



# OHIO DEPARTMENT OF HEALTH

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Columbus, Ohio 43215

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Ted Strickland/Governor

Alvin D. Jackson, M.D./Director of Health

**Date:** August 10, 2009  
**To:** Prospective Applicants for the 2010 Creating Healthy Communities Program  
**From:** Nan Migliozi, RN, Acting Chief, Office of Healthy Ohio  
Ohio Department of Health  
**Subject:** **Notice of Availability of Funds**

**Competitive Grant Applications for Fiscal Year 2010**  
**Creating Healthy Communities Program – 1/1/10-12/31/14**

The Ohio Department of Health (ODH), Office of Healthy Ohio, Bureau of Health Promotion and Risk Reduction, announces the availability of grant funds to support Healthy Communities Program initiatives. The Request for Proposals (RFP) will provide you guidance in completing the online application for the FY10 competitive program period. **Proposals are due Monday, October 5, 2009 for the funding period of January 1, 2010 through December 31, 2010. Late applications will not be accepted.**

### **Introduction/Background**

The Ohio Department of Health (ODH), Office of Healthy Ohio, Bureau of Health Promotion and Risk Reduction (BHPRR), announces the availability of Preventive Health and Health Services Block Grant (PHHSBG) funds to support the comprehensive population-based **Creating Healthy Communities Program (CHCP)**. This program reflects the continued commitment of the ODH to meet community needs with programming implemented at the local level. Diseases of the heart, cancer, stroke, chronic lower respiratory diseases, and diabetes mellitus accounted for 67 percent of resident deaths during 2005. Heart disease was the leading cause of death for Ohio residents in 2005, accounting for 28,995 deaths, and stroke was responsible for 6,183 deaths. Nationally, Ohio ranks 9<sup>th</sup> highest in coronary heart disease (CHD) mortality, and 19<sup>th</sup> highest in cardiovascular disease (CVD) mortality. Cancer, the second-leading cause of death for residents of Ohio, accounted for 24,825 deaths in 2005, and the estimated prevalence of diabetes among Ohio adults was 7.9 percent. Chronic lower respiratory diseases, which are causally related to cigarette smoking, were responsible for 6,170 deaths in 2005.

Premature death and disability are associated with specific modifiable risk factors of physical inactivity, obesity and poor nutrition, tobacco use and exposure, hypertension, high cholesterol, and diabetes. High-need populations bear a disproportionate burden of disability and premature mortality from chronic diseases and associated risk factors. Focusing on high-need populations is an important strategy to eliminate these disparities. Funding for the local CHCP is intended to improve the health of Ohioans, support the PHHS Block Grant initiatives at the community level,

and ultimately reduce the premature mortality from chronic diseases through expansion and implementation of comprehensive population-based programs in high-need communities.

### **Notice of Intent to Apply for Funding**

All interested parties must submit a Notice of Intent to Apply for Funding (NOIAF) form (attached to this RFP), no later than **4:00 pm AUGUST 28, 2009** to be eligible to apply for funding.

Once the Notice of Intent to Apply for Funding form is received by ODH, the Grants Administration Unit (GAU) will:

- a. Create a grant application account for your organization. This account number will allow you to submit an application via the Internet using the Grants Management Information System (GMIS). All grant applications must be submitted via the Internet using the GMIS.
- b. Assess your organization's GMIS training needs (as indicated on the completed *Notice of Intent to Apply for Funding* form) and contact you regarding those needs. Applicants must attend GMIS 2.0 training to be eligible to apply for funding. GMIS training is mandatory if your organization has never been trained on GMIS.

The RFP will provide detailed information about the background, intent and scope of the grant, policy, procedures, performance expectations, and general information about the grant. It will also provide requirements associated with submission of the grant application and administration of the grant.

Submit your NOIAF form to Ann Weidenbenner, Program Director, via U.S. mail, Email at [ann.weidenbenner@odh.ohio.gov](mailto:ann.weidenbenner@odh.ohio.gov) or fax to 614-564-2409 by **Friday, August 28, 2009**.

### **Bidders Conference**

A Mandatory Bidders Conference is scheduled for **Tuesday, August 25, 2009, from 10:00 a.m. to Noon, in Conference Room D, at the State Library of Ohio, 274 E. First Ave, Columbus, OH 43201**. Potential applicants may either attend in person or via a conference call. If you have questions or need assistance in completing this grant application, every effort should be made to participate in either the Bidders Conference or the conference call. **The toll-free conference call-in number is 800-510-7500; Participant Code: 1137871#**

**Please RSVP by Thursday, August 20, 2009** if you will be attending in person or calling in for the Bidders Conference to Ann Weidenbenner, Program Director, via U.S. mail, Email to [ann.weidenbenner@odh.ohio.gov](mailto:ann.weidenbenner@odh.ohio.gov) or fax to 614-564-2409. (No phone calls.) Also submit any RFP questions at this time. Responses to questions received will be discussed at the Bidders Conference.

### **Important Dates to Remember:**

GMIS 2.0 Training Request	As soon as possible
RSVP and Questions Submitted for Bidders Conference	Thursday, August 20, 2009
Mandatory Bidders Conference	Tuesday, August 25, 2009
Notice of Intent to Apply for Funding Due	Friday, August 28, 2009
Application Due	Monday, October 5, 2009

**NOTICE OF INTENT TO APPLY FOR FUNDING**  
**Ohio Department of Health**

**ODH Program Title: Creating Healthy Communities Program**

**ALL INFORMATION REQUESTED MUST BE COMPLETED.**  
**(Please Print Clearly or Type)**

**County of Applicant Agency** \_\_\_\_\_

**Federal Tax Identification Number** \_\_\_\_\_

NOTE: The applicant agency/organization name must be the same as that on the IRS letter. This is the legal name by which the tax identification number is assigned.

**Type of Applicant Agency**     County Agency                       City Agency  
    Not for Profit                       Other \_\_\_\_\_

**Applicant Agency/Organization** \_\_\_\_\_

**Applicant Agency Address** \_\_\_\_\_

**Agency Contact Person/Title** \_\_\_\_\_

**Telephone Number** \_\_\_\_\_

**E-mail Address** \_\_\_\_\_

**Please check all applicable:**     **Yes, our agency will need GMIS 2.0 training**  
    **No, our agency has completed GMIS 2.0 training**  
    **First time applying for an ODH grant**

**Application Category:**            \_\_\_\_\_ **Tier I - Capacity Building**  
   \_\_\_\_\_ **Tier II - Community-Based Expansion**

**Application will be submitted as:**    \_\_\_\_\_ **Single County**  
   \_\_\_\_\_ **Regional**  
**Please list partnering county (ies):** \_\_\_\_\_

**Mail, E-mail or Fax To:**            **Ann Weidenbenner, MS, RD, LD, Program Director**  
   **Ohio Department of Health**  
   **246 North High Street, Columbus, Ohio 43215**  
   **E-mail: [ann.weidenbenner@odh.ohio.gov](mailto:ann.weidenbenner@odh.ohio.gov)**  
   **Fax: 614-564-2409**  
   **Phone: 614-644-7035**

**THIS FORM MUST BE RECEIVED BY: 4:00 PM, August 28, 2009**



**ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET**

# **OHIO DEPARTMENT OF HEALTH**

**Office of Healthy Ohio**

**Bureau of Health Promotion and Risk Reduction**

**Creating Healthy Communities Program (CHCP)**

**REQUEST FOR PROPOSALS (RFP)**

**FOR**

**FISCAL YEAR 2010**

**1/1/2010 – 12/31/2010**

**Local Public Applicant Agencies**

**Non-Profit Applicants**

**COMPETITIVE GRANT APPLICATION INFORMATION**

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## **I. APPLICATION SUMMARY and GUIDANCE**

An application for an Ohio Department of Health (ODH) grant consists of a number of required parts – an electronic component submitted via the Internet Web site: ODH Application Gateway – GMIS 2.0 which includes various paper forms and attachments. All the required parts of a specific application must be completed and submitted by the application due date. **Any required part that is not submitted on time will result in the entire application not being considered for review.**

The application summary information is provided to assist your agency in identifying funding criteria:

**A. Policy and Procedure: Uniform administration of all the ODH grants is governed by the ODH Grants Administration Policies and Procedures (GAPP) Manual. This manual must be followed to ensure adherence to the rules, regulations and procedures for preparation of all subgrantee applications. The GAPP Manual is available on the ODH Web site <http://www.odh.ohio.gov>. (Click on “Funding Opportunities” [located under At a Glance]; click on “About ODH”, click on “ODH Grants” and then click on “GAPP Manual.”)**

**B. Application Name:** Creating Healthy Communities Program

**C. Purpose:** The Preventive Health and Health Services Block Grant (PHHSBG) Creating Healthy Communities Program (CHCP) reflects the commitment of the ODH to meet community needs with programming implemented at the local level. The CHCP is designed to enhance local communities’ abilities to develop and implement policy, systems, and environmental change strategies that can help prevent or manage health-risk factors for heart disease, stroke, diabetes, cancer, and obesity. Specific activities are directed toward reducing tobacco use and exposure, promoting physical activity and healthy eating, improving access to quality preventive health care services and eliminating health disparities.

The ODH, Bureau of Health Promotion and Risk Reduction (BHPRR), determined the following Guiding Principles to address chronic diseases using an integrated approach:

1. Funding decisions are data driven.
2. Interventions are evidence-based.
3. Achieving health equity is an overarching goal.
4. Develop state and local capacity/ infrastructure.
5. All resources are aligned and allocated to achieve PHHSBG goals.
6. Assessment, monitoring and evaluation are critical.
7. Stakeholder collaboration is important.
8. Integration occurs within ODH, and at the state, and local levels.

Key principles common to all CHCP initiatives are:

- **High-level community leaders are involved at every step**, utilizing their positions, influence and ability to make changes within their organization and within the greater community.
- **Multiple sectors and diverse organizations** are involved to maximize experience, assets, resources and skills.
- **The ultimate goal is to influence policy and environmental changes** to improve community environments.
- **Local initiatives are grass-roots efforts** with strategies specific to the needs of each community.

The focus of the interventions are directed towards reaching high-need populations residing in communities of varying sizes (urban, rural, suburban), hard-to-reach populations (low-income, underserved, and racial and ethnic populations), and geographically diverse populations who are at highest risk of developing chronic diseases.

- D. Qualified Applicants:** All applicants must be a local public health department and/or non-profit agency partnering with the local public health department. **All applications in each category are competitive. No applicant is guaranteed funding.**

**Applicants must demonstrate that all local health departments in the project area are aware of the proposed project by submitting a letter of acknowledgement with the application. Strong letters of commitment must be attached if a potential high need community IS NOT under the jurisdiction of the applicant agency.**

Applicant agencies must attend or document in writing prior attendance at Grants Management Information System (GMIS) 2.0 training and must have the capacity to accept an electronic funds transfer (EFT). See Appendix 1, page 32 for GMIS 2.0 Training form.

All counties/agencies are eligible to apply, however, those with highest need will be given priority. See Appendixes 8, 9, and 10, pages 52-60 for the county rankings.

County data were weighted based on the following:

- estimated number of persons below poverty,
- percent below poverty level (2007) and,
- number of deaths from selected chronic diseases including heart disease, chronic lower respiratory disease, stroke, diabetes for 2006 and the average annual number of deaths from cancer for the years 2001 – 2005.

- E. Service Area: One project will be funded per county.** Projects with an established multi-county region with a strong history of collaboration are allowed, but not required, to submit one application for the region. Each county within the multi-county region must adhere to the same program and staffing requirements as single-county projects. Funding for multi-county regions will be based on the application, workplan, budget justification, and budget submitted for each county in the region. **Multiple counties**

**applying as a region may not also apply as single-county projects and a county may not apply as part of more than one region.**

- F. Number of Grants and Funds Available:** Only one application per county will be funded. The CHCP anticipates having approximately \$1,700,000 for local grant awards.

The CHCP is structured in two tiers; however, counties/agencies can only apply for funding in **one** category. Each applicant must show evidence of high need in their county or target community.

**Tier I -- Capacity Building: Total of \$700,000 available**

Counties with a population of less than 200,000\* may apply for up to a maximum of \$75,000.

Counties with a population greater than 200,000\* may apply for up to a maximum of \$110,000.

Tier I is to empower communities *without* an existing chronic disease or similar *coalition* and is intended to build leadership and partnerships. This will assist communities to reorient organizational policies and to develop an infrastructure to implement comprehensive strategies to reduce chronic disease risk factors.

**Tier II – Community-Based Expansion: Total of \$1,000,000 available**

Counties with a population of less than 200,000\* may apply for up to a maximum of \$90,000.

Counties with a population greater than 200,000\* may apply for up to a maximum of \$140,000.

Tier II is designed for the chronic disease prevention efforts *which are already in place and in communities where a working coalition already exists*. This tier will enhance and expand interventions to a higher level of performance. Applicants must develop their annual workplan to include additional partnerships that ensure successful implementation of policies, systems and environmental changes. Tier II projects will be expected to develop a comprehensive evaluation plan during the first two years.

Funding levels for all Tier I and Tier II applicants will depend on the number and scope of proposals received, recommendations from the review panel, quality of each application, justification for the amount of funding requested, and adherence to the goals and objectives outlined in this RFP. No applicant is guaranteed a certain percentage of the total funds available.

ODH reserves the right to modify the number of grants awarded or amount of funding based on the applications, geographic representation and funds available.

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\*Per the US Census 2007 Population Estimates (See Appendix 2, page 33, for a list of counties ranked by population size.)

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

- G. Due Date:** Applications including any required forms and required attachments mailed or electronically submitted via GMIS 2.0 are **due by 4:00 pm, Monday, October 5, 2009**. Attachments and/or forms submitted electronically must be transmitted by 4:00 pm Monday, October 5, 2009. Attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before 4:00 pm, Monday, October 5, 2009.

Questions related to this RFP may be submitted via e-mail to Ann Weidenbenner at [ann.weidenbenner@odh.ohio.gov](mailto:ann.weidenbenner@odh.ohio.gov). FAQs will be posted on the Healthy Ohio Web site, [http://www.odh.ohio.gov/landing/phs\\_healthyohio/HOlandingpage.aspx](http://www.odh.ohio.gov/landing/phs_healthyohio/HOlandingpage.aspx).

