested in paid media (for example, purchasing an advertisement in your local newspaper or purchasing a billboard), please contact cessation@state.mn.us. There are creative resources you can use and the MDH Commercial Tobacco Cessation Communications Coordinator is available to work with you and encourage you to build on the existing branded materials, where appropriate.

The rest of this section lists ideas for you to consider. Different promotion/communication activities will have different goals. Some activities will increase awareness/knowledge of Quit Partner, others will increase trust, and others will motivate people to enroll. Aim to select a mix of activities to achieve each of these goals.

Embed Quit Partner information into your organization's communications

- Look through your communications resources (for example, your website and printed materials) to identify appropriate places to add information about Quit Partner programs
- For example, you may want to add Quit Partner information to your website where other community resources, health and wellness information, and services/programs are listed
- Follow us on social media and share our Quit Partner posts
- Quit Partner Facebook
- Quit Partner X
- Quit Partner YouTube
- Add information about Quit Partner to your newsletters
- Include a slide about Quit Partner in your presentations (email cessation@state.mn.us for sample slides)

Develop new partnerships and capitalize on existing partnerships to promote Quit Partner

- Ask your partners to include Quit Partner information in their communications, such as in newsletters.
- Identify appropriate staff at partner organizations, such as community health workers, health educators, or other staff who do direct service. Educate them about the harms of commercial tobacco use, how Quit Partner programs can help community members, and how to connect community members to Quit Partner through web referral, fax referral, or eReferral.

Implementing PSE change

The objective of implementing policy, systems, and environmental (PSE) changes is to build or increase knowledge, awareness, and trust of Quit Partner programs within communities. These types of PSE changes are implemented within organizations or through networks as integrated and sustainable practices that leverage where community members already go and who they already talk with for care or support. One way to establish PSE change is by establishing partnerships with community organizations or programs to integrate connections to Quit Partner. PSE changes should focus on creating and leveraging partnerships with community organizations, programs, and networks to establish and expand connections to Quit Partner.

Below are examples of this type of work.

- Use community feedback and input to determine the best approach and location for community-partnered work. Examples of potential partners may include but are not limited to community clinics, community places of worship, barber or beauty shops, community recreation centers, or other meeting/gathering spaces.
- Conducting a scan of communications offered within your organization, community partner organizations, or county-level public health agency is an important first step. Local public health programs such as WIC, child care assistance, or health care assistance services are examples of potential partners.
- Spend time meeting with internal or partner staff to discuss identified needs, provide information on Quit Partner resources, and determine capacity to support Quit Partner promotion with clients within your own organization or the partner site. A good way to improve knowledge and sustainable foundational change would be to use existing resources to provide basic education on commercial tobacco's harms and treatment.
- Work with partner organization(s) to educate staff on Quit Partner programs.
- Identify appropriate staff, such as community health workers, health educators, or other staff who provide direct service. Educate them about the harms of commercial tobacco use, how Quit Partner programs can help community members, and how to connect community members to Quit Partner.
- Embedding Quit Partner promotion within all community education and program areas of your organization, such as housing assistance, adult learning classes, or case management.
- Work with community partners to increase referrals to Quit Partner by helping partners implement a referral process within existing programs and community spaces. Staff within your organization can also refer clients or community members you work with to Quit Partner.
- The referral option is open to clinics, community-based organizations (CBO), places of worship, wellness centers and other organizations.
- While the decision to quit is personal, community partners can provide information about how commercial tobacco use affects one's health and how free Quit Partner programs can help them take steps to learn more. If they are ready to start, refer them.

- Partners can refer individuals by visiting www.QuitPartnerMN.com and clicking "Make a Referral" at the top of the page.
- It is easy to refer individuals by web or fax. Once you make a referral, Quit Partner will contact the individual within 24 hours and connect them to the program that is right for them.
- Use existing resources when educating and working with partners to build capacity, such as:
- Quit Partner: Minnesota Commercial Tobacco Cessation Services - Frequently Asked Questions for Healthcare Providers
- Quit Partner Provider Referral Presentation Summary

eReferral Guidance for Quit Partner

eReferral is the ability to refer, via an electronic health record (EHR) management system, patients to Quit Partner via a secure bi-directional connection. eReferral allows for a faster connection between Quit Partner and the referred patient. It also allows Quit Partner to send updates back to providers on the status of referred patients via the patient's chart within the EHR.

eReferral should be explored with clinics that have partnered with MDH (or local public health partners) to increase access and improve commercial tobacco dependence treatment services offered to patients to determine interest in and ability to implement eReferral to Quit Partner.

The MDH Commercial Tobacco Cessation Programs Coordinator can schedule a time to meet with your clinic's main contact/lead for referral. During the meeting, you will have the opportunity to share information about the clinic's readiness and interest in implementing eReferral to Quit Partner and ask questions about the project.

Commercial Tobacco Cessation Programs Coordinator	Heidi Larson, 651-201-3565 Heidi.Larson@state.mn.us
Commercial Tobacco Cessation Communications Coordinator	Michael Sheldon, 651-201-3663 Michael.Sheldon@state.mn.us

Strategy Resources

- SHIP 6 Health Care Strategy Guides

Potential strategy integration opportunities with other SHIP settings

- These combinations of strategies are presented as examples, not recommendations. The unique nature of your partnerships and locally defined needs should dictate the appropriate integration of SHIP settings.
- Comprehensive Mental Health Systems (Schools) + Community-Clinical Linkages for Mental Health (Healthcare) + Mental Wellbeing in the Workplace (Workplace)
- Breastfeeding Support (Workplace) + Baby Café (Healthcare)
- Food & Nutrition Security (Food Access in Community) + WIC Referrals (Healthcare)

- Comprehensive Planning, Land Use and Zoning (Active Living) + Park Rx (Healthcare)
- Smoke and Commercial Tobacco-Free Outdoor Spaces (Tobacco) + Behavioral Health Settings – Commercial Tobacco-Free (Healthcare)
- Outdoor Classrooms (Child Care) + Comprehensive School Physical Activity Program (Schools) + Supporting Students with Chronic Conditions (Healthcare)

Potential partners for strategies

Health Care Partners

- Clinics serving a high volume of uninsured and/or self-pay patients
- Clinics serving a high volume of Medicare/Medicaid patients
- Clinics serving Minnesota Health Care Program (MHCP) patients
- Outpatient primary care clinics
- Pediatric clinics
- Maternity Centers
- Physical therapy clinics
- Dental clinics
- Women's health/OB-GYN clinics
- Maternity Centers
- Public health clinics
- School-based clinics
- Visiting Nurse Association
- Hospitals
- Pharmacies
- Optometry clinics
- Ophthalmology clinics
- Chiropractic clinics
- Podiatrists
- Health care specialists
- Alternative medicine
- Behavioral Health or mental health facilities
- Long term care / skilled nursing facilities

Community Partners

- YMCA and/or YWCA
- Faith communities/groups
- Youth centers
- Senior centers
- Fitness centers
- Community Education Programs
- University of Minnesota Extension Programs
- Farmers Markets
- Food Shelves
- Area Agencies on Aging
- Community facilities that hold evidence-based programs, or other types of programs
- Community-based health or social service coalitions such as:
- Breastfeeding Coalition
- Commercial Tobacco Cessation
- Community Centers

School Settings

Definition of School Settings:

- A public school (including charter schools) or nonpublic school (including parochial schools but excluding home schools serving a single family) in which students from kindergarten through transition programs (students aged 18 - 21 who continue to need special education services) are provided instruction.
- Local Statewide Health Improvement Partnership (SHIP) staff may partner with Minnesota state statute defined school-based Community Education and with school coordinated youth before and after-school enrichment programs that are specifically connected to SHIP statute language (e.g., tobacco use or exposure, poor diet, and lack of regular physical activity). This excludes community-based youth programs such as those through parks and recreation, the YMCA, or faith-based organizations.

Purpose

The purpose of Statewide Health Improvement Partnership (SHIP) work in school settings is to reduce chronic disease by improving academic achievement and helping students do well in school. Additionally, the purpose is to increase the physical health and emotional wellbeing of students by reducing health disparities and by increasing the implementation of policies, practices, and programs that promote health.

- The Office of Statewide Health Improvement Initiatives School Health Systems Coordinator will provide leadership, guidance, training, and technical assistance to support local SHIP staff on the relevant skills and practices listed in this guide.

