



## MEMORANDUM

Date: August 1, 2012

To: Sub-grantee agencies

From: Steven A. Wagner  
Acting Chief, Division of Prevention and Health Promotion  
Ohio Department of Health

Subject: Sub-grantee Creating Healthy Communities (1/1/2013-12/31/2013)

The Ohio Department of Health (ODH), Division of Prevention and Health Promotion, Bureau of Healthy Ohio announces the availability of grant funds.

All electronic applications and attachments are due by 4:00 p.m., October 1, 2012. Applications received after the due date will not be considered for funding. Faxed, hand-delivered or mailed applications will not be accepted.

Electronic application components must be submitted via the on-line Grants Management Information System 2.0 (GMIS 2.0). For new staff requiring GMIS 2.0 access, you must successfully complete GMIS 2.0 training.

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

Submission of the continuation application constitutes acknowledgment and acceptance of ODH Grants Administration Policies and Procedures (GAPP) Manual rules and any other program-specific requirements as outlined in the competitive Request for Proposal (RFP). Budget Period: 1/1/2013-12/31/2013 for total program period, 1/1/2010-12/31/2014. Reference the competitive RFP for more information. The competitive RFP for this grant program can be found on the ODH Web site ([www.healthyohioprogram.org](http://www.healthyohioprogram.org)).

If you have questions, please contact Ann Weidenbenner, at 614-644-7035 or e-mail at [ann.weidenbenner@odh.ohio.gov](mailto:ann.weidenbenner@odh.ohio.gov).

## CONTINUATION FUNDING APPLICATION GUIDANCE

The Continuation Funding Application consists of three parts: Program Progress Reports (if applicable), Program Budget and Budget Narrative, and Other Required Attachments.

Submission of the continuation application constitutes acknowledgment and acceptance of ODH GAPP manual rules and any other program-specific requirements as outlined in the competitive RFP. Budget Period: 1/1/2013-12/31/2013 for total program period, 1/1/2010-12/31/2014 . Reference the competitive RFP for more information. The competitive RFP for this grant program can be found on the ODH Web site ([www.healthyohioprogram.org](http://www.healthyohioprogram.org)).

***Number of Grants and Funds Available:*** The source of funding is federal from the Preventive Health and Health Services Block Grant. Fifteen (15) grants may be awarded for a total amount of \$1,424,285.00 for local grant awards. Each funded CHC Program may apply for up to the total amount issued in the 2012 Notice of Award.

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

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

### FORMATTING REQUIREMENTS FOR ATTACHMENTS

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

#### I. PROGRAM UPDATES:

**Program Progress Report: 1) Attach the program progress report for the current grant period. If the program progress report is not scheduled to be submitted before the application due date, then it must be submitted with the application.** Submit with your 2013 Continuation Application your 2012 Second Quarterly Report including your Work Plan, Data Summary, and Success Stories.

**Program Narrative:** Complete and submit a narrative statement (do not exceed 10 pages) which explains any changes to program scope, personnel, partnerships with agencies or organizations, or other information the sub-grantee wishes to share for continuation funding. For purposes of this CHCP RFP, the three (3) risk factors are nutrition/obesity, physical activity, and tobacco use/exposure. Three (3) strategies for each priority community (see Appendix 1) need to be addressed in the Work Plan. Two (2) strategies should be from the Healthy Eating & Active Living section and one (1) strategy chosen from the Tobacco-Free Living section. Strategies from the Clinical and Preventive Services section are optional. Additional strategies not listed on Appendix 1 can be added with approval from the CHC Program Administrator.