- H. Authorization:** Authorization of funds for this purpose is contained in the *Catalog of Federal Domestic Assistance (CFDA) Number 93.991*.
- I. Goals:** The goal of the CHCP is to confront the epidemic of chronic diseases by mobilizing community resources and changing the places, organizations, and systems that touch people's lives every day, including schools, worksites, communities and health care settings. Key decisions related to policy, systems, and environmental changes depend on local decision makers who understand the importance and effectiveness of, and are committed to, making changes that promote and support good community health.

It is the goal that local communities will develop strategies that will help prevent or manage health-risk factors for heart disease, stroke, diabetes, cancer, and obesity. Specific activities will be directed towards reducing tobacco use and exposure, promoting physical activity and healthy eating in high need areas of Ohio. Population-based, evidence-based approaches will be utilized to achieve these goals.

The CHCP, in conjunction with the Centers for Disease Control and Prevention/PHHSBG, support the following goals:

- Achieve health equity and eliminate health disparities by impacting social determinants of health;
- Decrease premature death and disabilities due to chronic diseases by focusing on the leading preventable risk factors;
- Support local health programs, systems, and policies to achieve healthy communities; and,
- Provide opportunities to address emerging health issues and gaps.

Therefore the strategies that the ODH/ BHPRR will support for the CHCP will focus on the leading preventable risk factors, address and impact social determinants of health, and support local health programs, systems, and policies. These strategies will

be accomplished using tactics such as countywide initiatives, community grants, training and technical assistance, strategic planning, social marketing, and evaluation.

- J. Program Period and Budget Period:** The program period begins on January 1, 2010 and ends on December 31, 2014. The budget period for this application is January 1, 2010 through December 31, 2010.
- K. Local Health Districts Improvement Standards:** This grant program will address Local Health Districts Improvement Goal 3701-36-07- “Promote Healthy Lifestyles,” Standard 3701-36-07-03-“Prevention, health promotion, early intervention, and outreach services are not provided directly, rather contracts or partnerships exist.” Also Standard 3701-36-07-02- “Community members actively involved in addressing prevention priorities.” The Local Health District Improvement Standards are available on the ODH web-site <http://www.odh.ohio.gov>. Click on “Local Health Departments” then “Local Health Districts Improvement Standards,” Then click “Local Health District Improvement Goals/Standards/Measures.”
- L. Public Health Impact Statement:** All applicant agencies that are not local health districts must communicate with local health districts regarding the impact of the proposed grant activities on the Local Health Districts Improvement Standards.
1. *Public Health Impact Statement Summary* -- Applicant agencies are required to submit a summary of the program to local health districts prior to submitting the grant application to ODH. The program summary, not to exceed one page, must include:
    - a) The Local Health District Improvement Standard(s) to be addressed by grant activities:
      - A description of the demographic characteristics (e.g., age, race, gender, ethnicity) of the target population and the geographical area in which they live (e.g. census tracts, census blocks, block groups);
      - A summary of the services to be provided or activities to be conducted; and,
      - A plan to coordinate and share information with appropriate local health districts.

The applicant must submit the above summary as part of their grant application to ODH. This will document that a written summary of the proposed activities was provided to the local health districts with a request for their support and/or comment about the activities as they relate to the Local Health Districts Improvement Standards.

2. *Public Health Impact Statement of Support* -- Include with the grant application a statement of support from the local health districts, if available. If a statement of support from the local health districts is not obtained, indicate that when the program summary is submitted with the grant application. If an applicant agency

has a regional and/or statewide focus, a statement of support must be submitted from at least one local health district, if available.

**M. Statement of Intent to Pursue Health Equity Strategies**

The ODH is committed to the elimination of health inequities. All applicant agencies must submit a statement which outlines the intent of this application to address health disparities.

- This statement should not exceed 1½ pages and must:
  - (1) explain the extent in which health disparities are manifested within the health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) focus of this application;
  - (2) identify specific group(s) who experience a disproportionate burden for the disease or health condition addressed by this application; and,
  - (3) identify specific social and environmental conditions which lead to health disparities (social determinants). This statement must be supported by data. The following section will provide a basic framework and links to information to understand health equity concepts. This information will also help in the preparation of this statement as well as respond to other portions of this application.
  
- Basic Health Equity Concepts:

Certain groups in Ohio experience a disproportionate burden with regard to the incidence, prevalence and mortality of certain diseases or health conditions. These are commonly referred to as health disparities. Health disparities are not mutually exclusive to one disease or health condition and are measurable through the use of various public health data. Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors. People in such groups also tend to have less access to resources like healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as social determinants. Social determinants are necessary to support optimal health. The systematic and unjust distribution of social determinants among these groups is referred to as health inequities. As long as health inequities persist, marginalized groups will not achieve their best possible health. The ability of marginalized groups to achieve optimal health (like those with access to social determinants) is referred to as health equity. Public health interventions that incorporate social determinants into the planning and implementation of programs will contribute to the elimination of health disparities. For more resources on health equity, please visit the ODH Web site at:

<http://www.healthyohioprogram.org/healthequity/equity.aspx>.

**N. Appropriation Contingency:** Any award made through this program is contingent upon the availability of funds for this purpose. **In view of this, the subgrantee agency must be prepared to cover the costs of operating the program in the event of a delay in grant payments.**

**O. Programmatic, Technical Assistance and Authorization for Internet Submission:** Initial authorization for Internet submission will be distributed at your GMIS 2.0 Training Session (new agencies). All other agencies will receive their authorization upon receipt of the Notice of Intent To Apply For Funding (NOIAF) form by ODH. Questions related to this RFP may be submitted via e-mail to Ann Weidenbenner at [ann.weidenbenner@odh.ohio.gov](mailto:ann.weidenbenner@odh.ohio.gov). FAQs will be posted on the Healthy Ohio Web site, [http://www.odh.ohio.gov/landing/phs\\_healthyohio/HOlandingpage.aspx](http://www.odh.ohio.gov/landing/phs_healthyohio/HOlandingpage.aspx)

Applicants for competitive RFPs must attend, or must document in writing, prior attendance at GMIS 2.0 training by two staff members in order to receive authorization for Internet submission.

**P. Acknowledgment:** An ‘Application Submitted’ status will appear in GMIS 2.0 that acknowledges ODH system receipt of the application submission.

**Q. Late Applications:** Applications are dated the time of actual submission via the Internet utilizing GMIS 2.0. Required attachments and/or forms sent electronically must be transmitted by the application due date. Required attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before the application due date of **Monday, October 5, 2009 at 4:00 pm.**

Applicants should request a legibly dated postmark, or obtain a legibly dated receipt from the U.S. Postal Service, or a commercial carrier. Private metered postmarks shall **not** be acceptable as proof of timely mailing. Applicants can hand-deliver attachments to ODH, Grants Administration, Central Master Files; but they must be delivered by 4:00 p.m. on the application due date. FAX attachments will not be accepted. **GMIS 2.0 applications and required application attachments received late will not be considered for review.**

**R. Successful Applicants:** Successful applicants will receive official notification in the form of a “Notice of Award” (NOA) in GMIS 2.0. The NOA, issued under the signature of the Director of Health, allows for expenditure of grant funds.

**S. Unsuccessful Applicants:** Within 30 days after a decision to disapprove or not fund a grant application for a given program period, written notification, issued under the signature of the Director of Health, or his designee, shall be available in GMIS 2.0 to the unsuccessful applicant.

**T. Review Criteria:** All proposals will be judged on the quality, clarity and completeness of the application. Applications will be judged according to the extent to which the proposal:

1. Contributes to the advancement and/or improvement of the health of Ohioans;
2. Is responsive to policy concerns and program objectives of the initiative/program/activity for which grant dollars are being made available;
3. Is well executed and is capable of attaining program objectives;
4. Describes specific objectives, activities, milestones and outcomes with respect to time-lines and resources;
5. Estimates reasonable cost to the ODH, considering the anticipated results;
6. Indicates that program personnel are well qualified by training and/or experience for their roles in the program and the applicant organization has adequate facilities and personnel;
7. Provides an evaluation plan, including a design for determining program success;
8. Is responsive to the special concerns and program priorities specified in the request for proposal;
9. **Has demonstrated acceptable past performance in areas related to programmatic and financial stewardship of grant funds;**
10. **Has demonstrated compliance to GAPP, Chapter 100; and**
11. **Explicitly identifies specific groups in the service area who experience a disproportionate burden of the diseases or health condition(s) and explains the root causes of health disparities.**

The ODH will make the final determination and selection of successful/unsuccessful applicants and reserves the right to reject any or all applications for any given request for proposals. **There will be no appeal of the Department's decision.**

- U. Freedom of Information Act:** The Freedom of Information Act and the associated Public Information Regulations (45 CFR Part 5) of the U. S. Department of Health and Human Services require the release of certain information regarding grants requested by any member of the public. The intended use of the information will not be a criterion for release. Grant applications and grant-related reports are generally available for inspection and copying except that information considered to be an unwarranted invasion of personal privacy will not be disclosed. For specific guidance on the availability of information, refer to 45 CFR Part 5.
- V. Ownership Copyright:** Any work produced under this grant will be the property of the ODH/Federal Government. The department's ownership will include copyright. The content of any material developed under this grant **must** be approved in advance by the awarding office of the ODH. All material(s) must clearly state:

*“Funded by the Preventive Health and Health Services Block Grant from the Centers for Disease Control and Prevention (CDC) and administered by the Ohio Department of Health, Bureau of Health Promotion and Risk Reduction, Creating Healthy Communities Program. This publication (journal article, etc.) was supported by Grant Number 2B01DP009042-09 from CDC. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.”*

- W. Reporting Requirements:** Successful applicants are required to submit subgrantee program and expenditure reports. Reports must adhere to the ODH GAPP manual. Reports must be received before the Department will release any additional funds.

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

Reports shall be submitted as follows:

- **Program Reports:** Subgrantee Program Reports **must** be completed and submitted **via the Subgrantee Performance Evaluation System (SPES)** by the following dates:  
1<sup>st</sup> Quarter, January 1 – March 31 ..... April 15, 2010  
2<sup>nd</sup> Quarter, April 1 – June 30 ..... July 15, 2010  
3<sup>rd</sup> Quarter, July 1 – September 30 ..... October 15, 2010  
4<sup>th</sup> Quarter, October 1 – December 31 ..... January 15, 2011

Any paper non-Internet compatible report attachments must be submitted to Central Master Files by the specific report due date. **Program Reports that do not include required attachments (non-Internet submitted) will not be approved.** All program report attachments must clearly identify the authorized program name and grant number.

*Submission of Subgrantee Program Reports via the ODH’s SPES indicates acceptance of the ODH GAPP.*

- **Subgrantee Program Expenditure Reports:** Subgrantee Program Expenditure Reports **must** be completed and submitted **via GMIS 2.0** by the following dates:  
1<sup>st</sup> Quarter, January 1–March 31 ..... April 15, 2010  
2<sup>nd</sup> Quarter, April 1 – June 30 ..... July 15, 2010  
3<sup>rd</sup> Quarter, July 1 – September 30 ..... October 15, 2010  
4<sup>th</sup> Quarter, October 1 – December 31 ..... January 15, 2011

*Submission of Subgrantee Program Expenditure Reports via the ODH’s GMIS 2.0 indicates acceptance of ODH GAPP. Clicking the “Approve” button signifies your authorization of the submission as an agency official and constitutes your electronic acknowledgment and acceptance of GAPP rules and regulations.*

- 3. Final Expenditure Reports:** A Subgrantee Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS 2.0** on or before **February 15, 2011**. The information contained in this report must reflect the program’s accounting records and supportive documentation. Any cash balances must be returned with the Subgrantee Final Expense Report. The

Subgrantee Final Expense Report serves as an invoice to return unused funds.

*Submission of the Subgrantee Final Expenditure Report via the GMIS 2.0 indicates acceptance of ODH GAPP. Clicking the “Approve” button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations.*

4. **Inventory Report:** A listing of all equipment purchased in whole or in part with **current** grant funds (Equipment Section of the approved budget) must be submitted via GMIS 2.0 as part of the Subgrantee Final Expenditure Report. At least once every two years, inventory must be physically inspected by the subgrantee. Equipment purchased with ODH grant funds must be tagged as property of ODH for inventory control. Such equipment may be required to be returned to ODH at the end of the grant program period.

- X. **Special Condition(s):** Responses to all special conditions **must be submitted via GMIS 2.0 within 30 days of receipt of the first quarter payment.** A Special Conditions link is available for viewing and responding to special conditions. This link is viewable only after the issuance of the subgrantee’s first payment. The 30 day time period, in which the subgrantee must respond to special conditions, will begin when the link is viewable. Failure to submit satisfactory responses to the special conditions or a plan describing how those special conditions will be satisfied will result in the withholding of any further payments until satisfied.

*Submission of response to grant special conditions via the ODH’s GMIS 2.0 indicates acceptance of ODH GAPP. Checking the “selection” box and clicking the “approve” button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations.*

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

1. To advance political or religious points of view or for fundraising or lobbying; but must be used solely for the purpose as specified in this announcement;
2. To disseminate factually incorrect or deceitful information;
3. Consulting fees for salaried program personnel to perform activities related to grant objectives;
4. Bad debts of any kind;
5. Lump sum indirect or administrative costs;
6. Contributions to a contingency fund;
7. Entertainment;
8. Fines and penalties;
9. Membership fees -- unless related to the program and approved by ODH;
10. Interest or other financial payments;
11. Contributions made by program personnel;
12. Costs to rent equipment or space owned by the funded agency;

13. Inpatient services;
14. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building;
15. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
16. Travel and meals over the current state rates (see OBM Web site: <http://obm.ohio.gov/MiscPages/Publish/TravelPolicy.aspx>);
17. Costs related to out-of-state travel, unless otherwise approved by ODH, and described in the budget narrative;
18. Training longer than one week in duration, unless otherwise approved by ODH;
19. Contracts for compensation with advisory board members;
20. Grant-related equipment costs greater than \$300, unless justified and approved by ODH;
21. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants.