Health Equity and Community Engagement for this Setting

Using Data

- Reducing health disparities among students is a proven effective strategy to increase physical health and emotional wellbeing. Local Statewide Health Improvement Partnership (SHIP) staff working in School Settings can reduce health disparities by partnering with schools with populations that are known to have inequities. Data sources such as the Minnesota Student Survey and the Minnesota Report Card can provide information on indicators such as but not limited to:
- Students with chronic conditions or special health needs.
- Students with mobility or other physical challenges.
- Student demographics, such as race, ethnicity, and income status.
- When prioritization is needed, data measures should be used to make decisions on school partnerships, such as partnering with schools:
- In rural areas.
- With a higher percentage of students eligible for free or reduced meals.

- With a higher percentage of student demographic groups that report disparities.
- Overall, local SHIP staff should be skilled in identifying and using data to inform decisions to reduce health disparities. Local SHIP staff can find resources on reducing health disparities on Basecamp and receive additional support from the School Health Systems Coordinator.

Reducing Health Disparities

Local SHIP staff working in school settings can focus on specific activities that can reduce health disparities as part of policy, system, or environmental changes. For example, local SHIP staff working on the Comprehensive Framework for School Nutrition Environment and Services strategy can conduct food security activities to increase access to nutritious foods to underserved populations. Similarly, for example, if local SHIP staff are working on activities to increase physical activity during the school day, those activities should include modifications for students with mobility needs or ensure that students with special health needs such as asthma can participate. Overall, local SHIP staff should be able to analyze and apply changes in partner activities that reduce health disparities. Local SHIP staff can find resources on reducing health disparities on Basecamp, receive additional support from the School Health Systems Coordinator, and find examples in the School settings strategy section of this Implementation Guide.

Engaging Interest-Holders

Local SHIP staff working in school settings should work with partners to conduct engagement activities with diverse interest-holders, such as but not limited to school administrators, school staff, parents, youth, and community members. Although there are many definitions of engagement, for the purposes of school settings, engagement is a process to involve people, including youth, to create positive change. Engagement activities should:

- Intentionally welcome diverse interest-holders
- Make it practical to obtain feedback
- Make feedback meaningful
- Be age-appropriate
- Be interactive (especially when engaging youth)

There are numerous examples of how people can be engaged in wellness activities, from youth designing systems for active recess, to youth leading commercial tobacco policy efforts. Local SHIP staff may utilize staff time and SHIP funding to support engagement, such as but not limited to providing stipends or translating materials. Overall, local SHIP staff should be knowledgeable and skilled in how to incorporate engagement into partner activities, as well as being able to conduct engagement activities. Local SHIP staff can find resources on engagement on Basecamp and receive additional support from the School Health Systems Coordinator.

Getting Started

Relationship Building

Local Statewide Health Improvement Partnership (SHIP) staff should be able to describe, analyze, and put into practice the following principles and concepts related to relationship building and school wellness policy requirements. The National Association of State Boards of Education's, "How Schools Work and How to Work with Schools" identifies several guiding principles and concepts for working with schools. These concepts include but are not limited to:

- Education's primary goal is to educate students.
- Before approaching an education partner, consider ways to create connections and build relationships (e.g., attend school board meetings or arrange for an introduction by a mutual colleague).
- Learn as much as possible about the school district, or specific school, as well as any history with the topic of interest.
- Identify the people and processes that are involved in making changes.
- Identify how the work of local public heath can provide an added value to support student achievement.
- Similarly, the National Association of Chronic Disease Director's, "A Guide for Public Health Professionals Working with the Education Sector" provides guidance on how to work in school settings. Key takeaways include but are not limited to:
- Pitfalls to avoid, such as failing to do the background work around the "5 P's" of an education partner (e.g., priorities, politics, policies, practices, and programs) before developing plans to work with them.
- Recommendations for effective communication, such as avoiding public health language (e.g., evidence-based, primary prevention, social determinants of health) and instead using education language (e.g., standards, learning supports, graduation rates).
- Recommendations for working on health issues, such as making school priorities public health priorities.
- Be respectful of time – identify busy times during individual days and the schoolyear and keep requests specific, clear, and manageable.
- Lastly, the Minnesota Department of Education's, "School Wellness Works" toolkit describes foundational school wellness information. This information includes but is not limited to:
- The Centers for Disease Control and Prevention Healthy Schools
- The Whole School, Whole Community, Whole Child Model
- The Healthy, Hunger Free Kids Act
- School Wellness Policy Requirements

- Local SHIP staff can find these and other resources on relationship building on Basecamp and receive additional support from the School Health Systems Coordinator.

Foundational Practices

One-Year Goals for School Settings

- Increase the number of schools with a group that offers guidance on the development of health policies (this could include physical or mental health).
- Increase the number of schools that used an assessment tool to advance school health.
- Increase the percentage of schools that developed and implemented an action plan to improve health.

These goals align with measures from the School Health Profiles and can be used to evaluate SHIP activities.

Capacity Building

A one-year goal for local Statewide Health Improvement Partnership (SHIP) staff working in school settings is to increase the number of schools with a group that offers guidance on the development of health policies. This group could go by names such as a school wellness committee, health committee, nutrition committee, and so forth. In many situations, capacity building will be needed before being able to implement school settings strategies and local SHIP staff may use SHIP funding for capacity building purposes. This funding could include but is not limited to local SHIP staff time, stipends for wellness leaders or youth, or school staff time to develop job descriptions. Local SHIP staff working with school partners should be able to describe, analyze, and apply capacity building strategies, and should be involved in either starting, enhancing, or participating on the school group that offers guidance on health. The aforementioned “School Wellness Works” toolkit and the Alliance for a Healthier Generation’s, “School Wellness Committee Toolkit” provide best practices for building school capacity. These best practices include but are not limited to:

- Securing administrative support.
- Identifying a wellness champion(s) and contact person.
- Developing a leadership structure.
- Developing a vision and mission.
- Meeting regularly (at least quarterly).
- Local SHIP staff should ensure that if school administration is not an active member of the group, that they are informed of the group’s activities. Local SHIP staff can support reducing health disparities as part of capacity building by reviewing group membership to ensure participation by diverse and broad representation. Local SHIP staff can find these and other resources on capacity building on Basecamp and receive additional support from the School Health Systems Coordinator.

Assessment

A one-year goal for local SHIP staff working in school settings is to increase the number of schools that used an assessment tool to advance school health. Assessment activities are typically conducted after building capacity or if there is an established group that offers guidance on the development of health policies. Local SHIP staff may use SHIP funding for assessment activities. This funding could include but is not limited to SHIP staff time, stipends for wellness leaders or youth, or other aspects to support the participation of diverse interest-holders. Local SHIP staff working with school partners should be able to describe and analyze different assessment tools and should be skilled in conducting those assessments. There are a variety of assessment tools available, some of which are described in the Minnesota Department of Education's, "School Wellness Works" toolkit. The following assessments are recommended for school settings strategies.

Centers for Disease Control and Prevention, School Health Index

The School Health Index (SHI) is the standard for school health assessments. The SHI is a self-evaluation and planning tool that can assess the school health environment. The tool contains 11 modules that encompass the Whole School, Whole Community, Whole Child model. If conducting the SHI, local SHIP staff and their partners may choose to focus on Module 1: School Health and Safety Policies and Environment, Module 3: Physical Education and Physical Activity Programs, and Module 4: Nutrition Environment and Services. These modules are the most relevant for SHIP, but local SHIP staff may conduct the full assessment with their partners. The Centers for Disease Control and Prevention has additional resources to support the implementation of the SHI, including an online portal, a guidance document, an e-learning course, and planning tools.

The Alliance for a Healthier Generation, Thriving Schools Integrated Assessment

The Thriving Schools Integrated Assessment (TSIA) is an assessment tool that is an acceptable substitute to the SHI. The TSIA is used to identify strengths and opportunities for improving policies and practices that promote student achievement. The tool contains 14 sections, ranging from improving nutrition and food access, to cultivating staff wellbeing. For the purposes of school settings strategies, if also using the SHI, local SHIP staff and their partners may choose to focus primarily on the questions for promoting commercial tobacco-free schools, as the commercial tobacco-free schools questions in the TSIA are more comprehensive than the SHI, but local SHIP staff may conduct the full assessment with their partners. The Alliance for a Healthier Generation (with the creation of a free profile) has additional resources to support the implementation of the assessment, including an online portal, guidance documents, and planning tools.