**Use of grant funds for prohibited purposes will result in the loss and/or recovery of those funds.**

- Z. Audit:** Subgrantees currently receiving funding from the ODH are responsible for submitting an independent audit report that meets OMB Circular A-133 requirements, a copy of the auditor's management letter, a corrective action plan (if applicable) and a data collection form (for single audits) within 30 days of the receipt of the auditor's report, but not later than 9 months after the end of the subgrantee's fiscal year.

Subgrantees that have an agency fiscal year that ends on or after January 1, 2004 (and expend \$500,000 or more in federal awards per fiscal year) are required to have a single audit. The fair share of the cost of the single audit is an allowable cost to federal awards provided that the audit was conducted in accordance with the requirements of OMB Circular A-133.

**Subgrantees that have an agency fiscal year that ends on or after January 1, 2004 which expend less than the \$500,000 threshold require a financial audit conducted in accordance with Generally Accepted Government Auditing Standards.** The financial audit is not an allowable cost to the program.

Once an audit is completed, **a copy must be sent to the ODH, Grants Administration, Central Master Files address within 30 days.** Reference: *GAPP Chapter 100, Section 108 and OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.*

**Subgrantee audit reports** (finalized and published, and including the audit Management Letters, if applicable) **which include internal control findings, questioned costs or any other serious findings, must include a cover letter which:**

- Lists and highlights the applicable findings;

- Discloses the potential connection or effect (direct or indirect) of the findings on subgrants passed-through the ODH;
- Summarizes a Corrective Action Plan (CAP) to address the findings. A copy of the CAP should be attached to the cover letter.

#### AA. Submission of Application:

The GMIS 2.0 application submission must consist of the following:

<p><b>Complete &amp; Submit Via Internet</b></p>
--

1. Application Information
2. Project Narrative
  - Executive Summary
  - Description of Applicant Agency/Documentation of Eligibility/Personnel
  - Problem/Need **including the Statement of Intent to Pursue Health Equity Strategies**
  - Methodology
3. Project Contacts
4. Budget
  - Primary Reason
  - Funding
  - Cash Needs
  - Justification
  - Personnel
  - Other Direct Costs
  - Equipment
  - Contracts
  - Compliance Section D
  - Summary
5. Civil Rights Review Questionnaire (EEO Survey)
6. Assurances Certification
7. Attachments as required by Program
  - a. Attachment A – Personnel/Position, Percent of Time Devoted to and Paid by Grant and Function
  - b. CV or Resumes for all personnel on grant
  - c. Attachment B or C – Creating Healthy Communities Program Work Plan
  - d. Attachment D -- Demographics Table
  - e. Letters of Support
  - f. Statement of Intent to Pursue Health Equities Strategies

An original and one (1) copy of the following forms, available on GMIS 2.0, must be completed, printed, signed in blue ink with original signature by the Agency Head or Agency Financial Head and mailed to the address listed below:

<p><b>Complete, Sign &amp; Mail To ODH</b></p>
--

1. Electronic Funds Transfer (EFT) Form **(Required if new agency, thereafter only if banking information has**

- changed.)**
2. IRS W-9 Form (**Required if new agency, thereafter only when tax identification number or agency address information has changed.**) **One of the following forms must accompany the IRS W-9 Form:**
    - a. Vendor Information Form (**New Agency Only**)
    - b. Vendor Information Change Form (**Existing Agency with tax identification number, name and/or address change(s).**)
    - c. Change request in writing on Agency letterhead (**Existing Agency with tax identification number, name and/or address change(s).**)

Two (2) copies of the following documents must be mailed to the address listed below:

<p><b>Copy &amp; Mail To ODH</b></p>
--

1. Public Health Impact Statement (**for competitive cycle only; for continuation, only if changed**)
2. Statement of Support from the Local Health Districts (**for competitive cycle only; for continuation, only if changed**)
3. Liability Coverage (**Non-Profit Organizations only; proof of current liability coverage and thereafter at each renewal period**)
4. Evidence of Non-Profit Status (**Non-Profit Organizations only; for competitive cycle only; for continuation, only if changed**).

One (1) copy of the following documents must be mailed to the address listed below:

<p><b>Complete Copy &amp; Mail To ODH</b></p>
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1. Current Independent Audit (latest completed organizational fiscal period; **only if not previously submitted**)
2. Declaration Regarding Material Assistance/Non Assistance to a Terrorist Organization (DMA) Questionnaire (**Required by ALL Non-Governmental Applicant Agencies**)
3. An original and copies of Attachments (non-Internet compatible) as required by Program: None

**Ohio Department of Health  
Grants Administration  
Central Master Files, 4<sup>th</sup> Floor  
246 N. High Street  
Columbus, Ohio 43215**

## II. APPLICATION REQUIREMENTS AND FORMAT

Access to the on-line GMIS 2.0, will be provided after GMIS 2.0 training for those agencies requiring training. All others will receive access after the submission of the Notice of Intent To Apply For Funding (NOIAF) form to ODH.

*All applications must be submitted via GMIS 2.0. Submission of all parts of the grant application via the ODH's GMIS 2.0 indicates acceptance of ODH GAPP. Submission of the Application signifies authorization by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations in lieu of an executed Signature Page document.*

- A. **Application Information:** Information on the applicant agency and its administrative staff must be accurately completed. This information will serve as the basis for necessary communication between the agency and the ODH.
- B. **Budget:** Prior to completion of the budget section, please review pages 10-11 of the RFP for unallowable costs.

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

- 1. **Primary Reason and Justification Pages:** Provide a detailed budget justification narrative that describes how the categorical costs are derived. Discuss the necessity, reasonableness, and allocability of the proposed costs. Describe the specific functions of the personnel, consultants and collaborators. Explain and justify equipment, travel, (including any plans for out-of-state travel), supplies and training costs. If you have joint costs refer to GAPP Chapter 100, Section 103 and the Compliance Section D (9) of the application for additional information.
- 2. **Personnel, Other Direct Costs, Equipment and Contracts:** Submit a budget with these sections and form(s) completed as necessary to support costs for the period January 1, 2010 to December 31, 2010.

**Each funded county is required to employ one (1) full-time staff assigned as the Creating Healthy Communities Program Coordinator whose sole duties are to administer the Creating Healthy Communities Program.**

**Mandatory Project Meetings:** The Creating Healthy Communities Program Coordinator from each county must attend these meetings.

- a. **Tier I: Capacity Building Projects:** Budget for two (2) training meetings and two (2) All-Project meetings in Columbus.

- b. **Tier II: Community- Based Expansion Projects:** Budget for two (2) All-Project meetings in Columbus.

**Other Recommended Meetings: One (1)** training sponsored by the ODH, BHPRR to be held in Columbus during 2010. Other trainings within Ohio related to chronic disease risk reduction or health promotion strategies not specifically mentioned in this RFP may be included in the budget if adequate justification is provided in the budget narrative.

Costs associated with these meetings are an allowable cost for this grant proposal.

Funds may be used to support personnel, their training, travel (see OBM Web site <http://obm.ohio.gov/MiscPages/Publish/TravelPolicy.aspx>) and supplies directly related to planning, organizing and conducting the initiative/program activity described in this announcement.

When appropriate, retain all contracts on file. The contracts should not be sent to ODH. A completed “Confirmation of Contractual Agreement” (CCA) form must be submitted via GMIS 2.0 for each contract once it has been signed by both parties. The submitted CCA must be approved by ODH before contractual expenditures are authorized.

*Submission of the “Confirmation of Contractual Agreement” (CCA) via the ODH’s GMIS 2.0 indicates acceptance of ODH GAPP. Clicking the “Approve” button signifies authorization of the submission by an agency official and constitutes electronic acknowledgement and acceptance of GAPP rules and regulations. CCAs cannot be submitted until after the 1<sup>st</sup> quarter grant payment has been issued.*

Where appropriate, itemize all equipment (**minimum \$300 unit cost value**) to be purchased with grant funds in the Equipment Section.

3. **Compliance Section D:** Answer each question on this form as accurately as possible. Completion of the form ensures your agency’s compliance with the administrative standards of ODH and federal grants.
  4. **Funding, Cash Needs and Budget Summary Sections:** Enter information about the funding sources and forecasted cash needs for the program. Distribution should reflect the best estimate of need by quarter. Failure to complete and balance this section will cause delays in receipt of grant funds.
- C. **Assurances Certification:** Each subgrantee must submit the Assurances (Federal and State Assurances for Subgrantees) form. This form is submitted as a part of each application via GMIS 2.0. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive and any omission of other statutes does not

mean such statutes are not assimilated under this certification. Review the form and then press the “Complete” button. By submission of an application, the subgrantee agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

*Note: The following sections describe the application requirements for Tier I and Tier II. (See page 3, F. for the explanation of Tier I -- Capacity Building and Tier II – Community-Based Expansion applicants.) Detailed instructions for Tier I applicants begin on page 16; Tier II begin on page 21.*

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## **Tier I – Capacity-Building Applicants**

*For purposes of this CHCP RFP, the four (4) settings are Schools, Healthcare, Worksites, and Community. The three (3) risk factors are nutrition/obesity, physical activity, and tobacco use/exposure. The five (5) chronic diseases are heart disease, stroke, cancer, diabetes, and chronic lower respiratory disease. All of the above need to be addressed in the Work Plan either in combination or as individual strategies.*

### **D. Project Narrative:**

#### **1. Executive Summary: (Limit to no more than two [2] pages)**

- Identify that the application is for Tier I and the amount of funding the applicant is requesting.
- Identify the target community (ies) to be reached.
- Provide a one-page summary of the plan for 2010, including a brief overview of the impact and process objectives, how the target communities will be addressed, how the four settings will be addressed, and a description of how the program activities will be evaluated.

#### **2. Description of Applicant Agency/Documentation of Eligibility/Personnel:**

- Briefly discuss the applicant agency's eligibility to apply including a brief description of previous experience with chronic disease risk reduction and prevention, the three risk factors and the four settings addressed in this RFP, and implementing population-based/evidence-based interventions. Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program.
- Describe the capacity of your organization, its personnel or contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English proficiency, those who are not literate, have low literacy skills, and individuals with disabilities.

- Note any personnel or equipment deficiencies that will need to be addressed in order to carry out this grant. Describe plans for hiring and training, as necessary. Delineate all personnel who will be directly involved in program activities by completing Attachment A. Include a **CV or resume for each staff person on the grant**. If the position is currently vacant, attach a copy of a current Position Description. Every personnel dollar spent on the PHHSBG needs to be aligned with meeting the goals of this RFP.
- Include the relationship between program staff members, staff members of the applicant agency, and other partners and agencies that will be working on this program.

### 3. Problem/Need:

- Identify and describe the local health status concern that will be addressed by the program. Do not restate national data. Comparisons of your county to state data are encouraged. (Refer to the 2008 Healthy Communities Profiles at [www.healthyohioprogram.org/resources/profiles.aspx](http://www.healthyohioprogram.org/resources/profiles.aspx) for Ohio and county-specific data.) The specific health status concerns that the program intends to address may be stated in terms of health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which the evaluation will be based. Clearly identify the target community(ies).
- **Explicitly describe segments of the target population who experience a disproportional burden of the local health status concern.** (This information must correlate with the Statement of Intent to Pursue Health Equity Strategies.)
- **Describe how program activities will address health disparities**, including process objectives and activities specifically designed to reduce the identified health disparities of the target community and are incorporated into the workplan.
- Complete Attachment D, page 31, “Demographics Table” for each target community/zip code/census tract included in your Work Plan using the link <http://factfinder.census.gov>.

### 4. Partnerships

- **Letters of Support or Commitment**  
Three (3) letters of support are required. Letters of support should be specific and describe the unique role of the supporting agency or organization in the community coalition and action planning process. Community partners must demonstrate commitment and willingness to collaborate with the applicant agency. Letters of commitment will be necessary from partners who will be integral in completing workplan objectives, i.e. community planners for walking

trails, school board members for tobacco-free campus policy, etc.

- **Description of other agencies and organizations** in your county or target community(ies) which also address the same risk factors, settings, and chronic diseases as the CHCP.
  - a. Identify how the CHCP will collaborate with these programs. Applicants are encouraged to identify and leverage opportunities which will enhance your work with other programs that address related chronic diseases or risk factors. This includes joint planning activities, joint trainings, coalition partners, combined development and implementation of environmental policy, systems, or community interventions that relate to this RFP.
  - b. Also identify and list the other **state or federally funded grants** in your county/community that pertain to the risk factors and settings discussed in this RFP. Describe how the applicant agency will collaborate and not duplicate efforts of these grants.

## 5. Methodology

The initial application for Year 1, Capacity-Building projects must identify a plan to assess specific high need areas of the county (ies) based on available data. The plan must identify multiple communities within the county (ies) to be targeted. These communities must have a significant high need population. The project will identify potential intervention communities by using existing county community needs assessment data and data available from other sources.

During the first six months of the grant after the Notice of Award is received, **only the funded applicants** will be expected to determine baseline assessment of health programs available in each target community as they relate to environmental, systems, and policy issues specific to becoming a Healthy Community. A Healthy Communities (HC) Checklist tool will be provided by ODH for this assessment. The HC Checklist will provide the applicant with a consistent tool to identify strengths, weaknesses, opportunities and threats in each community to be addressed in their plan.

Over the five-year project period, the CHCP Capacity-Building projects will develop a logical sequence to implement strategies in four settings, addressing the three risk factors and five chronic diseases in the identified high need, target communities.

## 6. CHCP Work Plan for 2010 (See: Attachment B)

- The applicant must use existing community needs assessments which were completed within the past 5 years, along with the input from the coalition and the community to develop a Work Plan for 2010.
- Using the template provided in Attachment B, page 29, develop a Work Plan that includes the following Impact Objectives:

- a. **Coalition Development**
- b. **Completing the Healthy Communities Checklist for each target community**
- c. **Conducting at least one training**
- d. **Completing at least one evidence-based intervention**

- **SMART:** Impact and Process Objectives must be written in SMART (Specific, Measurable, Achievable, Relevant, and Time-framed) format. See Appendix 4, pages 38 – 41 for more information on SMART Objectives and guidance on completing the Work Plan template.
- **Impact Objectives** must address each of the **four settings** (worksite, schools healthcare, and community), each of the **three risk factors** (poor nutrition/obesity, lack of physical activity, and tobacco use) and each of the **five chronic diseases** (heart disease, cancer, stroke, chronic lower respiratory disease, and diabetes) for each target community.
- **Population-based:** Interventions must be population-based and emphasize policy, environmental and systems changes specific to the high need populations to be addressed. See Appendix 5, page 42 for an explanation of population-based interventions.
- **Evidence-based:** The objectives and activities discussed in your Work Plan should be proven to be effective. Impact and Process objectives and activities should reflect evidence-based strategies as shown in Appendix 6, page 43. Discuss how your activities were selected and where they rank on the evidence-based list. Also see <http://www.cdc.gov/NCCDPHP/DNPAO/Publications/index.html> for the *CDC's Recommended Community Strategies for Obesity Prevention* for additional evidence-based activities.

#### a. **Coalition Development**

- Write an Impact Objective (“SMART”) to develop a project-wide coalition within the **first three months**. (See Sample Impact Objective below.) Describe the new coalition to be formed for this program. Membership should include all local health departments in the county and target community (ies), related agencies and organizations from the four settings, the chronic diseases and the associated risk factors addressed in this RFP. Identify key community stakeholders and representatives of the identified target communities and high need population groups, i.e. health professionals, mayors, city council members, members of school boards, physicians, city planners, etc., who are able to provide input, make decisions, assist with program interventions, and assist with partnerships necessary for conducting a needs assessment.
- Submit three (3) Letters of Support/ Commitment from coalition members with this application. Letters of Support/ Commitment should indicate agreement with the CHCP needs in the project area, their willingness to

work together on proposed projects and specific areas in which they will provide support or services.

**Sample Impact Objective:** By March 2010 a representative coalition will be operational to direct program activities, as evidenced by letters of commitment and a written timetable to complete the assessment and planning tasks.

**b. Healthy Communities Checklists: Capacity-Building**

- Write one Impact Objective (“SMART”) describing the process of how you would plan to complete the Healthy Communities (HC) Checklist during the first six (6) months of the grant for each target community. The HC Checklist will also include a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis for each target community. (See Sample Impact Objective below.) **ONLY funded** applicants will submit the **completed** checklists and SWOT analysis with the 2<sup>nd</sup> Quarterly Report.
  - A SWOT analysis must first start with defining a desired end state or objective. **Strengths:** attributes of the county or coalition that is helpful to achieving the objective.
  - **Weaknesses:** attributes of the county or coalition that is harmful to achieving the objective.
  - **Opportunities:** *external* conditions that is helpful to achieving the objective.
  - **Threats:** *external* conditions which could do damage to the program’s performance.
- You will be expected to determine a baseline assessment of health programs available in each target community as they relate to environmental, systems and policy issues specific to chronic diseases using the HC Checklist provided by ODH to funded projects. The HC Checklist will provide the applicant with a consistent tool to use through 2014 to identify strengths, weaknesses, opportunities and threats in each community to be addressed in the CHC Work Plan.

**Sample Impact Objective:** By June 2010 one HC Checklist and one SWOT analysis will be completed for each target community selected for interventions.

**c. Training**

- Write an Impact Objective (“SMART”), after reviewing completed county health assessment(s), and select an identified training need to reach the identified target community(ies). The training should be a train-the-trainer model so that there will be a greater impact on the target population. Use the list of evidence-based interventions in Appendix 6, page 43 for evidence-based training ideas.

- Develop process objectives and activities to complete the training before the end of Year 1.
- The objective must include an evaluation of the training and the plans for follow-up based on the evaluation.

Examples of trainings would include accurate glucose monitoring trainings for office and clinic health professionals, training on Ounce of Prevention materials at nursing or physician meetings, training human resource and CEO’s on the benefit of healthy snack, lunches, and vending machines at worksites, or training a school district on the benefits of recess before lunch.

**d. Intervention**

- Write an Impact Objective (“SMART”) to complete at least one intervention that will reach the identified target community(ies) and address an identified need from a completed county health assessment. Community and coalition members should be involved in the development, implementation, and evaluation of the intervention.
- The intervention must be evidence-based and address any of the risk factors, any of the chronic diseases, and any one of the four settings. Review Appendix 6, page 43 for a list of evidence-based interventions.
- Develop process objectives and activities to complete the intervention by the end of Year 1.
- The intervention must include an evaluation component including plans for improving or continuing the intervention.

Examples of interventions include implementing Snack Wise in all the vending machines in a hospital, organizing a farmers’ market in a high-need community, conducting a community nutrition assessment to bring a grocery store to a target community, or planning weekly walking groups in a faith-based organization.

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**Tier II – Community-Based Expansion Applicants**

*For purposes of this CHCP RFP, the four (4) settings are Schools, Healthcare, Worksites, and Community. The three (3) risk factors are nutrition/obesity, physical activity, and tobacco use/exposure. The five (5) chronic diseases are heart disease, stroke, cancer, diabetes, and chronic lower respiratory disease. All of the above need to be addressed in the Work Plan either in combination or as individual strategies.*

**E. Project Narrative**

**1. Executive Summary: (Limit to no more than two [2] pages)**

- Identify that the application is for Tier II and the amount of funding the applicant is requesting.
- Identify the target community(ies) to be reached.

- Provide a one-page summary of the plan for 2010, including a brief overview of the impact and process objectives, how the target communities will be addressed, how the settings will be addressed, and a description of how the program activities will be evaluated.
- Describe plans to enhance and sustain your existing programs in current target communities.

## **2. Description of Applicant Agency/Documentation of Eligibility/Personnel:**

- Briefly discuss the applicant agency's eligibility to apply for Tier II funding including a brief description of previous experience with chronic disease risk reduction and prevention, the three risk factors and the four settings addressed in this RFP, and implementing population-based/evidence-based interventions. Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program.
- Describe the capacity of your organization, its personnel or contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English proficiency, those who are not literate, have low literacy skills, and individuals with disabilities.
- Note any personnel or equipment deficiencies that will need to be addressed in order to carry out this grant. Describe plans for hiring and training, as necessary. Delineate all personnel who will be directly involved in program activities by completing Attachment A. Include a **CV or Resume** for **each staff person on the grant**. For vacant positions, include a Position Description. Every Personnel dollar spent on the PHHSBG needs to be aligned with meeting the goals of this RFP.
- Include the relationship between program staff members, staff members of the applicant agency, and other partners and agencies that will be working on this program.

## **3. Problem/Need:**

- Identify and describe the local health status concern that will be addressed by the program. Do not restate national data. Comparisons of your county to state data are encouraged. (Refer to the 2008 Healthy Communities Profiles at [www.healthyohioprogram.org/resources/profiles.aspx](http://www.healthyohioprogram.org/resources/profiles.aspx) for Ohio and county-specific data.) The specific health status concerns that the program intends to address may be stated in terms of health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which the evaluation will be based. Clearly identify the target community(ies).

- **Explicitly describe segments of the target population who experience a disproportional burden of the local health status concern** (this information must correlate with the Statement of Intent to Pursue Health Equity Strategies.)
- Complete Attachment D, page 31, “Demographics Table” for each target community/zip code/census tract included in your Work Plan using the link <http://factfinder.census.gov>.
- **Describe how program activities will address health disparities.** Incorporate process objectives and activities specifically designed to reduce the identified health disparities of the target community.

#### 4. Partnerships:

- **Letters of Support or Commitment**  
Three (3) letters of support are required. Letters of support should be specific and describe the unique role of the supporting agency or organization in the community coalition and action planning process. Community partners must demonstrate commitment and willingness to collaborate with the applicant agency. Letters of commitment will be necessary from partners who will be integral in completing workplan objectives, i.e. community planners for walking trails, school board members for tobacco-free campus policy, etc.
- **Description of other agencies and organizations** in your county or target community(ies) which also address the same risk factors, settings, and chronic diseases as the CHCP.
  - a. Identify how the CHCP will collaborate with these programs. Applicants are encouraged to identify and leverage opportunities which will enhance your work with other programs that address related chronic diseases or risk factors. This includes joint planning activities, joint trainings, coalition partners, combined development and implementation of environmental policy, systems, or community interventions that relate to this RFP.
  - b. Also identify and list the other **state or federally funded grants** in your county/community that pertain to the risk factors and settings discussed in this RFP. Describe how the applicant agency will collaborate and not duplicate efforts of these grants.
- **Description of Progress and Experience:** Describe and document current efforts and progress made in the past four years towards preventing chronic diseases in the four settings (worksite, school, healthcare, and communities).
- **Community Partnerships -- Coalition Expansion**
  - 1) List current members of your working coalition and describe their role in

implementation of the Work Plan and evaluation of the program interventions. Describe how the coalition provides strong leadership to achieve program objectives.

2) Describe subcommittees which exist under the current coalition and their role or function. Explain if there are plans to add, expand or eliminate any subcommittees to the coalition.

3) Identify and recruit at least four (4) additional coalition members who would strengthen the coalition and who will be committed to implementing formal policies, built environments and systems that will have a significant impact on the health of the residents of your target communities. List their names and the organizations they represent.

Be sure to consider high-level policy and decision makers, key community, healthcare, and professional organizations, business, community and faith-based leaders, lay person representatives of the population to be served, existing community coalitions, especially those already focusing on chronic diseases, migrant workers and academic health centers, hospitals, universities, food manufacturers and distributors, aging service organizations, parks and recreation departments, transportation, city planners, law enforcement, consumer groups and the media.

**5. CHCP Work Plan for 2010 (See Attachment C): Community-Based Expansion**

- Using the template provided in Attachment C, page 30, develop a Work Plan for each of the target communities. Identify long term Impact Objectives that address each of the **four** settings, each of the **three** risk factors and each of the **five** chronic diseases.
- Identify **one (1) new** target community and provide data to explain how this community was selected.
- The Work Plan should identify and address objectives for **up to three (3)** target communities, including the one new community.
- Impact and Process Objectives must be written in **SMART** (Specific, Measurable, Achievable, Relevant, and Time-framed) format and emphasize population-based, evidence-based interventions. See Appendix 4, pages 38-41 for more information on SMART objectives.
- **Population-Based:** Objectives and activities must be population-based and emphasize policy, environmental and systems changes specific to the high need populations to be addressed. Refer to Appendix 5, page 42 for an explanation of population-based interventions.

- **Evidence-Based:** The objectives and activities discussed in your work plan should be proven to be effective. Impact and Process objectives and activities should reflect evidence-based strategies as shown in Appendix 6, page 43. Discuss how your activities were selected and where they rank on the evidence-based list. Also see <http://www.cdc.gov/NCCDPHP/DNPAO/Publications/index.html> for the CDC's *Recommended Community Strategies for Obesity Prevention* for additional evidence-based activities.

## 6. Healthy Communities Checklists: Community-Based Expansion

- Write **one** Impact Objective describing the process you plan to follow to complete a Healthy Communities Checklist and a SWOT analysis for **each** of the target communities. In this one Impact Objective, write **one process objective per community** detailing who will be responsible, and when and how the HC checklist and SWOT analysis will be completed for each target community.
  - **ONLY funded** applicants will submit the completed HC checklists and SWOT analysis. The HC Checklist will be provided by ODH.
  - The HC checklists and SWOT analysis must be submitted with the 2<sup>nd</sup> Quarterly Report. This HC Checklist will be used when developing the Work Plans through 2014 for comparison and evaluation purposes.
    - Using input from your coalition and other stakeholders complete a SWOT analysis for each target community.
      - A SWOT analysis must first start with defining a desired end state or objective.
      - **Strengths:** attributes of the county or coalition that is helpful to achieving the objective.
      - **Weaknesses:** attributes of the county or coalition that is harmful to achieving the objective.
      - **Opportunities:** *external* conditions that is helpful to achieving the objective.
      - **Threats:** *external* conditions which could do damage to the program's performance.
- F. Civil Rights Review Questionnaire - EEO Survey:** The Civil Rights Review Questionnaire (EEO) Survey is a part of the Application Section of GMIS 2.0. Subgrantees must complete the questionnaire as part of the application process. This questionnaire is submitted automatically with each application via the Internet.
- G. Attachment(s):** Attachments are documents deemed necessary to the application that are not a part of the GMIS 2.0. Attachments that are non-Internet compatible must be postmarked or received on or before the application due date. An original and the required number of copies of non-Internet compatible attachments must be mailed to

the ODH, Grants Administration, Central Master Files address on or before **4:00 pm, October 5, 2009**. All attachments must clearly identify the authorized program name and program number.

- H. Electronic Funds Transfer (EFT) Form:** Print in PDF format and mail to ODH, Grants Administration, Central Master Files address. The completed EFT form **must be** dated and signed, in blue ink, with original signatures. Submit the original and one copy. **(Required only if new agency, thereafter only when banking information has changed.)**
- I. Internal Revenue Service (IRS) W-9 and Vendor Forms:** Print in PDF format and mail to ODH, Grants Administration, Central Master Files address. The completed IRS W-9 form **must be** dated and signed, in blue ink, with original signatures. Submit the original and one copy. **(Required if new agency, thereafter only when tax identification number or agency address information has changed.) One of the following forms must accompany the IRS, W-9:**
- **Vendor Information Form (New Agency Only), or**
  - **Vendor Information Change Form (Existing Agency with tax identification number, name and/or address change(s).)**
  - **Change request in writing on Agency letterhead (Existing Agency with tax identification number, name and/or address change(s).)**

Print in PDF format and mail to ODH, Grants Administration, Central Master Files address. The completed appropriate Vendor Form **must be** dated and signed, in blue ink, with original signatures. Submit the original and one copy of each.