The National Center for School Mental Health, School Mental Health Quality Assessment and Trauma Responsive School Implementation Assessment

The School Mental Health Quality Assessment is designed for school teams to assess school mental health systems and to identify priority areas for improvement. The assessment can be conducted at either a school or district level. The assessment includes seven domains. These domains include, Teaming, Needs Assessment and Resource Mapping, Mental Health

Screening, Mental Health Promotion, Early Intervention and Treatment, Funding and Sustainability, and Impact.

The Trauma Responsive School Implementation Assessment can be used to identify trauma responsive programming and policy domains. The tool includes eight domains. These domains include Whole School Safety Planning, Whole School Prevention Programming, Whole School Trauma Programming, Classroom-Based Strategies, Prevention Trauma Programming, Targeted Trauma Programming, Staff Self-Care, and Community Context. Resources to support both assessments can be found on the School Health Assessment Performance Evaluation (SHAPE) System website (with the creation of a free profile), including an online portal, guidance documents, and implementation tools.

The University of Connecticut, WellSAT

The Wellness School Assessment Tool (WellSAT) Policy and the WellSAT Practice are tools designed to assess written district wellness policies and the implementation of specific practices. The tools were developed with the intention of supporting local education agencies in meeting the United States Department of Agriculture's triennial assessment requirements and is strongly recommend for school partners when needing to meet triennial assessment requirements. Resources to support conducting the assessment, including an online portal and step by step guidance with videos can be found on the WellSAT website (with the creation of a free profile).

- Local SHIP staff can support reducing health disparities as part of assessment by ensuring that diverse interest-holders are engaged in the assessment process. Local SHIP staff can find these and other resources on assessment on Basecamp and receive additional support from the School Health Systems Coordinator.

Note about Triennial Assessments and the Administrative Review

School districts that participate in the National School Lunch or Breakfast Program must assess their wellness policy every three years, as indicated in the Healthy, Hunger Free Kids Act. The assessment must identify compliance with the wellness policy, how the wellness policy compares to model policies, and progress made towards the goals of the wellness policy. Whereas both the United States Department of Agriculture and the Minnesota Department of Health have tools to support the completion of the triennial assessment, conducting the WellSAT is one of the best ways to ensure that the requirements of the assessment are met. The triennial assessment is one aspect that is monitored as part of the administrative review. The administrative review is not the triennial assessment, the administrative review is the process for state agencies, (the Department of Education in Minnesota), to monitor school meal programs and school wellness policies. The administrative review is conducted on a rotating basis that can be more than every three years. Local SHIP staff can find additional information on the triennial assessment on Basecamp and receive additional support from the School Health Systems Coordinator.

Action Planning

- A one-year goal for local SHIP staff working in school settings is to increase the percentage of schools that developed and implemented an action plan to improve health. An action

plan should include specific goals and objectives related to specific policy, system, or environmental changes. The action plan should also include evaluation measures and identify how the project will try to reduce health disparities. Additionally, plans should highlight sustainability and communications plans, if needed. Local SHIP staff may use SHIP funding for developing action plans, including SHIP staff time or school staff time. Local SHIP staff working with school partners should be able to analyze different action planning tools and should be skilled in developing action plans. The identified assessments and their accompanying websites typically include tools for action planning, or the Minnesota Department of Education's, "Action Plan Template School Wellness Policy", could be utilized. Local SHIP staff can find these and other resources on action planning on Basecamp and receive additional support from the School Health Systems Coordinator.

Schools Strategies

- Healthy students are better learners and people with higher levels of education are more likely to be healthier and live longer. To address the purpose of work in school settings and to increase the implementation of policies, practices, and programs that promote health, local Statewide Health Improvement Partnership (SHIP) staff may work with school partners on one or more of the following proven effective strategies (in no order):
- Comprehensive School Physical Activity Program
- Comprehensive Framework for School Nutrition Environment and Services
- Comprehensive Commercial Tobacco-Free Schools
- Comprehensive School Mental Health Systems

Five-Year Strategy Goals

- Increase the number of schools that established or implemented (one or more of the following):
  - Comprehensive School Physical Activity Program
  - Comprehensive Framework for School Nutrition Environment and Services
  - Comprehensive Commercial Tobacco-Free Schools
  - Comprehensive School Mental Health Systems
- Implement strategy activities at the three different levels of influence of the Social Ecological Model (Individual, Interpersonal, and Organizational)
- Reduce Health Disparities

These goals align with measures from the School Health Profiles and can be used to evaluate SHIP activities.

When implementing strategy activities, local SHIP staff and their partners may select one or more of the strategy activities (see below) to work on at a time. Local SHIP staff and their partners do not need to work on all the strategy activities to fully implement the strategy, (this framework is designed to provide flexibility and to meet the needs of local partners) but local SHIP staff and their partners should work to conduct activities at multiple levels of influence of

the Social Ecological Model. The Social Ecological Model states that there are multiple levels of influence on health behaviors and that these levels influence each other. The levels include individual (e.g., knowledge and skills), interpersonal (e.g. social networks), organizational (e.g., policies, systems, and environments), and community (e.g., cultural values and norms). Research on the Social Ecological Model has found that multi-level interventions are more likely to change behavior. Therefore, for example, if in year three, local SHIP staff work with a partner on an activity that addresses the individual level of the Social Ecological Model, in year four they should try to work on an activity that addresses a different level of influence of the model. Additional information on the Social Ecological Model is on Basecamp.

Before implementing strategy activities, the following reflection questions should be considered to ensure that activities are striving to reduce health disparities.

Which students will most benefit and who might be left out?

Does this strategy address specific barriers for rural, low-income, or students with disabilities (for example)?

Who has been involved in decision-making so far? Who is missing?

Are materials available in multiple languages or accessible formats?

Local SHIP staff may use SHIP funding for all the strategy activities, including but not limited to:

- Their staff time
- Assessment
- Planning
- School staff training
- Engagement activities
- Youth stipends
- Development and implementation of policy, system, or environmental changes
- Grant writing
- Developing local or statewide linkages
- Communications
- Evaluation activities
- (Note: Generally, the purchase of equipment alone is not an environmental change).

Comprehensive School Physical Activity Program (CSPAP)

- A Comprehensive School Physical Activity Program (CSPAP) is a multifaceted, proven effective strategy to create opportunities for students to be physically active and to develop the knowledge, skills, and confidence to be physically active for a lifetime. For SHIP, the overarching goal of the CSPAP strategy is to increase the physical health of students. The five-year goals are to increase the number of schools that established or implemented a CSPAP, to implement strategy activities at the three different levels of the Social Ecological Model (individual, interpersonal, and organizational), and to reduce health disparities.

- The Centers for Disease Control and Prevention's, "Comprehensive School Physical Activity Programs: A Guide for Schools", and the Minnesota Department of Education's, "Moving Matters", identify the guiding principles, concepts, and step-by-step processes for the CSPAP strategy. With support from the School Health Systems Coordinator, local Statewide Health Improvement Partnership (SHIP) staff working in school settings should be able to describe, analyze, and apply those principles, concepts, and processes.