- J. Public Health Impact Statement Summary:** Submit two (2) copies of a one-page program summary regarding the impact to proposed grant activities on the Local Health Districts Improvement Standards **(for competitive cycle only; for continuation, only if changed)**.
- K. Public Health Impact:** Submit two copies of the response/statement(s) of support from the local health district(s) to your agency's communication regarding the impact of the proposed grant activities on the Local Health Districts Improvement Standards. If a statement of support from the local health district is not available, indicate that and submit a copy of the program summary your agency forwarded to the local health district(s) **(for competitive cycle only; for continuation, only if changed)**.
- L. Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations **must** submit documentation validating current liability coverage. Submit two copies of the Certificate of Insurance Liability **(Non-Profit Organizations only; current liability coverage and thereafter at each renewal period.)**

**M. Non-Profit Organization Status:** Non-profit organizations **must** submit documentation validating current status. Submit two copies of the Internal Revenue Services (IRS) letter approving non-tax exempt status (**Non-Profit Organizations only; for competitive cycle only; for continuation, only if changed.**)

**N. Declaration Regarding Material Assistance/Non-Assistance to a Terrorist Organization (DMA) Questionnaire:** The DMA is a questionnaire that must be completed by all non-governmental grant applicant agencies to certify that they have not provided “material assistance” to a terrorist organization (Sections 2909.32, 2909.33 and 2909.34 of the Ohio Revised Code). The completed DMA Questionnaire **must be** dated and signed, in blue ink, with the Agency Head’s signature. The DMA Questionnaire (in PDF format. [Adobe Acrobat](http://www.adobe.com/products/acrobat) is required) is located at the Ohio Department of Public Safety /Ohio Homeland Security Web site: <http://www.publicsafety.ohio.gov/links/HLS0038.pdf>

- Print a hard copy of the form once it has been downloaded. The form must be completed in its entirety and your responses must be truthful to the best of your knowledge. (**Required by all Non-Governmental Applicant Agencies.**)

**O. Attachments as Required by Program.**

1. Attachment A – Personnel/Position, Percent of Time Devoted to and Paid by Grant and Function
2. CV or Resumes for all personnel on grant
3. Attachment B or C – Creating Healthy Communities Program Work Plan
4. Attachment D- Demographics Table
5. Letters of Support
6. Statement of Intent to Pursue Health Equities Strategies

**III. ATTACHMENTS**

- A. Personnel/Position, Percent of Time Devoted to and Paid by Grant/Function
- B. Tier I 2010 Creating Healthy Communities Work Plan
- C. Tier II 2010 Creating Healthy Communities Work Plan
- D. Demographics Table: Tier I and Tier II

**IV. APPENDICES**

1. GMIS 2.0 Training Form
2. Population Counts and Estimates
3. Application Review Criteria
4. Guidelines for Completing the Creating Healthy Communities Work Plan
5. Population-Based Interventions
6. Evidence-Based Public Health Interventions
7. Program Definitions
8. Ranking by County of Estimated Persons Below Poverty
9. Ranking by County of Percent Below Poverty Level (2007)
10. Ranking of Ohio Counties by Number of Deaths from Selected Chronic Disease, Ohio, 2006

**ATTACHMENT A**

**PERSONNEL/POSITION, PERCENT OF TIME DEVOTED TO AND PAID BY GRANT,  
AND FUNCTION**

<b>Person/Position**</b>	<b>% of Time</b>	<b>% of Time Paid by the Grant</b>	<b>Function</b>

***\*\*Attach a CV/Resume for each staff person on this grant.***

**Tier I Applications – Capacity-Building**

**2010 Creating Healthy Communities Work Plan**

\_\_\_\_\_ County \_\_\_\_\_ Community

**Type of Objective:** \_\_\_\_\_ Coalition Development \_\_\_\_\_ Healthy Communities Checklist \_\_\_\_\_ Training \_\_\_\_\_ Intervention

**Settings:** \_\_\_\_\_ Community \_\_\_\_\_ Health Care \_\_\_\_\_ School \_\_\_\_\_ Worksite

**Risk Factor:** \_\_\_\_\_ Nutrition/Obesity \_\_\_\_\_ Physical Activity \_\_\_\_\_ Tobacco

**Chronic Disease:** \_\_\_\_\_ Heart disease \_\_\_\_\_ Cancer \_\_\_\_\_ Stroke \_\_\_\_\_ Diabetes \_\_\_\_\_ Chronic Lower Respiratory Disease

*Copy additional pages*

Long Term Objective:					
_____					
Program Impact Objective:					
_____					
Impact Evaluation Indicator:					
_____					
Process Objectives	Related Activities	Agency or Person Responsible	Specific Dates for Each Activity		Evaluation Measures
			Start	End	

**Tier II Applications – Community-Based Expansion**

**2010 Creating Healthy Communities Work Plan**

\_\_\_\_\_ County \_\_\_\_\_ Target Community

Type of Objective: \_\_\_\_\_ Coalition Expansion \_\_\_\_\_ Healthy Communities Checklist

Setting: \_\_\_\_\_ Community \_\_\_\_\_ Health Care \_\_\_\_\_ School \_\_\_\_\_ Worksite

Risk Factor: \_\_\_\_\_ Nutrition/Obesity \_\_\_\_\_ Physical Activity \_\_\_\_\_ Tobacco

Chronic Disease: \_\_\_\_\_ Heart disease \_\_\_\_\_ Cancer \_\_\_\_\_ Stroke \_\_\_\_\_ Diabetes \_\_\_\_\_ Chronic Lower Respiratory Disease

*Copy additional pages*

Long Term Objective:					
Program Impact Objective:					
Impact Evaluation Indicator:					
Process Objectives	Related Activities	Agency or Person Responsible	Specific Dates for Each Activity		Evaluation Measures
			Start	End	

Demographics Table: Tier I and Tier II

<http://factfinder.census.gov>

Target Community: City

Zip /Census Tract

Demographic	Category	Number	Percent
Total population	All residents		
Gender	Male		
	Female		
Age	Under 1 year		
	1 – 4 years		
	5 – 9 years		
	15 – 19 years		
	25 – 34 years		
	35 – 44 years		
	55 – 64 years		
	65 years and older		
Race	White		
	African American or Black		
	Hispanic		
	Non Hispanic		
	American Indian/Alaskan Native		
	Native Hawaiian/Pacific Island		
	Asian		
Education	Less than 8 <sup>th</sup> grade		
	High school graduate		
	Bachelors degree or higher		
Families below poverty	Families below poverty level		
	Individuals below poverty		

Ohio Department of Health

GMIS 2.0 TRAINING

ALL INFORMATION REQUESTED MUST BE COMPLETED FOR EACH EMPLOYEE FROM YOUR AGENCY WHO WILL ATTEND A GMIS 2.0 TRAINING SESSION.

(Please Print Clearly or Type)

Grant Program \_\_\_\_\_ RFP Due Date \_\_\_\_\_

County of Applicant Agency \_\_\_\_\_

Federal Tax Identification Number \_\_\_\_\_

NOTE: The applicant agency/organization name must be the same as that on the IRS letter. This is the legal name by which the tax identification number is assigned and as listed, if applicable, currently in GMIS.

Applicant Agency/Organization \_\_\_\_\_

Applicant Agency Address \_\_\_\_\_

Agency Employee to Attend Training \_\_\_\_\_

Telephone Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

GMIS 2.0 Training Authorized by \_\_\_\_\_

(Signature of Agency Head or Agency Fiscal Head)

REQUIRED

Please Check One: \_\_\_\_\_ Yes – I ALREADY have access to the ODH GATEWAY (SPES, ODRS, LHS, etc.)

\_\_\_\_\_ No – I DO NOT have access to the ODH GATEWAY

Please indicate your training date choices: 1<sup>st</sup> choice \_\_\_\_\_ 2<sup>nd</sup> choice \_\_\_\_\_ 3<sup>rd</sup> choice \_\_\_\_\_

Mail, E-mail or Fax to:

GAIL BYERS
Grants Administration Unit
Ohio Department of Health
246 North High Street
Columbus OH 43215
E-mail: gail.byers@odh.ohio.gov
Fax: 614-752-9783

CONFIRMATION OF YOUR GMIS 2.0 TRAINING SESSION WILL BE E-MAILED TO YOU

**POPULATION COUNTS AND ESTIMATES**

**TABLE 2: COUNTIES RANKED BY 2007 POPULATION ESTIMATE**

Rank	Area	Population	Percent	Rank	Area	Population	Percent
	Ohio	11,466,917	100.0%	44	Knox	58,961	0.5%
				45	Seneca	56,705	0.5%
1	Cuyahoga	1,295,958	11.3%	46	Ashland	54,902	0.5%
2	Franklin	1,118,107	9.8%	47	Pickaway	53,809	0.5%
3	Hamilton	842,369	7.3%	48	Darke	52,205	0.5%
4	Summit	543,487	4.7%	49	Shelby	48,834	0.4%
5	Montgomery	538,104	4.7%	50	Union	47,234	0.4%
6	Lucas	441,910	3.9%	51	Auglaize	46,429	0.4%
7	Stark	378,664	3.3%	52	Logan	46,279	0.4%
8	Butler	357,888	3.1%	53	Crawford	44,227	0.4%
9	Lorain	302,260	2.6%	54	Brown	43,956	0.4%
10	Mahoning	240,420	2.1%	55	Clinton	43,071	0.4%
11	Lake	233,392	2.0%	56	Highland	42,653	0.4%
12	Trumbull	213,475	1.9%	57	Fulton	42,562	0.4%
13	Warren	204,390	1.8%	58	Preble	41,739	0.4%
14	Clermont	193,490	1.7%	59	Madison	41,499	0.4%
15	Medina	169,832	1.5%	60	Holmes	41,369	0.4%
16	Delaware	160,865	1.4%	61	Ottawa	41,084	0.4%
17	Licking	156,985	1.4%	62	Mercer	40,888	0.4%
18	Portage	155,869	1.4%	63	Guernsey	40,409	0.4%
19	Greene	154,656	1.3%	64	Champaign	39,522	0.3%
20	Fairfield	141,318	1.2%	65	Defiance	38,543	0.3%
21	Clark	140,477	1.2%	66	Williams	38,378	0.3%
22	Richland	125,679	1.1%	67	Coshocton	36,341	0.3%
23	Wood	125,399	1.1%	68	Perry	34,839	0.3%
24	Wayne	113,554	1.0%	69	Putnam	34,635	0.3%
25	Columbiana	108,698	0.9%	70	Morrow	34,520	0.3%
26	Allen	105,233	0.9%	71	Jackson	33,314	0.3%
27	Ashtabula	101,141	0.9%	72	Hardin	31,650	0.3%
28	Miami	101,038	0.9%	73	Gallia	30,841	0.3%
29	Geauga	95,029	0.8%	74	Hocking	28,959	0.3%
30	Tuscarawas	91,398	0.8%	75	Henry	28,931	0.3%
31	Muskingum	85,333	0.7%	76	Van Wert	28,889	0.3%
32	Erie	77,323	0.7%	77	Carroll	28,516	0.2%
33	Scioto	75,958	0.7%	78	Fayette	28,308	0.2%
34	Ross	75,398	0.7%	79	Adams	28,160	0.2%
35	Hancock	74,204	0.6%	80	Pike	27,918	0.2%
36	Jefferson	68,730	0.6%	81	Meigs	22,895	0.2%
37	Belmont	67,908	0.6%	82	Wyandot	22,471	0.2%
38	Marion	65,248	0.6%	83	Paulding	19,182	0.2%
39	Athens	63,275	0.6%	84	Harrison	15,506	0.1%
40	Lawrence	62,609	0.5%	85	Morgan	14,613	0.1%
41	Washington	61,576	0.5%	86	Monroe	14,258	0.1%
42	Sandusky	60,997	0.5%	87	Noble	14,096	0.1%
43	Huron	59,801	0.5%	88	Vinton	13,372	0.1%

Source: U.S. Bureau of the Census. Prepared by: Policy Research & Strategic Planning, Ohio Dept.

of Development (DL & JH, 3/08).

## APPLICATION REVIEW CRITERIA

Applications will be reviewed and scored by program staff, and internal and external reviewers based on the review criteria listed below. A total of 125 points are allowed. Scores will be based on an average of all reviewers' scores. Grants with scores of **70** or higher will be ranked and considered for funding. For those grants scoring **70** or higher, additional points will be awarded based on the county's high need population. See Appendix 8 for an explanation of the formula used to determine the county rankings.

### **Tier I -- Capacity Building**

#### **Executive Summary (5 Points)**

- ✓ Identifies as Tier I and amount of funding for the application
- ✓ Identifies target community(ies)
- ✓ Provides a one-page summary of the 2010 plan, objectives, target communities, settings to be addressed, and description of how activities will be evaluated
- ✓ Executive summary is no more than two pages

#### **Description of Applicant Agency/Documentation of Eligibility/Personnel (20 Points)**

- ✓ Discusses agency's eligibility to apply including a brief description of previous experience with chronic disease, three risk factors, four settings, and population-based interventions
- ✓ Adequately summarizes the agency's structure as related to this program and how the agency will manage the program
- ✓ Describes capacity to communicate in a manner easily understood by diverse audiences
- ✓ Noted personnel or equipment deficiencies
- ✓ Describes plans for hiring and training
- ✓ Delineates all personnel who will be involved in the program activities
- ✓ Attachment A, Personnel/Position form is completed
- ✓ Resume/CV included for each staff person on the grant
- ✓ Adequately describes the relationship between program staff and other partners/agencies who are working on this program
- ✓ Proposes full-time project coordinator who appears qualified to manage the program

#### **Problem/Need (25 Points)**

- ✓ Identifies and clearly described local health status concerns
- ✓ State and local data was discussed
- ✓ Target communities are clearly identified
- ✓ Clearly describes segments of the target population who have the greatest burden of chronic disease
- ✓ Attachment D--Demographics Table for each target community/zip code/census tract completed
- ✓ Clearly describes how program activities will address health disparities

#### **Partnerships (15 Points)**

- ✓ Three Letters of Support or commitment included
- ✓ Identifies other agencies/organization which address the same risk factors/chronic diseases

- ✓ Describes how the program will collaborate with these programs
- ✓ Identifies other state or nationally funded programs which address the same risk factors
- ✓ Clearly describes how they will collaborate with these programs

#### **CHC Work Plan for 2010 (30 Points)**

- ✓ The Work Plan includes four impact objectives; 1) Coalition Development; 2) Completing the Healthy Community Checklist; 3) Conducting one training; and, 4) Conducting one community intervention.
- ✓ Work Plan addressed all four settings and at least one of the three risk factors.
- ✓ Evidence-based objectives and activities proposed
- ✓ Evaluation measures are appropriate

#### **Coalition Development (5 Points)**

- ✓ Objective describes how new coalition will be formed in first three months
- ✓ Members are key stakeholders and are representative of their target community
- ✓ Three Letters of Commitment submitted

#### **Healthy Community Checklist (5 Points)**

- ✓ Objective describes how the Community Needs assessment will be completed during the first quarter
- ✓ Discussed how SWOT analysis will be completed in first quarter

#### **Training (5 Points)**

- ✓ Training need and target community identified based on data from Community Needs assessment
- ✓ Adequately describes training topic selected and participants for train-the-trainer model
- ✓ Clearly identifies timeline for training, training evaluation indicators and plans for follow-up

#### **Intervention (5 Points)**

- ✓ Identifies evidence-based intervention and target community selected based on data from Community Needs assessment
- ✓ Identifies intervention setting and risk factors addressed
- ✓ Proposed evaluation component and continuation plan are appropriate

#### **Budget (10 Points)**

- ✓ Primary reason and justification is satisfactory and relates expenditures to Work Plan.
- ✓ Clearly describes how categorical costs are derived
- ✓ Adequately discusses the reasonableness of proposed costs
- ✓ Clearly describes the specific functions of the personnel
- ✓ Adequately explains and justifies equipment, travel, supplies, and training costs
- ✓ Personnel, Other Direct Costs, Equipment and Contracts are identified and appropriate to program scope of work
- ✓ Project Coordinator is 100% time on CHC Program
- ✓ Budget is reasonable and adequate to meet the goals and objectives of the project

\*\*\*\*\*  
\*\*\*\*\*

## **Tier II: Community-Based Expansion**

### **Executive Summary (5 Points)**

- ✓ Identifies Tier II and amount of funding for the application
- ✓ Identifies target community(ies)
- ✓ Provides a one-page summary of the 2010 plan, objectives, target communities, settings to be addressed, and description of how activities will be evaluated
- ✓ Executive summary is no more than two pages
- ✓ Describes plans to enhance and sustain existing programs in target communities

### **Description of Applicant Agency/Documentation of Eligibility/Personnel (15 Points)**

- ✓ Discusses agency's eligibility to apply including a brief description of previous experience with chronic disease, three risk factors, four settings, and population-based interventions
- ✓ Summarizes the agency's structure as related to this program and how the agency will manage the program
- ✓ Describes capacity to communicate in a manner easily understood by diverse audiences
- ✓ Noted personnel or equipment deficiencies
- ✓ Describes plans for hiring and training
- ✓ Delineates all personnel who will be involved in the program activities
- ✓ Attachment A – Personnel/Position Form is completed
- ✓ Resume/CV included for each staff on the grant
- ✓ Adequately describes the relationship between program staff and other partners/agencies who are working on this program
- ✓ Proposes full-time project coordinator appears qualified to manage the program

### **Problem/Need (20 Points)**

- ✓ Identifies and clearly describes local health status concerns
- ✓ State and local data is discussed
- ✓ Target communities are clearly identified
- ✓ Clearly describes segments of the target population who have the greatest burden of chronic disease
- ✓ Attachment D -- Demographics Table for each target community/zip code/census tract complete
- ✓ Clearly describes how program activities will address health disparities

### **Partnerships (15 Points)**

- ✓ Three Letters of Support or commitment included
- ✓ Identifies other agencies/organization that address the same risk factors/chronic diseases
- ✓ Clearly describes how the program will collaborate with these programs
- ✓ Identifies other state and nationally funded programs which address the same risk factors
- ✓ Clearly describes how they will collaborate with these programs

### **Description of Progress and Experience (5 points)**

- ✓ Clearly documents current efforts and progress made towards preventing chronic diseases in the four settings

### **Community Partnerships-Coalition Expansion (15 points)**

- ✓ Identifies members of coalition and adequately describes role in work plan implementation and evaluation.
- ✓ Describes how coalition provides leadership for program objectives.
- ✓ Describes how coalition will be strengthened and who will be approached to expand coalition.
- ✓ Discusses plans to include high-level decision makers.
- ✓ Describes subcommittees which exist and their role/function and any plans to expand subcommittees to the coalition

### **Creating Healthy Communities Work Plan (30 Points)**

- ✓ For each target community, Impact objective addresses each of the four settings, three risk factors, and five chronic diseases
- ✓ Identifies one **new** target community and provides data explaining how it was selected
- ✓ Work Plan identifies and addresses objectives for up to 3 (three) target communities, including the one new community
- ✓ Objectives are SMART
- ✓ Objectives and activities are population-based
- ✓ Objectives and activities are evidence-based and ranked using information in Appendix 6.
- ✓ Evaluation measures are appropriate

### **Healthy Community Checklist (10 Points)**

- ✓ One Impact Objective describes how the Checklist will be completed during the first quarter
- ✓ Discusses how SWOT analysis will be completed in first quarter

### **Budget (10 Points)**

- ✓ Primary reason and justification is satisfactory and relates expenditures to Work Plan
- ✓ Adequately describes how categorical costs are derived
- ✓ Clearly discusses the reasonableness of proposed costs
- ✓ Clearly describes the specific functions of the personnel
- ✓ Adequately explains and justifies equipment, travel, supplies, and training costs
- ✓ Personnel, Other Direct Costs, Equipment and Contracts are identified and appropriate to program scope of work
- ✓ Project Coordinator is 100% time on CHC Program
- ✓ Budget is reasonable and adequate to meet the goals and objectives of the project.

## GUIDELINES FOR COMPLETING THE CHC WORKPLAN

**Impact and Process Objectives must be written in SMART (Specific, Measurable, Achievable, Relevant, and Time-Framed) format and emphasize population-based interventions. Visit <http://66.156.96.194/BGMISBroadband/BGMIS/Welcome.aspx> to test if your objectives are SMART.**

- **Specific** -- Identifies a specific event of action that will take place or change that will occur. Who is expected to change or benefit?
  - **Measurable** -- It quantifies the number of events or the amount of change to be achieved. What or how much is expected? Measurable objectives use action verbs such as “establish,” “enact,” “train,” “adopt,” “commit,” “institute,” or “organize.”
  - **Achievable** -- Realistic given available resources and plans for implementation, yet challenging enough to accelerate program efforts. Uses baseline measures to assist in estimating potential success.
  - **Relevant** -- It is logical and relates to the program’s goals. It is sufficiently meaningful and important. Considers the financial and human resources and the cost benefit of the intervention.
  - **Time Framed** -- It specifies a time by which the objective will be achieved. When will the event or change occur?

### 1. Long Term Objective: Complete one long term objective for each of the four settings.

An example of a long term objective for the school setting is: By December, 2014, 100 percent of the schools in the target community will adopt and implement at least four policies for nutrition, physical activity, tobacco, and/or the clinical risk factors.

### 2. Year One Program Impact Objectives

- Complete a separate Work Plan page for each program impact objective.
- Components of Objectives
 

Who?	The group of people or system expected to change.
What?	The action or changes in behavior, health practice or system change to be achieved.
Where?	The location of the activity.
How Much?	The extent of the change to be achieved.
By When?	The time in which the change is expected to occur.
- Impact objectives can specify health outcomes, behavioral outcomes or environmental outcomes.
- Objectives should describe the desired program outcome on the intermediate and/or primary target populations.
- A generic format for a system outcome objective is:
 

By     (date)    ,     (system)     will     (specify how system will change)     as measured or evaluated by     (how you will determine that the desired change has occurred)    .

*Example: By June 20, 2010 one school district will adopt a policy to make physical activity a part of the daily schedule for all K-8 buildings.*

*Example: By October 30, 2010 one new community garden will be created near a subsidized housing project.*

*Example: By December 31, 2010, 50 percent of the four family practice offices will utilize the Ounce of Prevention program with their pediatric (0-6 years) patients.*

*Example: By December 31, 2010, 3 community churches will implement policies to make healthy foods available during church-related functions.*

*Example: By October 30, 2010, 2 worksites will adopt a 100 percent tobacco-free campus policy.*

### **3. Impact Evaluation Indicator**

Briefly state the impact evaluation indicator as defined in the objective. What will tell you whether or not you have achieved your program impact objective? What changes will have occurred, i.e., policy adopted, systems change is in place, resources/facilities available in the community, practices adopted, trained personnel hired, or referrals increased.

*Example: Four family practice offices have identified 40 patients with elevated blood pressure and diabetes and have scheduled 80 percent of them for follow-up visits.*

*Example: Three faith-based organizations have policies approved by their Council for healthy food options during all faith-based related functions.*

### **4. Process Objectives**

For each Impact Objective write Process Objectives which are the intermediate steps or specific, measurable actions that need to be completed in a specific timeframe. They explain what you are going to do and when you are going to do it.

Sample 1: By October 31, 2010, 80 percent of clinic nurses and office staff in four family practice offices will be trained on current guidelines for hypertension, diabetes, and cholesterol by the CHC Program.

Activities:

- a. Meet with Office Manager to set up training date.
- b. Prepare handouts and presentation for training.
- c. Assess current level of knowledge with attendees.
- d. Conduct training.
- e. Evaluate gain of knowledge of guidelines.
- f. Follow up with offices regarding use of guidelines.

Sample 2: By December 31, 2010, the CHC Program will assist the ACME vending company in implementing the nutrition policy for the nine YMCA's which will increase healthy options from 30 percent to 100 percent.

Activities:

- a. Provide nutrition information supporting healthy vending choices.

- b. Educate YMCA staff on the importance of vending policy and having healthy options available for patrons.
- c. Provide technical assistance to implement healthy vending policy.
- d. Provide signage and other supportive materials to YMCA promoting healthy vending options.
- e. Utilize the media to promote the vending initiative through PSA's, newsletter articles, etc.
- f. Measure usage and sales data to determine increase in healthy vending options.

Sample 3: By December 31, 2010, the CHC Program will facilitate the development of one worksite wellness policy in three local worksites.

Activities:

- a. Collaborate with coalition partners to identify a minimum of three worksites willing to develop a policy at their worksite.
- b. Schedule meeting with Human Resources, Business Department and Occupational Health Nurse to review benefits of worksite wellness.
- c. Complete Worksite Assessment tool for baseline data.
- d. Identify area the worksite team wants to start developing strategies and policies to improve.
- e. Provide technical assistance and resources to worksite as they progress.
- f. Assist in developing policy.
- g. Assist with policy implementation.
- h. Evaluate the impact of the policy on the employees.

Sample 4: By August 30, 2010, the CHC Program coalition, School Subcommittee, and school health teams will work together to increase the School Health Index score in Nutrition, Physical Activity and Tobacco by at least one point in all of the school districts.

Activities:

- a. Assist schools that are developing wellness centers at school for their staff and community.
- b. Assist schools in creating alternatives to candy as fund raisers and rewards.
- c. Assist local school in developing a walking trail at their school for staff, students, and community members.
- d. Assist school in finding creative ways to implement walking and physical activity into the existing curriculum.
- e. Assist schools in removing candy sales from their cafeterias.
- f. Promote district-wide staff training opportunity for physical education teachers.
- g. Identify other training and technical assistance needs that schools require to adequately meet the goals of their action plans.
- h. Reassess School Health Index and determine score changes in Nutrition, Physical Activity and Tobacco sections.

**5. Related Activities,** specific name of Agency/Person Responsible, Specific beginning and ending dates throughout the year, and Evaluation Measures. **Related activities should reflect Evidence-based interventions as described in Appendix 5, page 43 for each of the four settings.**

## **6. Agency or Person Responsible**

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

## **7. Evaluation Measure(s)**

Evaluation can help to identify needed changes, find out how well objectives are being met, determine the effects of the program, and identify ways to improve to the program.

**Tier II: Creating Healthy Communities Coordinators** will receive training during Year 1 to develop a comprehensive evaluation plan for Year 2.

## **Evaluation Measures for Process Objectives & Activities**

With the work plan, include a brief description of the evaluation measure/indicator for each Process Objective.

As you develop the evaluation measures/indicators consider what criteria and methods are acceptable to your stakeholders.

After the measures/indicators are developed, gather and record data carefully. Then, share, report, and use the data to make decisions or improve the program.

Examples of evaluation measures/indicators:

### **1. Records**

- Absenteeism, participation in voluntary programs
- Utilization of fitness facility or health center services
- Proficiency exam scores
- Record keeping systems developed for specific purpose, e.g. phone call logs, cost analysis, self-completed logs of activity
- Physical measures, e.g. HBP, cholesterol, strength, flexibility, aerobic capacity, BMI percentile
- Documentation, e.g. written policy, adoption of curriculum, meeting minutes, news clippings, medical records, police records

### **2. Observations**

- Behavior, e.g. smoking on grounds, bike helmet usage, food choices, amount of time spent in activity during physical education class, plate waste, purchasing healthy vending items
- Environment, e.g. educational messages, posters, cleanliness, safety, improved lighting
- Photographs, e.g. before and after pictures of walking paths, and recreation areas.

### **3. Questions/surveys/questionnaires/interviews**

- Paper-pencil tests
- Face-to-face interviews
- Phone interviews
- Focus groups
- Key opinion leaders input
- Community forums
- Survey Monkey

## POPULATION-BASED INTERVENTIONS

Population-based interventions refer to planned and systematic activities that create change in social systems and environmental conditions at the community level that will influence and support individual behavior change.