CSPAP Strategy Activities

- When developing plans, the following are the CSPAP strategy activities (in no order). Each activity has the Social Ecological Model level in parenthesis and is followed by a short description of the activity with examples (not exhaustive) of policy, system, and environmental (PSE) changes. (Click here for a corresponding visual representation of this model that includes interrelationships between the activities.)
- **Physical Activity During the Day – Classroom (Organizational):** The implementation of policy and systems and the creation of environments that increase physical activity of students during the day in the classroom. This could include transitions between classrooms and the use of outdoor classrooms. Potential PSE changes should address policy language for classroom activity or for the use of outdoor classrooms, systems such as training and implementation of activity breaks, classroom energizers, and the integration of physical activity into curriculum, and environmental changes to encourage activity such as active seating and outdoor classrooms.
- **Physical Activity During the Day – Recess (Organizational):** The implementation of policy and systems and the creation of environments that increase physical activity of students during recess, or similar for older students. Potential PSE changes should address policy language about prohibiting withholding recess or minimum requirements for recess time (or similar for older students), systems such as the development of written practices on supervision, facilities/playground mapping, structured and unstructured games, indoor recess, and other practices that support recess (or similar for older students), and the creation of spaces for both indoor and outdoor activity.
- **Staff Involvement (Interpersonal):** The implementation of systems to encourage staff to be physically active, providing modeling of physical activity for students. Potential PSE changes should include systems such as training and implementation of activity breaks, systems to engage staff in recess (or similar for older students), and opportunities for staff to participate in before and after school physical activity programs with students (such as those connected to walking and biking). Note, this work is separate from an employee wellness program, but an employee wellness program would support this activity.
- **Community Engagement (Interpersonal):** The implementation of policy or systems to involve the community, including families, in supporting students to be physically active. Potential PSE changes should include policies for joint-use or shared-use agreements and formalized partnerships with community organizations that work on physical activity. Systems should include identifying school events and developing processes for engagement or developing systems for community members to volunteer in physical activity opportunities (such as those connected to walking and biking).

- **Physical Education (Individual and Organizational):** The implementation of policy and systems and the creation of environments during Physical Education that increase physical activity and develop the knowledge and skills of students to be physically active for a lifetime. Potential PSE changes should include policy language on requirements for physical education, minimum instruction minutes per week, and prohibiting waivers out of physical education. Systems should include implementation of standards-based curriculum to develop knowledge and skills (such as skills in walking and biking), processes to ensure students are active for most of the instructional time, and the development of assessment and evaluation processes. The creation of environments should ensure that there is adequate and age-appropriate equipment.
- **Physical Activity and Social Emotional Learning (SEL) (Individual and Interpersonal):** The implementation of policy and systems to incorporate SEL into physical activity to develop the knowledge and skills of students to be physically active for a lifetime. Potential PSE changes should include policy language that prohibits activity as a punishment and includes weight neutral language. Systems should be developed to train staff and to implement mindfulness into activity breaks, to support SEL at recess such as buddy benches and promoting positive interactions, and to ensure that before and after school physical activity providers are knowledgeable in including SEL competencies into programming.
- **Physical Activity Before and After School (Organizational):** The implementation of systems and the creation of environments that increase physical activity of students before and after school. Potential PSE changes should include systems that support biking, walking, and rolling to school, that support the implementation of clubs and intramurals, that formalize Community Education partnerships, and that integrate physical activity into homework. The creation of environments could also be developed to support physical activity.
- **Climate Action**: Climate action activities must be paired with an additional activity. For the CSPAP strategy, climate action most likely will center around how physical activity can be a mode of transportation and thus reduce emissions. Specific Safe Routes to Schools activities, such as a policy on vehicle idling, could also be included.

Additionally, local SHIP staff working in school settings on CSPAP should work with their partners to include components that reduce health disparities in any of the above activities. Examples of this include adding culturally relevant activities into physical education or before and after school physical activity, making modifications for students with mobility needs, addressing the needs of students with special health needs or chronic conditions, and increasing access to physical activity. Correspondingly, local SHIP staff may need to collaborate and develop systems with School Health Services as part of these activities.

- The CSPAP strategy can be paired with strategies in other SHIP settings to form a project to increase physical activity. These strategies include but are not limited to the Active Living in Community Settings Safe Routes to Parks strategy or the Workplace Supporting Movement Throughout the Day strategy.
- Local SHIP staff can receive additional support from the School Health Systems Coordinator and find the resources mentioned in this section, additional information on the CSPAP strategy, examples from other local SHIP staff, and guidance on the implementation of

specific activities, such as active recess, classroom activity breaks, outdoor classrooms, and Safe Routes to School, on Basecamp.

Comprehensive Framework for School Nutrition Environment and Services

- The Comprehensive Framework for School Nutrition Environment and Services (CFSNES) is a multifaceted, proven effective strategy to create opportunities for students to eat a wide variety of nutritious food, limit the consumption of less nutritious food, and to develop the knowledge, skills, and confidence to eat nutritious food for a lifetime. For SHIP, the overarching goal of the CFSNES strategy is to increase the physical health of students. The five-year goals are to increase the number of schools that established or implemented CFSNES changes, to implement strategy activities at the three different levels of the Social Ecological Model (individual, interpersonal, and organizational), and to reduce health disparities.
- The Centers for Disease Control and Prevention's, "Comprehensive Framework for Addressing the School Nutrition Environment and Services", identifies the guiding principles, concepts, and activities for the CFSNES strategy. With support from the School Health Systems Coordinator, local Statewide Health Improvement Partnership (SHIP) staff working in school settings should be able to describe, analyze, and apply those principles, concepts, and processes.

CFSNES Strategy Activities

- When developing plans, the following are the CFSNES strategy activities (in no order). Each activity has the Social Ecological Model level in parenthesis and is followed by a short description of the activity with examples (not exhaustive) of policy, system, and environmental (PSE) changes. (Click here for a corresponding visual representation of this model that includes interrelationships between the activities.)
- **Celebrations, Rewards, and Fundraisers (Interpersonal and Organizational):** The implementation of policy or systems to limit student consumption of less nutritious food or to highlight alternatives when conducting celebrations, rewards, and fundraisers. This could include venues such as school stores and concessions. Potential PSE changes should address policy language on food guidelines, smart snack standards, goals, healthy alternatives, and non-food rewards. Systems should be developed to train staff and engage families in the implementation of policy.
- **Food Security (Organizational):** The implementation of policy or systems or the creation of environments to increase student access to nutritious food outside of traditional meal programs (e.g. school breakfast or lunch). This work could include summer feeding programs. Potential PSE changes should include policy language on smart snack standards in food security programs, systems should identify processes for delivery such as take-home programs and the utilization of school-based agriculture programs, and environments such as school-based food shelves could be created.
- **Nutrition Education and Social Emotional Learning (SEL) (Individual and Organizational):** The implementation of policy and systems to provide nutrition education for students to develop the knowledge, skills, and confidence to eat nutritious food for a lifetime. Potential

PSE changes should include policy language for nutrition education requirements or goals, systems to implement farm to school and other nutrition education curriculum, and systems to include mindfulness and weight neutral practices into lessons.

- **Staff Role Modeling (Interpersonal):** The implementation of systems to encourage staff to demonstrate healthy eating, providing modeling for students. Potential PSE changes include training and implementation of healthy rewards, systems to encourage or incentivize staff to eat meals with students, and training on weight neutral language. Note, this work is separate from an employee wellness program, but an employee wellness program would support this activity.
- **Smart Snacks (Organizational):** The implementation of policy to create opportunities for students to eat nutritious food by ensuring that competitive foods and food served outside of meal programs meet standards, as determined by the United States Department of Agriculture. This could apply to vending, fundraisers, a al carte, out of school time, or other venues. PSE changes should include policy language on smart snack guidelines.
- **Food and Beverage Marketing (Organizational):** The implementation of policy and systems and the creation of environments to create opportunities for students to eat a wide variety of nutritious food and limit the consumption of less nutritious food through food and beverage marketing. Potential PSE changes should include policy language on the implementation of smarter lunchroom techniques, system changes such as techniques to focus on fruit, varying the vegetables, boosting reimbursable meals, and point-of-purchase promotions, and the creation of welcoming and positive lunchroom environments.
- **School Meals (Organizational):** The implementation of policy and systems to ensure that students eat a wide variety of nutritious food and limit the consumption of less nutritious food. Potential PSE changes include policy language on nutrition standards, goals, local procurement and other farm to school strategies, and systems should include activities to promote participation in meal programs, such as breakfast strategies and taste tests.
- **Time for Meals (Interpersonal | Organizational):** The implementation of policy and systems to ensure that students have adequate time to eat a wide variety of nutritious food. Potential PSE changes include policy language on requirements for adequate time to eat, and systems should include strategies to be more effective with time, such as additional or enhanced points of service and grab and go options.
- **Healthy Out of School Time (Individual | Organizational):** The implementation of policy and systems during out of school time to create opportunities for students to eat a wide variety of nutritious food, limit the consumption of less nutritious food, and to develop the knowledge, skills, and confidence to eat nutritious food for a lifetime. Potential PSE changes should include policy language on food guidelines or the use of smart snacks, and systems should include opportunities to learn about nutritious food.
- **Water Access and Limiting Energy Drinks (Organizational):** The implementation of policy and systems and the creation of environments to ensure that students have access to drinking water and have less access to energy drinks. Potential PSE changes include policy language on water access and caffeine restrictions for competitive food, systems should include processes for when and how students can access drinking water, systems to

promote water consumption, and hydration stations can be added to create environments to promote water consumption.