**Population-based interventions include the following categories:**

- A. **Policy Adoption** – steps taken or facilitated by program staff to bring about development or change of policy. Some examples include policies for regular calibration of blood pressure equipment, local school board policy to allow adults access to school facilities for physical activity, referral policy for CVH risk factors among health organizations, vending machine policy to offer more healthy options, alternative to suspension policies in schools, etc.
- B. **Environmental or Systems Change** – steps taken or facilitated by program staff to bring about changes in the county environment or community or organizational systems. For example, marked walking routes in communities or at worksites, restaurants featuring healthy options, signs promoting use of stairs instead of elevators, etc.
- C. **Training** – steps taken or facilitated by program staff to train individuals to provide services that will extend beyond the project period. For example, recruit and train instructors for health education programs, standardize blood pressure measurement practices, develop and support networks of parish nurses, train health professionals on appropriate screening techniques and interventions for childhood overweight, etc.
- D. **Resource/Facility Availability** -- steps taken or facilitated by program staff to develop new or expand existing services or facilities to priority populations that will extend beyond the project period, e.g., smoking cessation services, hypertension or diabetes referral and counseling services available for high-risk populations, making malls available before/after store hours for walking programs, etc.

### **For Tier I only:**

**Supplemental Activities** are intended to support primary population-based activities. Supplemental activities include **direct** education/services, media campaigns, information dissemination and support. They can enhance and complement primary activities, but are not meant as stand-alone initiatives. These activities should be kept to a minimum.

## Evidence-Based Public Health Interventions

Evidence-Based Public Health interventions are defined as the use of agreed-upon standards of evidence in making decisions about public health policies and practices to protect or improve the health of populations. They provide a base to increase the *effectiveness, impact and cost-effectiveness* of public health activities which lead to improved health outcomes. As the public health arena becomes more competitive for federal, state, and local dollars, it is important to use evidence-based disease prevention and health promotion interventions. Does what you do work?

The CDC Community Guide <http://thecommunityguide.org> lists categories of Recommended, Insufficient Evidence, or Not Recommended for numerous activities. This Guide is known as the gold standard for evidence-based public health. Note that a determination of “Insufficient evidence to determine effectiveness” does not mean that the intervention does not work, but rather indicates that additional research is needed to determine whether or not the intervention is effective.

Other resources:

- Recommended Community Strategies and Measurements to Prevent Obesity in the United States: Implementation and Measurement Guide, July 2009  
<http://www.cdc.gov/NACCDPHP/DNPAO/Publications/index.html>
- Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent Obesity in the United States. MMWR 2009; 58 (No. RR-7); 1 – 27. [www.cdc.gov/mmwr](http://www.cdc.gov/mmwr)
- <http://www.preventioninstitute.org/sa/policies/>
- Partnership for Prevention *Investing in Health: Evidence-Based Health Promotion Practices for the Workplace*  
<http://www.prevent.org/content/view/133>
- Partnership to Fight Chronic Disease, A Vision for a Healthier Future : Promising Practices <http://promisingpractices.fightchronicdisease.org/programs>
- *Healthier Schools: A Brighter Tomorrow: Evidence Based practices to Jump Start Ohio School Wellness Plans* [www.ode.state.oh.us](http://www.ode.state.oh.us)
- *Nutrition and Physical Activity Guide: A Policy Resource Guide*  
<http://www.doh.wa.gov/cfh/steps/default.htm>
- Ohio Public Health and Health Promotion Library <http://www.ohplibrary.org>
- <http://www.center-trt.org/index.cfm?fa=evidence.overview>
- SAMHSA - National Registry of Evidence-based Programs and Practices (NREPP) <http://nrepp.samhsa.gov/>

- Cancer Control PLANET- <http://cancercontrolplanet.cancer.gov/> (Look under Research-tested Intervention Programs [RTIPs])

**A-Level Interventions—Strong Evidence that the intervention works. These are sustainable, replicable programs that have demonstrated health improvements, a positive impact on costs, and/or achieved other stated outcomes.**

### **Physical Activity**

Informational approaches to increasing physical activity

- Community-wide campaigns
- Provide after hours access to recreational facilities to students, faculty, staff and community members.
- Improve the transportation infrastructure, e.g. crosswalks, sidewalks, around schools and on school routes.

- Point of decision prompts, e.g. stairwell signs, vending machine labels

Behavioral and social approaches to increasing physical activity

- Require School-based physical education
- Increase the amount of physical activity in physical education programs in schools
- Increase opportunities for extracurricular physical activity
- Social support interventions in community settings
- Individually-adapted health behavior change
  - Active For Life
  - Enhance Fitness

Environmental and policy approaches to increasing physical activity

- Reduce screen time in public service venues
- Improve access to outdoor recreational facilities
- Enhance infrastructure supporting bicycling
- Enhance infrastructure supporting walking
- Support locating schools within easy walking distance of residential areas
- Improve access to public transportation
- Zone for mixed-use development
- Enhance personal safety in areas where persons are or could be physically active
- Enhance traffic safety in areas where persons are or could be physically active
- Participate in community coalitions or partnerships to address obesity
- Policy adoption for public land use for nutrition/physical activity use
- Creation of or enhanced access to places for physical activity combined with informational outreach activities
- Provide funding of a network of paved pedestrian and bicycle paths that serve as an alternative to roadways and as a way to travel through neighborhoods, shopping, parks, and schools
- Safe Routes to Schools
- Provide funding for transportation to increase access to existing physical activity programs for underserved populations
- Point of decision prompts

- Street-scale urban design and land use policies and practices
- Community-scale urban design and land use policies and practices
- Provide incentives to encourage employers to provide wellness programs that have significant physical activity components, including subsidized health club memberships
- Make as part of the employee benefit package to provide a worksite wellness program with a physical activity component.

### **Nutrition – Access to Healthy Food**

- Increase availability of healthier food and beverage choices in public service venues
- Improve availability of affordable healthier food and beverage choices in public service venues
- Improve geographic availability of supermarkets in underserved areas
- Provide incentives to food retailers to locate in and/or offer healthier food and beverage choices in underserved areas
- Improve availability of mechanisms for purchasing foods from farms
- Provide incentives for the production, distribution, and procurement of foods from local farms
- Restrict availability of less healthy foods and beverages in public service venues
- Institute smaller portion size options in public service venues
- Limit advertisements of less healthy foods and beverages
- Discourage consumption of sugar-sweetened beverages
- Increase support for breastfeeding
- Promote Farm to School programs
- Institute a farm – institution program to incorporate fresh. Local produce and other foods into cafeteria or patient meals
- Farmers Markets
- Require the creation and implementation of food pricing strategies that encourage purchase of nutritious foods by students, faculty, and staff.
- Provide price incentives for the purchase of healthy food at worksite cafeteria, snack bars, and vending machines (decrease price of healthy, increase price of unhealthy foods)
- Body Mass Index (BMI) Surveillance system
- WECAN! Ways to Enhance Children’s Activities and Nutrition-Educational Program (Train-the-trainer)
- Coordinated Approach to Child Health (CATCH) trainings

### **Healthcare Strategies**

- Work with insurance companies to offer coverage for preventative services including nutritionists
- Promote high standards of nutrition and physical activity practice to healthcare and provider associations
- Promote baby-friendly hospital policies to increase the rates of mothers who initiate and continue to breastfeed their infants
- Provide trainings to providers to conduct screening and counseling in both a culturally appropriate and sensitive manner
- Adopt standards of practice that include routine screening of all patients regarding physical activity and eating behavior

- Eliminate the co-location of fast food restaurants at hospitals and other health care facilities
- Ounce of Prevention is Worth a Pound trainings
- Medicaid coverage of obesity in children and adults

### **Heart Disease and Stroke Prevention**

- Community Health Care Workers
- Trainings for health professionals on updated blood pressure and cholesterol guidelines
- Chronic Disease Self-Management

### **Diabetes**

- Chronic Disease Self-Management Program
- Diabetes Self-Management Program (CDSMP)
- Glucose Monitoring – train-the-trainer
- Trainings for health professionals on updated diabetes guidelines

### **Tobacco**

- LifeSkills Training Curriculum
- Smoking cessation programs
- Ohio Tobacco Quit Line
- Comprehensive tobacco policies, e.g., tobacco-free campuses

**B-Level Interventions – Some Evidence that the intervention works (Promising Practices). These have some documented success, but did not have information needed to determine their full impact.**

### **Physical Activity**

Informational approaches to increasing physical activity

- Provide walking/biking maps for trails and paths
- Classroom-based health education focused on providing information
- Mass media campaigns

Behavioral and social approaches to increasing physical activity

- Classroom-based health education focused on reducing television viewing and video game playing
- Family-based social support

Environmental and policy approaches to increasing physical activity

- Transportation and travel policies and practices Require that new developments install sidewalks and internal connections to form a pedestrian and bicycle network
- Disallow the creation of cul-de-sacs and dead-end roads in new development projects.
- Create safer pedestrian and bicyclist areas by instituting traffic calming measures.
- Encourage creating mixed-use neighborhoods
- Provide incentives to encourage builders of new multi-level buildings to make stairways accessible and attractive
- Encourage housing developments near public transit hubs

- Eliminate sales tax for the purchase of exercise equipment by individuals
- Provide funding to enhance physical activity facilities at schools. (Add bike racks, install lights in outdoor fields, build walking trails, on school grounds and maintain well-equipped playing fields and physical activity centers)
- Provide funding to expand Safe Routes to School Programs
- Make stairs accessible and inviting in worksites to encourage stair use by employees.
- Provide fiscal incentives for design features in new office buildings that encourage physical activity, onsite fitness facilities, walking paths, and inviting stairways

### **Nutrition**

- School-based nutrition programs
- School gardens
- Providing incentives for grocery stores or farmers markets to locate in underserved communities
- Funding or providing bus service or transportation to farmer's markets and large grocery stores
- Nutrition standards for daycare/preschools so that all foods available are consistent with the Dietary Guidelines or other nutrition standards
- Require restaurants to provide nutrition information on menus, wrappers, menu boards, etc.
- Provide incentives for restaurants or grocery stores to adopt a nutrition labeling system to identify food items that met certain nutrition standards.
- Implement sales tax for foods of minimal nutritional value and direct accumulated funds toward health promotion
- Disallow sale of foods that compete with the National School Lunch and Breakfast Program
- Require the development and implementation of nutritional standards so that all foods and beverages available on school campuses and at school events are consistent with nutrient standards
- Provide free breakfast and/or free lunch to all students, regardless of their eligibility for free or reduced meals
- Develop a school policy that requires the establishment of salad bars in all K-12 schools
- Require that certain percent of meals offered in the worksite, hospital, or healthcare cafeteria, vending machines, and other food outlets will meet certain nutrition standards
- Posting nutrition information for all menus and food sold in worksite cafeteria, hospital or healthcare clinic, or other areas
- Adopting a nutrition labeling system to identify foods that meet certain nutrition standards
- Providing incentives to encourage employers to provide wellness programs that have significant healthy eating components
- Require or provide incentives for health insurance companies to include preventive services related to nutrition as part of their benefit packages

## Evidence-Based Interventions (continued)

### Heart Disease and Stroke Prevention

- EMS Educational trainings – train-the-trainer classes

**C-Level Interventions—These are cutting-edge efforts that may not have sufficient documented results to make the needed assessment of their impact. They are Untested Policy Ideas or Locally developed interventions\***

\*Need to provide documentation including outcomes, from this intervention that show a knowledge or behavior change has occurred.

### Nutrition

- Tax incentives for small storeowners to provide healthy food items in underserved areas.
- Provide incentives for development of community gardens on public and private land.
- Provide free water, trash pick-up and other municipal resources to community gardens.
- Provide garden space for resident use at apartment housing complexes, including low-income housing facilities.
- Provide funding to expand the Summer Food Service Program for Children
- Prohibit exclusive marketing contracts between school districts and soft drink companies.
- Schools establish criteria for purchasing from local farmers.
- Disallow marketing of food and beverages on school grounds and at school-sponsored events.
- Policy that requires schools to provide students with a reasonable minimum time to eat lunch.
- Develop a policy that requires recess to be scheduled before lunch, not after lunch.
- Establish a policy that only food meeting certain nutrition standards will be served at meetings, seminars, and workshops.
- Work with farmers markets to establish a farmer's market or community supported agriculture drop-off at the worksite.

### Physical Activity

- Improve existing public facilities to support physical activity before building additional facilities.
- Install bike racks and bike lockers near worksites, shopping centers, transit hubs, and other places that encourage the use of a bicycle for transportation.
- Require that all new building projects consider the impact of the effect on physical activity.
- Locate parking lots out of the way of pedestrian and bicycle paths.
- Encourage remodeling of existing school buildings rather than construction of new buildings
- Adapt school board recommendations to minimize the amount of land required for new school buildings.
- Require creation of walking/biking map that details safe routes students can take to school.
- Develop incentives that encourage faculty, staff, and students to commute via non-

motorized means.

- Require schools to design parking lots to minimize interference with pedestrian or bicycle traffic.
- Provide workers with shower facilities and flex time to encourage physical activity before or during the workday.
- Offer lower insurance premiums, cash rebates, vacation days, or other incentives for employees who can document participation in regular physical activity.
- Offer routine screening of patients regarding physical activity behaviors and provisions of physical activity recommendation or prescriptions.

### Program Definitions

- **Best Practices Programs** utilize STRATEGIES that have been shown to be effective. Strategies found in the *Guide to Community Preventive Services* (Community Guide) or the *Guide to Clinical Preventive Services* (Clinical Guide) provide strategies that can serve as best practices for programs. The Community Guide can be found at <http://www.thecommunityguide.org>. An example of best practices being used can be found at: <http://www.cdc.gov/tobacco/bestprac.htm>.
- **Built Environment** -- Refers to the manmade surroundings that provide the setting for human activity, from the largest-scale civic surroundings to the smallest personal place.
- **County-wide Coalition** -- Projects will maintain a coalition which includes representation from all local health departments within the county and from all settings; members from populations and communities identified as high-need as well as appropriate agencies, organizations, and providers.
- **Environmental Change** -- Refers to changes in both the social, cultural, and political environment, as well as the physical environment, at the community level; a change in organizational practice or policy.
- **Evidence-Based Programming** – The use of agreed-upon standards of evidence in making decisions about public health policies and practices to protect or improve the health of populations.
- **Evidence-based** programs have been proven to be effective in the populations and settings in which they were studied. Using an evidence-based program shortens the time it takes to develop a new program, reduces the amount of research needed, and helps focus the evaluation process.
- **Four Settings** – worksites, schools, communities, and health care sites in identified high-need communities.
- **Health Equity** – the fair distribution of health determinants, outcomes, and resources within and between segments of the population, regardless of social standing (*CDC's working definition*) Health equity means striving to eliminate **avoidable** social disparities in health and in the pre-requisites needed to be healthy.
- **Health Disparities** – differences in the overall rate of disease incidence, prevalence, mortality, disease burden, and survival rates that exist among specific population groups as compared to the health status of the general population. (*adapted from "Minority Health & Health Disparities Research & Education Act of 2000"*). Health disparities are **preventable** differences in the burden of disease, injury and violence, or opportunities to achieve optimal health experience by socially disadvantaged racial, ethnic, and other population groups and communities.
- **High-need Communities** -- “A specific group of people, often living in a defined geographical area, who share a common culture, values, and norms and are arranged in a social structure according to relationships the community has developed over time.” (*Healthy People 2010*). The program must reach, support and expand collaborative relationships, continue established coalitions, assess communities, plan, and implement strategies over the project period. Projects are expected to work collaboratively with appropriate individuals and organizations in high-need communities to plan and implement culturally specific programs.
- **High-need Populations** -- Persons at higher risk for the development of chronic diseases because of poverty or being a member of a disparate population group.
- **Intermediate Populations** -- influential persons, leaders, and decision-makers such as

school superintendents, teachers, physicians, local government officials, etc.

- **Modifiable Risk Factors**--physical inactivity, nutrition, high blood pressure, high blood cholesterol, tobacco use and exposure, and diabetes. **If the county receives funding from other sources for chronic disease risk factor reduction, representatives from these agencies should be included on the Healthy Communities Coalition to coordinate activities.**
- **Partnerships** – Bringing decision makers together to make sure indicators are used in local and regional planning processes, as well as by policy makers, businesses, organizations, diverse community members and funders.
- **Policy Change** -- A shift in the formal operations of organizations and/or governmental institutions that allows new or different activities to occur and thrive. These shifts may arise from information-sharing, community participation, professional input, compromise, and consensus-building and are usually the result of effective advocacy.
- **Research Tested** -- Research-tested is a feature of evidence-based practice. It means the program was tested in a peer reviewed and funded research study. A program may not be as effective once it leaves the research setting if there are changes in parts of the program used, the environment, or the population served. However, the program serves as a good starting place. Research-tested programs can be found on Step 4 of Cancer Control PLANET (<http://cancercontrolplanet.cancer.gov/>).
- **Social Determinants of Health** – factors in the social environment that contribute to or detract from the health of individuals and communities. These factors include, but are not limited to the following: socioeconomic status, transportation, housing, access to services, discrimination by race, gender, or class, and social or environmental stressors. Social determinants of health are the economic and social conditions under which people live which determine their health.
- **Supplemental Activities** are intended to support primary population-based activities. They can enhance and complement primary activities, but are not meant as stand-alone initiatives. **These activities should be kept to a minimum.** Supplemental activities include **direct** education/services, media campaigns, information dissemination and support.
- **Sustainability** -- Ensuring that an effort or change lasts. Note: sustainability is often misunderstood as securing further or ongoing funding for a program that otherwise would end. It is important to understand that sustainability can be achieved without ongoing funding by changing policies, norms, attitudes, etc.
- **Systems Change** -- A permanent change to the policies, practices, and decisions of related organizations or institutions in the public and/or private sector.
- **Target community** is a specific group of people, often living in a defined geographical area, who share a common culture, values, and norms and are arranged in a social structure according to relationships the community has developed over time. (*Healthy People 2010*)
- **Ultimate Population** -- Community residents without access to resources, school children, employees, parents and children in well-child clinics, and low-income families and residents with diabetes, high blood pressure and/or elevated cholesterol levels.

**Ranking by County of Estimated Persons Below Poverty**

<i>County</i>	<i>Persons, 2008</i>	<i>Percent Below Poverty Level (2007)</i>	<i>Estimated Persons</i>
Cuyahoga	1,283,925	15.7%	201,576
Franklin	1,129,067	16.2%	182,909
Hamilton	851,494	13.0%	110,694
Montgomery	534,626	14.8%	79,125
Summit	542,562	14.0%	75,959
Lucas	440,456	16.9%	74,437
Butler	360,765	11.9%	42,931
Stark	379,214	10.9%	41,334
Mahoning	237,978	16.6%	39,504
Lorain	304,373	11.2%	34,090
Trumbull	211,317	14.6%	30,852
Clark	139,859	15.5%	21,678
Athens	63,255	29.4%	18,597
Clermont	195,385	9.0%	17,585
Licking	157,721	11.0%	17,349
Portage	155,991	10.8%	16,847
Columbiana	107,873	15.1%	16,289
Lake	234,030	6.8%	15,914
Scioto	76,587	20.6%	15,777
Ashtabula	100,648	15.5%	15,600
Allen	105,168	14.5%	15,249
Richland	124,999	11.9%	14,875
Greene	159,190	9.2%	14,646
Muskingum	85,087	16.4%	13,954
Lawrence	62,573	21.9%	13,704
Wood	125,340	10.8%	13,537
Fairfield	142,223	8.9%	12,658
Jefferson	68,526	16.9%	11,581
Medina	171,210	6.7%	11,471
Tuscarawas	91,348	12.0%	10,962
Warren	207,353	5.1%	10,575
Ross	76,073	13.8%	10,498
Belmont	67,975	15.3%	10,400
Wayne	113,812	8.8%	10,016
Marion	65,768	14.6%	9,602
Miami	101,085	9.0%	9,098
Erie	77,062	11.1%	8,554
Washington	61,567	13.5%	8,312

<b>County</b>	<b>Persons, 2008</b>	<b>Percent Below Poverty Level (2007)</b>	<b>Estimated Persons</b>
Delaware	165,026	4.5%	7,426
Gallia	30,912	23.1%	7,141
Seneca	56,461	12.0%	6,775
Knox	59,324	11.3%	6,704
Huron	59,659	11.1%	6,622
Hancock	74,273	8.9%	6,610
Pickaway	54,544	11.9%	6,491
Pike	27,967	22.9%	6,404
Guernsey	40,177	15.5%	6,227
Brown	43,960	13.6%	5,979
Highland	42,349	14.1%	5,971
Sandusky	60,637	9.7%	5,882
Jackson	33,270	17.2%	5,722
Clinton	43,200	13.0%	5,616
Logan	46,220	12.1%	5,593
Crawford	43,696	12.8%	5,593
Adams	28,213	19.6%	5,530
Ashland	55,125	10.0%	5,513
Perry	35,241	14.8%	5,216
Geauga	94,753	5.4%	5,117
Hardin	31,948	15.0%	4,792
Darke	52,027	9.1%	4,735
Shelby	48,919	9.5%	4,647
Hocking	28,975	16.0%	4,636
Coshocton	35,981	12.8%	4,606
Meigs	22,722	19.8%	4,499
Holmes	41,445	10.7%	4,435
Champaign	39,650	11.0%	4,362
Madison	41,861	10.1%	4,228
Fayette	28,319	13.6%	3,851
Preble	41,643	9.1%	3,789
Defiance	38,637	9.5%	3,671
Morrow	34,455	10.2%	3,514
Ottawa	40,823	8.5%	3,470
Fulton	42,485	8.1%	3,441
Mercer	40,818	8.4%	3,429
Williams	38,158	8.9%	3,396
Auglaize	46,576	7.2%	3,354

<b>County</b>	<b>Persons, 2008</b>	<b>Percent Below Poverty Level (2007)</b>	<b>Estimated Persons</b>
Carroll	28,439	11.5%	3,271
Morgan	14,510	20.2%	2,931
Harrison	15,387	17.0%	2,616
Vinton	13,281	18.9%	2,510
Union	48,223	5.1%	2,459
Noble	14,333	16.4%	2,351
Henry	28,841	8.1%	2,336
Monroe	14,221	15.9%	2,261
Putnam	34,543	6.4%	2,211
Van Wert	28,748	7.0%	2,012
Paulding	19,096	9.4%	1,795
Wyandot	22,354	7.4%	1,654

**Ranking by County of Percent Below Poverty Level (2007)**

<i>County</i>	<i>Persons, 2008</i>	<i>Percent Below Poverty Level (2007)</i>	<i>Estimated Persons</i>
Athens	63,255	29.4%	18,597
Gallia	30,912	23.1%	7,141
Pike	27,967	22.9%	6,404
Lawrence	62,573	21.9%	13,704
Scioto	76,587	20.6%	15,777
Morgan	14,510	20.2%	2,931
Meigs	22,722	19.8%	4,499
Adams	28,213	19.6%	5,530
Vinton	13,281	18.9%	2,510
Jackson	33,270	17.2%	5,722
Harrison	15,387	17.0%	2,616
Lucas	440,456	16.9%	74,437
Jefferson	68,526	16.9%	11,581
Mahoning	237,978	16.6%	39,504
Muskingum	85,087	16.4%	13,954
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Guernsey	40,177	15.5%	6,227
Belmont	67,975	15.3%	10,400
Columbiana	107,873	15.1%	16,289
Hardin	31,948	15.0%	4,792
Montgomery	534,626	14.8%	79,125
Perry	35,241	14.8%	5,216
Trumbull	211,317	14.6%	30,852
Marion	65,768	14.6%	9,602
Allen	105,168	14.5%	15,249
Highland	42,349	14.1%	5,971
Summit	542,562	14.0%	75,959
Ross	76,073	13.8%	10,498

<b>County</b>	<b>Persons, 2008</b>	<b>Percent Below Poverty Level (2007)</b>	<b>Estimated Persons</b>
Brown	43,960	13.6%	5,979
Fayette	28,319	13.6%	3,851
Washington	61,567	13.5%	8,312
Hamilton	851,494	13.0%	110,694
Clinton	43,200	13.0%	5,616
Crawford	43,696	12.8%	5,593
Coshocton	35,981	12.8%	4,606
Logan	46,220	12.1%	5,593
Tuscarawas	91,348	12.0%	10,962
Seneca	56,461	12.0%	6,775
Butler	360,765	11.9%	42,931
Richland	124,999	11.9%	14,875
Pickaway	54,544	11.9%	6,491
Carroll	28,439	11.5%	3,271
Knox	59,324	11.3%	6,704
Lorain	304,373	11.2%	34,090
Erie	77,062	11.1%	8,554
Huron	59,659	11.1%	6,622
Licking	157,721	11.0%	17,349
Champaign	39,650	11.0%	4,362
Stark	379,214	10.9%	41,334
Portage	155,991	10.8%	16,847
Wood	125,340	10.8%	13,537
Holmes	41,445	10.7%	4,435
Morrow	34,455	10.2%	3,514
Madison	41,861	10.1%	4,228
Ashland	55,125	10.0%	5,513
Sandusky	60,637	9.7%	5,882
Shelby	48,919	9.5%	4,647
Defiance	38,637	9.5%	3,671
Paulding	19,096	9.4%	1,795
Greene	159,190	9.2%	14,646
Darke	52,027	9.1%	4,735
Preble	41,643	9.1%	3,789
Clermont	195,385	9.0%	17,585
Miami	101,085	9.0%	9,098
Fairfield	142,223	8.9%	12,658
Hancock	74,273	8.9%	6,610

<b>County</b>	<b>Persons, 2008</b>	<b>Percent Below Poverty Level (2007)</b>	<b>Estimated Persons</b>
Williams	38,158	8.9%	3,396
Wayne	113,812	8.8%	10,016
Ottawa	40,823	8.5%	3,470
Mercer	40,818	8.4%	3,429
Fulton	42,485	8.1%	3,441
Henry	28,841	8.1%	2,336
Wyandot	22,354	7.4%	1,654
Auglaize	46,576	7.2%	3,354
Van Wert	28,748	7.0%	2,012
Lake	234,030	6.8%	15,914
Medina	171,210	6.7%	11,471
Putnam	34,543	6.4%	2,211
Geauga	94,753	5.4%	5,117
Warren	207,353	5.1%	10,575
Union	48,223	5.1%	2,459
Delaware	165,026	4.5%	7,426

**Ranking of Ohio Counties by Number of Deaths from Selected Chronic Diseases, Ohio, 2006**

<b><i>County</i></b>	<b><i>Total</i></b>
Cuyahoga	7,583
Franklin	4,075
Hamilton	4,074
Montgomery	2,709
Summit	2,617
Lucas	2,403
Stark	1,981
Mahoning	1,574
Trumbull	1,375
Butler	1,370
Lorain	1,293
Lake	1,196
Clark	809
Clermont	698
Richland	664
Licking	657
Columbiana	613
Portage	613
Warren	601
Jefferson	597
Greene	587
Medina	587
Wood	585
Ashtabula	584
Allen	579
Fairfield	562
Scioto	509
Belmont	498
Tuscarawas	497
Miami	484
Wayne	482
Muskingum	462
Erie	422
Ross	378
Lawrence	372
Marion	370

<b><i>County</i></b>	<b><i>Total</i></b>
Delaware	363
Seneca	359
Geauga	356
Washington	351
Hancock	350
Sandusky	329
Knox	287
Ashland	278
Pickaway	270
Auglaize	264
Huron	264
Darke	259
Ottawa	253
Athens	251
Highland	244
Crawford	234
Logan	232
Mercer	231
Guernsey	228
Shelby	220
Jackson	216
Brown	210
Williams	197
Preble	196
Champaign	192
Fulton	191
Clinton	184
Coshocton	184
Defiance	184
Fayette	183
Madison	182
Hardin	181
Gallia	178
Van Wert	169
Meigs	168
Perry	165
Putnam	159
Union	157
Adams	156
Carroll	156

<b><i>County</i></b>	<b><i>Total</i></b>
Hocking	153
Holmes	148
Pike	145
Morrow	142
Wyandot	140
Harrison	125
Henry	108
Morgan	96
Monroe	91
Paulding	83
Vinton	73
Noble	65