- **Healthy Eating Learning Opportunities (Individual | Organizational):** The implementation of policy and systems and the creation of environments to provide opportunities for students to eat a wide variety of nutritious food and to develop the knowledge, skills, and confidence to eat nutritious food for a lifetime. Potential PSE changes include policy language on school-based agriculture (including outdoor gardens or indoor aquaponics), systems should include taste tests and connections to nutrition education, and environmental changes should include school-based gardens.
- **Climate Action:** Climate action activities must be paired with an additional activity. For the CFSNES strategy, most likely this will be centered around school meals or healthy eating learning opportunities. Potential PSE changes include systems to reduce or address plate waste, composting, or policy language on plant-based meals.
- Additionally, local SHIP staff working in school settings on CFSNES should work with their partners to include components that reduce health disparities. Examples of this include using food that is culturally relevant in meals or healthy eating learning opportunities, addressing the needs of students with special health needs or chronic conditions such as food allergies, and increasing access to nutritious food. Correspondingly, local SHIP staff may need to collaborate and develop systems with School Health Services as part of these activities.
- The CFSNES strategy can be integrated with other SHIP settings to form a project to increase healthy eating. These strategies include but are not limited to the Food Access in the Community Food Shelves strategy, the Food Access in the Community Local Food Procurement strategy, or the Workplace Healthy Eating strategy.
- Local SHIP staff can receive additional support from the School Health Systems Coordinator and find the resources mentioned in this section, additional information on the CFSNES strategy, examples for other local SHIP staff, and guidance on the implementation of specific activities, such as celebrations, school-based food shelves, farm to school, smarter lunchrooms, and school-based gardens on Basecamp.

Comprehensive Commercial Tobacco-Free Schools

- Comprehensive Commercial Tobacco-Free Schools (CCTFS) is a multifaceted, proven effective strategy to prevent and address student commercial tobacco use and for students to develop the knowledge and skills to be commercial tobacco-free for a lifetime. For SHIP, the overarching goal of the CCTFS strategy is to increase the physical health of students. The five-year goals are to increase the number of schools that established or implemented CCTFS changes, to implement strategy activities at the three different levels of the Social Ecological Model (individual, interpersonal, and organizational), and to reduce health disparities.
- The Minnesota Department of Health's, "School Toolkit for E-Cigarette Use Prevention and Cessation", and the Alliance for a Healthier Generation's, "Tobacco-Free District Model Policy", identify the guiding principles, concepts, and activities for the CCTFS strategy. With support from the School Health Systems Coordinator, local Statewide Health Improvement

Partnership (SHIP) staff working in school settings should be able to describe, analyze, and apply those principles, concepts, and processes.

CCTFS Strategy Activities

- When developing plans, the following are the CCTFS strategy activities (in no order). Each activity has the Social Ecological Model level in parenthesis and is followed by a short description of the activity with examples (not exhaustive) of policy, system, and environmental (PSE) changes. To note, work in this area must focus on commercial tobacco-free schools; please refer to the Comprehensive School Mental Health Systems strategy for work related to broader primary prevention. (Click here for a corresponding visual representation of this model that includes interrelationships between the activities.)
- **Policy (Organizational):** The implementation of policy to prevent and address student commercial tobacco use. Potential policy changes should include model policy language such as expansive definitions, education requirements, processes for policy violations including restorative practices and cessation support, and exceptions such as traditional sacred uses.
- **Cessation (Individual | Interpersonal | Organizational):** The implementation of systems to address student commercial tobacco use. Potential system changes should include systems for staff training, screening, the implementation of cessation as an alternative to suspension, the development of clinical linkages and referral pathways, and the creation of peer to peer supports.
- **Leveraging Partnerships (Organizational):** The implementation of systems to leverage partnerships to prevent and address student commercial tobacco use. Potential PSE changes should include policy or systems to formalizing partnerships with Drug-Free Communities, healthcare organizations, and technical assistance providers to provide resources or cessation support.
- **Environmental Supports (Organizational):** The creation of environments, including physical and digital environments, that prevent student commercial tobacco use. Potential PSE changes should include the use of media campaigns, signage, and the creation of spaces to promote being commercial tobacco-free.
- **Family Engagement (Interpersonal):** The implementation of systems to involve the community, including families, in supporting students to be commercial tobacco-free. Potential PSE changes include policies and systems for volunteering, cessation support, and input on policy development.
- **Health Education and Curriculum (Individual):** The implementation of systems for health education on commercial tobacco to prevent and address student commercial tobacco use and for students to develop the knowledge and skills to be commercial tobacco-free for a lifetime. Potential PSE changes should include adding vaping education and the integration of prevention lessons into health education. This work could be supported by the implementation of the CDC Health Education Curriculum Analysis Tool (HECAT).

- **Climate Action:** Climate action activities must be paired with an additional activity. For the CCTFS strategy, most likely this will focus on vape disposal as part of the continuum of policy implementation or to support cessation efforts.
- Additionally, local SHIP staff working in school settings on CCTFS should work with their partners to include components that reduce health disparities. Examples of this include supporting students from diverse populations, ensuring the cultural appropriateness of education, and addressing the needs of students with special health needs or chronic conditions, such as asthma. Correspondingly, local SHIP staff may need to collaborate and develop systems with School Health Services as part of these activities.
- The CCTFS strategy can be integrated with other SHIP settings to form a project for the prevention and cessation of commercial tobacco use. These strategies include but are not limited to the Commercial Tobacco-Free in the Community Point of Sale strategy or the Commercial Tobacco-Free Youth Engagement strategy or the Workplace Quit Partner Referral strategy.
- Local SHIP staff can receive additional support from the School Health Systems Coordinator and find the resources mentioned in this section, additional information on the CCTFS strategy, examples from other local SHIP staff, and guidance on the implementation of specific activities, such as referral pathways, engagement activities, and policy implementation on Basecamp.

Comprehensive School Mental Health Systems

- Comprehensive School Mental Health Systems (CSMHS) is a multifaceted, proven effective strategy that promotes positive school climate and connectedness, social and emotional learning, and trauma responsiveness so that students can feel positive about themselves and develop the knowledge and skills to support positive mental health for a lifetime. For SHIP, the overarching goal of the CSMHS strategy is to increase the emotional wellbeing of students. The five-year goals are to increase the number of schools that established or implemented CSMHS changes, to implement strategy activities at the three different levels of the Social Ecological Model (individual, interpersonal, and organizational), and to reduce health disparities. For school partners, this strategy can support goals related to upstream prevention, such as but not limited to suicide prevention, safety, Positive Behavioral Interventions and Supports (PBIS), bullying, digital wellbeing, and substance use.
- The Substance Abuse and Mental Health Services Administration's, "Advancing Comprehensive School Mental Health Systems", the Collaborative for Academic, Social, and Emotional Learning's, "Guide to Schoolwide Social and Emotional Learning" and the National Center for School Mental Health quality guides, identify the guiding principles, concepts, and activities for the CSMHS strategy. With support from the School Health Systems Coordinator, local Statewide Health Improvement Partnership (SHIP) staff working in school settings should be able to describe, analyze, and apply those principles, concepts, and processes.

CSMHS Strategy Activities

- When developing plans, the following are the CSMHS strategy activities (in no order). Each activity has the Social Ecological Model level in parenthesis and is followed by a short description of the activity with examples (not exhaustive) of policy, system, and environmental (PSE) changes. (Click here for a corresponding visual representation of this model that includes interrelationships between the activities.)
- Screening and Clinical Linkages (Organizational): The implementation of systems to enhance referral pathways, both internal and external to school partners, so that students can feel positive about themselves and develop the knowledge and skills to support positive mental health for a lifetime. Potential PSE changes should include planning process on screening tools, collection processes, systems to identifying and communicate with partners, and follow-up systems.
- Trauma-Informed and Responsive (Organizational): The implementation of policy and systems and the creation of environments to support trauma responsive practices so that students can feel positive about themselves. Potential PSE changes should include policy language on restorative practices, bullying prevention, and school climate, systems should include process for safety programming, prevention programming, trauma programming, and the implementation of classroom-based strategies. Environments, such as calming corners, can also be established as part of this activity.
- Well-Trained Educators and Staff (Organizational): The implementation of systems to support well-trained educators so that students can feel positive about themselves. Potential PSE changes should include systems to strengthen adult social emotional learning, process for staff selfcare, and systems to train staff in mindfulness. Note, this work is separate from an employee wellness program, but an employee wellness program could support this activity.
- Mental Health Literacy (Individual and Organizational): The implementation of policy and systems that include mental health literacy so that students can develop the knowledge and skills to support positive mental health for a lifetime. Potential PSE changes should include policy language on health education goals and topics such as digital wellbeing, and systems should include classroom-based curriculum and peer-led modeling programs.
- Social Emotional Learning (SEL) (Individual | Organizational): The implementation of systems and the creation of environments that utilize SEL components so that students can feel positive about themselves and develop the knowledge and skills to support positive mental health for a lifetime. Potential PSE changes should include systems for building SEL foundations, planning, systems to promote SEL for students, and systems for continuous improvement. Environments can be created to support the implementation of SEL competencies.
- Connectedness (Interpersonal | Organizational): The implementation of policy and systems and the creation of environments that support student connectedness and support students in feeling positive about themselves. Potential PSE changes should include policy language to include connectedness into wellness policies, systems to support the development of affinity groups, student-led clubs, positive youth development, and the use

of classroom management strategies, and environmental changes can be made that facilitate connections.

- Additionally, local SHIP staff working in school settings on CSMHS should work with their partners to include components that reduce health disparities. Examples of this include adding culturally relevant activities into mental health literacy, addressing the needs of diverse students, and increasing access to services.
- Local SHIP staff can receive additional support from the School Health Systems Coordinator and find the resources mentioned in this section, additional information on the CSMHS strategy, examples from other local SHIP staff, and guidance on the implementation of specific activities, such as the implementation of school-wide SEL or referral pathways, on Basecamp.

Workplace

Purpose

The SHIP Workplace Wellness setting supports partnerships with local public health and the employers in their communities to implement workplace wellness initiatives to support policies, systems and environmental changes that provide access to healthy foods, breastfeeding support, movement throughout the day, mental wellbeing, and a reduction in the use of commercial tobacco.

Supporting PSE changes in these key strategy areas supports the reduction of health risks for illness and chronic disease. SHIP workplace wellness ultimately benefits the employer and the community by decreasing absenteeism, decreasing employee turnover, and increasing worker productivity and retention, and creating a community where people want to work.

Health equity and community engagement for this setting

While SHIP continues to focus efforts across the entire population to impact communities with the greatest health disparities, priority populations for the workplace include:

- Workplaces with fewer than 100 employees. Minnesota and national data show they are least likely to have established wellness initiatives.
- Workplaces with more adults over the age of 45 compared to the general Minnesota adult population. Workforce projections show a continued growth of older employees as a percentage of the workforce. These employees enter an age where preventable chronic diseases are more apparent.
- Industries that historically offer lower wages (and/or may not offer health care benefits) such as hospitality, retail, service, some manufacturing, and care-provider industries.
- Workplaces that employ a significant number of limited or non-English speaking workers and/or workers who have limited education.
- Workplaces that employ a population with a high percentage of workers who are experiencing health disparities identified through local or county-specific data.

Getting started

LPH SHIP will engage employers as partners in workplace wellness by implementing the foundational practices that build a wellness infrastructure within workplaces. With the infrastructure in place, workplaces can begin to address different strategy areas.

Relationship building/recruiting

There are two options to consider when deciding how to work with workplace partners.

The collaborative model: Recruit 3-16 worksites to commit to a process to implement wellness programs in their organizations. During the collaborative local SHIP staff provides the tools and free consultation and workplaces commit to implementing foundational steps to start their programs. Workplace representatives attend regular meetings (either virtually or in person) facilitated by LPH SHIP staff, learn from other members, work to create a healthier workplace, and contribute to building a healthier community.

The collaborative is considered best practice in working with workplace partners; however, there are circumstances when working in a collaborative may not be possible.

Working one on one with employers: While working in a collaborative is considered best practice for SHIP, if your recruitment is slow, working one on one with an employer may have its merits. If a small number of employers (1 or 2) have agreed to work with SHIP, one on one maybe preferred. Some advantages to this method include moving at their own pace and providing more consultation for each step.

Workplace wellness partnerships fall into one or more of the following categories:

Recruitment allies: Organizations to help you identify and recruit workplaces.

- Local business organizations such as: Chamber of Commerce, Society of Human Resource Managers (SHRM), Rotary Club, Lions Club, etc.
- Department of Economic Development website (https://mn.gov/deed/)
- Regional service cooperatives (https://www.mnservcoop.org)
- Area visitors center
- Community Health Boards and Community Leadership Teams
- Health insurance brokers
- **Workplace partners:** Employers interested in developing or expanding workplace wellness initiatives at their workplace(s).
- Area employers: private, non-profit and public sector, including schools, cities, counties, and health care organizations.
- **Supporting partners:** Use “expert” organizations to speak at collaborative meetings to identify support in the community:
- Minnesota Breastfeeding Coalition and regional chapters and other breastfeeding support organizations
- Departments of Health, Human Services, etc.

- Organizations working on workplace wellness or related health improvement efforts (e.g., Center for Racial and Health Equity at Blue Cross and Blue Shield of Minnesota, American Lung Association, American Heart Association, etc.)
- Other MDH programs (e.g., Eliminating Health Disparities Initiative)(https://www.health.state.mn.us/comminities/equity/ehdi/index.html), CDC or SAMSA grants,
- Commercial Tobacco-Free Communities, (https://www.health.state.mn.us/communities/tobacco/initiatives/tfc/index.html, etc.)
- Local businesses with an interest in wellness or community initiatives.

To recruit workplace partners, create a list of potential employers.

There are two methods that may be used to develop a list: using information from local organizations or brainstorming a list. Choose from the group method or selective recruitment outlined below to create a list of employers to invite to a collaborative process.

Consider working with employers who employ mostly hourly workers or those who offer traditionally low-wage jobs (some manufacturing, food service, retail, and hospitality industries). Working people with lower incomes have fewer health care options and fewer opportunities to be optimally healthy. Worksite wellness programs may offer them more resources.

Group method

Meet with the local Chamber of Commerce President, Rotary Club President, or other business organization leaders in the community to provide information on how SHIP can assist employers in creating a sustainable workplace wellness program. Ask for their support to:

- Provide their membership list (in an electronic file) so that you may reach out to members to participate in SHIP.
- Invite you to speak at an existing/upcoming membership meeting to deliver a brief announcement or a presentation about SHIP.

Selective recruitment

Brainstorm a quick list of businesses, city and county governments, school districts, hospitals, and health clinics. Engage existing network of partners (previous SHIP partners).

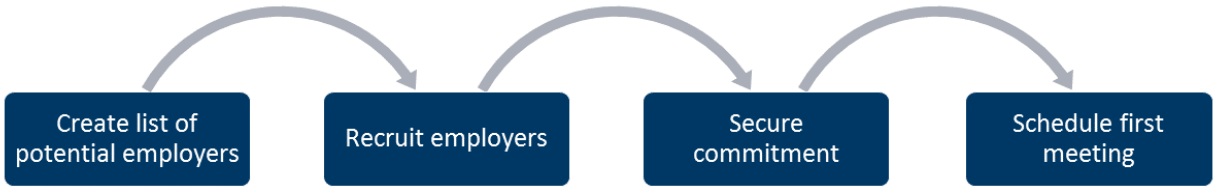
- Ideally, identify the name of a senior leader or human resources manager within the organization.
- Some LPH SHIP staff has chosen to focus on a particular employer niche, such as schools as worksites, assisted living facilities, group homes, etc. This method offers possible professional connections to leverage when recruiting and when meeting with a more cohesive group who share similar work situations.

Recruit employers

From the list of potential employers, are there some that may be more receptive to wellness, based on their community involvement activities? Are there employers that publicly take an interest in the welfare of their employees? Do you or others you know have contacts within these organizations? Start with these employers and recruit with the following steps:

- Write a letter to invite the employer/organization to participate in the SHIP workplace initiative. See recruiting in Basecamp for a sample letter and recruiting materials.
- Contact human resources staff or a senior leader via phone to schedule an in-person meeting or short phone call.
- In advance of the meeting, find out about past health and wellness initiatives, community programs and company information to help guide questions about their culture and work concerns.
- During the meeting, discuss SHIP workplace wellness initiatives, including SHIP benefits and resources available (consulting and support, networking, and helpful information). It is recommended not to lead with the financial benefits (what SHIP can tangibly give the employer).
- Discuss the organization's interest and motivation for pursuing change.
- Explain how prevention can enhance business or employee health goals, and how SHIP can provide the start to a sustainable program.
- Determine the level of interest and buy-in among organization leadership.

Figure 1: Recruiting employers



Secure commitment

- Conduct an informational/interest meeting to continue recruitment with all potential employers (this is optional but has worked well for employers to better understand the process and their commitment), or secure commitment with individual employers as they indicate interest at a face-to-face meeting or in a follow-up call.
- When the employer decides to make the commitment, ask the organization contact person to complete the registration form and invite them to the first meeting, if scheduled. This form acknowledges commitment by the leaders of the organization that they intend to participate in the SHIP workplace initiative. It gives LPH SHIP staff contact information to

create a roster of participating employers. See Basecamp for Recruiting and Onboarding information.

Prep for collaborative meetings

- Once a group of 3-12 employers has committed to participate, LPH SHIP staff will lead them through a 6–12-month process, meeting with them regularly to create a wellness program foundation. LPH SHIP staff administer the SEWA and will coach participants about the SEWA results they choose through one of several workplace strategies (healthy eating, movement throughout the day, commercial tobacco reduction, well-being, or breastfeeding support). See Figure 2
- Supporting Movement Throughout the Day
- Healthy Eating
- Breastfeeding Support
- Commercial Tobacco-Free
- Mental Wellbeing
- **Work individually as needed:** Smaller LPH SHIP may choose to support employers by meeting individually. The tools and practices are the same, but there are disadvantages: it takes more time to meet individually, employers do not learn from each other, and it duplicates effort for the LPH SHIP. However, working individually with employers is advantageous in smaller, rural areas where there may be few employers and recruiting more than three can be a challenge. The Employer Workbook is a good tool to use when working one on one with employers.
- Some LPH SHIP partners do four group meetings and then meet individually with each employer two times during the year. This allows for more support in working through employer concerns and keeps the employer contact engaged and moving forward.
- **Stages of Working with Employers:** In the first year, the collaborative can be referred to as a "learning collaborative" After the first year, employers move into a "Networking Phase" that is made up of all past collaborative attendees. The best practice for these groups is to meet or connect quarterly to continue working on PSE with additional strategy areas. Some employers prefer to continue with the next learning collaborative if they missed steps or need additional support.
- **Review all materials:** Review all PowerPoint presentations and the SHIP Workplace Employer Workbook to gain an understanding of the curriculum. See an overview of the topics for each meeting and review the PowerPoint presentations found on Basecamp.
- **Virtual collaborative meetings:** If your county or CHB encompasses a large geographic area, consider using virtual meetings as an option for some or all meetings. Virtual meetings can be as engaging and productive as in-person meetings. Use a doodle poll to determine when your group would like to meet. If possible, an initial and final in-person meeting will both kick off and wrap up a collaborative with a personal touch.

Figure 2: Meeting topics

Meeting schedule

The meeting schedule can vary according to the size of the recruiting area and employers' schedules. The recommended schedule is to meet four to six times within one year to form the group, support members in completing the foundational steps, and complete at least one activity in their chosen strategy. They schedule may adjust to the timeline you choose for the collaborative.

After the first few meetings, employers do not need to meet as often as they are on their way to completing foundational tasks and have momentum with their committee to move forward.

Longer quarterly meetings work in locations that are geographically spread out. In all meeting models, one-on-one meetings with each employer provide extra attention to ensure they have the support to complete their tasks and be successful. See the Figure 3 for a sample meeting schedule.

Create each meeting agenda: Once all PowerPoint presentations and the SHIP Workplace Employer Workbook are reviewed and there is an understanding of the curriculum, create lesson plans for each meeting. Each meeting agenda should include:

- An icebreaker
- Check in on progress (most employers' favorite part!)
- New material
- Wrap up and next steps: homework, reminder of next meeting
- Go to Basecamp for all Collaborative materials, including handouts and PowerPoint presentations for each meeting. See the meeting agenda for working individually with employers if this is the method you will use.

Figure 3: Suggested quarterly meeting format

The Final Celebration

Whether you meet with employers individually or through a collaborative, it's important to celebrate the successes of your time together. Within Basecamp materials, there is a template for a Final Celebration for each workplace to share their successes and changes with the group. This offers members a chance to show their work and learn from each other. It creates a celebratory atmosphere and most importantly, allows you to document their achievements through a PowerPoint presentation.

Encourage employers to continue to participate in SHIP. Here are some ways to continue to engage employers:

- **Conduct one-on-one exit interviews:** Ask participants how the collaborative progressed. What are their goals for the program and their workplace? What support do they need to continue? Determine how to provide support. See the Exit Interview in Basecamp
- **Stay connected:** Keep a current database of employer contacts and periodically call former participants to check on outcomes. Some SHIP LPH use newsletters to keep the group connected during the year while building a mailing list of past participants
- **Employer follow up:** Check in with employers as they complete activities.
- **New collaborative:** Encourage past employer participants to join a new collaborative to continue their work. They can opt out of the first few training sessions if their foundational work is complete. If a new staff member has taken on the wellness coordinator role, this offers an opportunity for training on the PSE approach to wellness.
- **Encourage past participants to take the workplace assessment (the SEWA) annually. N**ew results can help participants prioritize their wellness strategies or share success stories with new collaborative members.

- **Check-in:** Four to six months after the collaborative ends, meet with employer contacts to review the goals document: Check on progress, offer support and encourage them to expand goals.

Transitioning to Networking Phase

The goal of transitioning to the networking phase is to continue developing relationships with employers who have completed SHIP Workplace Wellness strategies (whether through a collaborative or working individually with employer) and support employers' efforts to continue to build their programs. Establishing networking groups builds workplace wellness sustainability and contributes to healthier communities.

How can relationships be fostered in a way that will encourage participants to continue to work on healthier communities? Participants' work capacity and the level of employers' commitment will guide the process. The information on the next page provides the next steps to help transition collaboratives and working individually with employers into a networking group.

As meetings with employers end, encourage employers to continue to participate SHIP. Here are some suggestions:

Create a schedule of meetings and topics

If there is interest for the group to continue meeting face to face or virtually, here are some suggestions:

- Include the group in the planning and ownership of meetings to encourage ownership and reduce your workload. Ask employers to host meetings, plan the agenda, or present their program success.
- Gauge member involvement and commitment to ensure successful meetings.
- Poll the group to learn about their meeting preferences. Keep meetings under two hours. And consider virtual options.
- **Offer regular (bi-monthly/quarterly) networking meetings.** Participants can make connections and will benefit from support and ideas that can advance wellness efforts.
- **Offer information on relevant SHIP topics** and networking opportunities can keep participants involved and coming to meetings. Employers appreciate helpful information and peer support that sustains wellness initiatives. Offer presentations on current wellness programs by "veteran" employers.
- **Use the Networking Group Materials.** A variety of materials tools have been developed to assist LPH SHIPs in providing fresh topics, such as Engaging Families in Workplace Wellness, Worksites as Community Partners, Hundreds of Ideas, and more are being developed.
- Offer a discussion series called "Creating a Culture of Health". This series provides information on five important aspects of organizational culture and how to positively impact it through understanding it at a deeper level. This series includes narrated PowerPoint presentations that wellness committees or leadership teams can view to look at their internal culture and make changes. A Leader's Guide offers questions and resources to help organizations start this important work.

- If employers do not have interest or ability to keep meeting, create a running mailing list of employers and send out quarterly information and topics of interest to support them in continuing building their wellness program.

Broaden Networking Meetings for Future Employer Recruitment

- **Partner with other stakeholder organizations** (e.g., Service Cooperatives, local Chambers of Commerce, Safety Councils, etc.) can increase reach and numbers. Consider offering open meetings to provide ways to recruit employers into future partnerships.
- Try working across CHBs to share the workload and to capitalize on employer locations that are more likely to attract participants who live or work in that area.
- E-Blasts: Start a collection of articles and information (e.g., engagement opportunities, resources, ideas for new activities, invitation to trainings, etc.) on workplace wellness. Two to four times a year, send an email blast that includes past participants' success stories and topics of interest to your group.

Evaluate and plan for next year

Think of ways to keep the Networking Group fresh and vibrant. Use the Networking Group as an invitation for other organizations doing wellness (but did not go through the collaborative) to join. They may be interested in joining an upcoming collaborative if they see what they gain from participating!

How Long Should I Work with an Employer Partner?

The goal of the workplace setting is to offer assistance to employers in starting a sustainable wellness program through your guidance and the SHIP Workplace tools. As an organization creates their foundational structure (i.e., leadership support, dedicated staff/wellness committee, assessment through the SEWA, and evaluation of chosen activities) and identifies a strategy and activities to complete, they are on their way to developing their wellness program. Strategy support dollars, if you have them, should be given in the first two years. Consulting can continue, and slowly they will become experts and work toward a more comprehensive program. Workplaces who have worked with SHIP and successfully implemented PSE changes can also be asked to champion SHIP to other workplaces in the community.

Foundational practices

LPH SHIP will engage employers as partners in workplace wellness by implementing the foundational practices that build a wellness infrastructure within workplaces. The foundational practices are a required part of the workplace setting and should be done prior to any strategy implementation:

Leadership Support:

- Places workplace wellness in the organization's strategic plan.
- Authorizes resources like the wellness committee and a budget and actively participates on the committee or in initiatives.
- Ensures supervisors support the wellness initiative.

- Models participation in initiatives.
- Communicates regularly to all staff.

Create a wellness committee:

- Integral in planning, promoting and sharing out any wellness initiatives to staff and leadership.
- A cross section of staff from different departments, units, shifts.
- Small organizations should have 2-4 people working together on wellness initiatives. Larger organizations should have 8-10 if possible.

Evaluation: This is an important step. Workplaces should evaluate their workplace wellness activities to track impact, satisfaction and outcomes.

Assessment

The SHIP Employer Wellness Assessment (SEWA) is an assessment workplace partners must take when they begin working with LPH SHIP. The assessment is required and allows workplaces to determine what strategies they may work on, and how they are doing in the SHIP-related strategy areas.

The workplace will complete the SEWA when they start their work with SHIP and again at the end of the collaborative or their time working one on one with LPH. The follow up SEWA allows the employer to see progress and hopefully continue their work with SHIP. Only the start-up SEWA is required. The follow up SEWA is not required but highly encouraged.

Workplace Strategies

There are five strategies for the workplace setting. Employers must implement two of the three PSE changes. They may not only implement one environmental change, policy change, or systems change. There should be two of the three. For example, a workplace should not simply add a lactation space. They must also add a systems change or a policy or both. Examples of PSE changes for each setting can be found below.

Description

Healthy Eating – Provide access to healthy foods while at work. This can include policy, systems and environmental changes providing a healthy snack station, vending options (including food and beverages), and cafeteria options (not all employers have a cafeteria) Please see the Healthy Eating Strategy Guide.

Supporting Movement Throughout the Day – Provide opportunities for employees to be active while at work. This can include implementing policy, systems, and environmental changes to implement an exercise room, provide sit/stand desks, provide walking maps. Please see the Physical Activity Strategy Guide

Breastfeeding Support – This includes policy, systems and environmental changes that support breastfeeding parents upon their return to work. This includes the STEP process of providing Support, Time, Education and Place. Please see the Breastfeeding Strategy Guide.

Commercial Tobacco-Free Workplaces – This includes commercial tobacco-free policies and quit supports when possible. Please see the CTF Strategy Guide.

Mental Wellbeing - create a healthy workplace culture to foster mental wellbeing through policies, systems changes, and environmental support. Please see the Mental Wellbeing Strategy Guide.

Examples of SHIP PSE

Healthy Eating in the Workplace

Policy: Promote healthy food and beverages in meetings, cafeterias, vending and snack stations

Systems:

- RFP/contracts for vending services
- Vending quality assurance practices
- Pricing structure that encourages health food purchases
- Catering guide
- Management of healthy snack station
- Labeling and signage

Environment:

- Healthy food and beverage choices in vending
- Create a healthy snack station
- Cafeteria improvements
- Meetings and events

Allowable expenses for this strategy

- Healthy snack station startup costs
- Labeling and signage

Creating Opportunities for Movement Throughout the Day

Policy:

- Employees can combine breaks for physical activity time
- Casual dress code to support commuting to work or being active during the day
- Walking meetings
- Work accommodations that support physical activity

System: Trainings for managers to develop flexible schedules to accommodate PA at work, walking meetings framework, active transportation

Environment:

- Physical activity space
- Walking/running maps
- Standing desks, treadmill desks
- Bike racks

Allowable Expenses for this Strategy

- Small exercise equipment for a fitness room
- Larger pieces of exercise equipment for a fitness room – LPH must consult MDH workplace staff about requirements for funding larger pieces of equipment.
- Standing desks and treadmill desks that are accessible to all employees – SHIP will not fund a standing desk for every employee. We will fund a number of standing desks that are accessible to all staff.
- Bike racks
- A bike fleet designed to help staff commute between buildings if necessary
- Bike Friendly Business recognition fee
- Light recreational equipment to be used at breaks, lunch time, and before and after work. Can include bocce ball, cornhole, ladders, horseshoes, or pickleball net, paddles and balls. Cannot include court surfaces or structures.

Breastfeeding Support

Policy: Breastfeeding support policy that includes lactation room, FMLA leave, and management role in supporting new parents.

System: Training for management staff is developed and implemented

Environment: Lactation room: Locks from inside, chair, table, breast pump, electrical outlet, clean, near water source, place to store milk.

Allowable expenses for this strategy:

- Items for a lactation space that include comfortable seating, a mini fridge, rugs for the floor (if floor is hard like tile or hardwood), a table, mirror, breast pump, electrical outlets, capping off and removing a toilet (if workplace in converting a bathroom to a lactation space).

Commercial Tobacco-Free Workplaces

Policy: Commercial tobacco-free worksite policy that includes non-smokable tobacco and vaping products.

System: Medications - pharmacy benefit fully covers over the counter (OTC) quit medications and prescription meds with no (or minimal) copay or deductible

Environment: Completely commercial tobacco-free worksite: buildings, grounds, vehicles

Note: As part of the SHIP 6 application, CHBs will be asked to complete a CTF worksite certification form and provide a copy of their commercial tobacco-free worksite policy for each county or add a commercial tobacco-free workplace project to work towards a commercial tobacco-free worksite policy for any county that does not currently have one.

Allowable expenses for this strategy:

- Tobacco free signage

How to implement this setting with and without funds to grant to local partners

The workplace work may done with or without funding. Some examples of how to do a no funds option include:

- Offer consulting/technical assistance
- Promote access to wellness tools
- Leverage non-monetary motivations (recognition, network building)

Evaluation

This is also listed as a foundational element for workplace. It is important workplaces evaluate their workplace wellness initiatives. This can help with process improvement as well as provide leadership with information on how their workplace wellness efforts are being received among the employees. Evaluation helps build the case among leadership for continued workplace wellness resources. For workplaces who continue to work with SHIP in subsequent years, evaluation will be required. The Strategy Guides linked earlier in this document describe what evaluation for each strategy may look like.

Potential project integration opportunities with other SHIP settings

SHIP workplace wellness can be integrated with any other setting that would like to create workplace wellness initiatives for their employees. The workplace setting can also be connected to the community work in active living. Some examples include:

- **Schools** – e.g. supporting staff through the school's wellness policy
- **Healthcare** – e.g. aligning with mental health initiatives or Food Rx
- **Community** – e.g. connecting bike racks at worksites with active living efforts

LPH SHIP staff may decide to run collaboratives focused on one type of employer. Holding a healthcare partner only collaborative may be one example.

Potential partners for strategies in this setting

The local chamber of Commerce, service clubs like the Rotary, local coalitions