1. Provide a **one-page** summary of the program plan for 2013, including a brief overview of the impact and process objectives. Describe any changes in priorities and impact objectives as a result of completing any SWOT analysis, Healthy Communities Checklist, community assessments, other data, and/or experience in the area. Describe how program objectives will address health disparities.
2. Provide a **one-two-page** summary of the impact you have made in your county/priority communities since October 2011.
  - a) Plans for sustaining policy, system, and environmental changes accomplished
  - b) Partnerships developed, positive coalition changes
  - c) Major accomplishments
  - d) Outcomes
  - e) Barriers overcome

Include a description of other agencies/organization also addressing the problem/needs in your community. List other state or federal grants received in your communities/county such as Pioneering Healthier Communities, ACHIEVE, and Community Transformation Grant and describe how you will collaborate with them and not duplicate grant initiatives.

Identify a “community champion” in each priority community. List either the person or the organization for each community. This champion is empowered as an advocate, has respect from the priority population and can address social determinants of health. They will be considered as a “go to” person that can assist you with successfully accomplishing interventions in each priority community.

1. **Objectives and Work Plan:** Complete and submit a short summary of any changes in the Specific, Measurable, Achievable, Results-Oriented, and Time-Based (SMART) objectives and submit an updated work plan. Reference the competitive RFP for information. This should be based on a review of the Progress Plans submitted to date. Provide a brief report addressing elements of each objective and activity, including current status (met, ongoing or unmet); major findings; and barriers and how barriers were addressed. **CHC Program Work Plan for 2013 (See Attachment B)** Using the template provided in Attachment B, complete Long Term Objective, Impact Objective, Program Evaluator Indicator and Outcome of the PSEC from the Impact Objective for each strategy in each of the priority communities. For each Impact Objective identify a well-developed Outcome Evaluation in the section provided. Complete Process

Objectives, Related Activities, Agency Responsible, Dates for each Activity, and Evaluation Measures for each priority community. Complete One Impact Objective as an evaluation of your coalition(s). Required with your final quarterly report, January 2014, will be a Success Story on one of your chosen Impact Objectives based on an in-depth Outcome Evaluation. This will be accomplished by using templates provided to you by your consultant..

2. **Health Disparity/Inequity Activities:** Complete and submit a short summary statement of how program activities over the last year addressed health disparities and/or health inequities based on the focus of your application. This should include: specific objectives to address disparities/inequities; a summary of data to support your statement; and future plans to address this issue. This information should also be reflected in past program reports.

**II. PROGRAM BUDGET:** Prior to completion of the budget section, reference the competitive RFP for unallowable costs and review criteria.

**a. Budget Narrative:**

Provide a detailed budget justification in a narrative that describes how categorical costs are derived. Discuss the necessity, reasonableness, and allocation of the proposed costs. Describe the specific functions of the personnel, consultants and collaborators. Explain and justify equipment, travel, (including plans for out-of-state travel), supplies and training costs. If you have shared costs refer to GAPP Chapter 100, Section 103 and the Compliance Section D (9) of the original RFP for additional information. Please refer to the GMIS 2.0 bulletin board for attachment instructions.

For your convenience, a budget justification narrative example is available at (GMIS Bulletin Board Announcement Dated 4/5/12.)

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.

**b. 2013 Budget via GMIS 2.0:** Complete requested budget information as follows:

- **Funding, Cash Needs and Justification Sections:** Enter information about the funding sources and forecasted cash needs for the program.
- **Personnel, Other Direct Costs, Equipment and Contracts Sections:** Submit a new budget completed as necessary to support costs for the period 1/1/2013 to 12/31/2013 funds may be used to support personnel, staff training, travel (see OBM Web site <http://obm.ohio.gov/MiscPages/TravelRule>), and supplies directly related to planning, organizing and conducting the program activity. Itemize all equipment

(minimum \$300 unit cost value) to be purchased with grant funds in the Equipment Section.

- Retain all contracts on file; do not send contracts 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. CCAs must not be submitted until after the 1st quarter grant payment has been issued.
- **Compliance:** Answer each question on this form. Completion of the form ensures your agency’s compliance with the administrative standards of ODH and federal grants.
- **Summary:** Review for accuracy.

### III. OTHER APPLICATION REQUIREMENTS:

**Program Specific Attachments:** Complete and submit the following attachments.

#### ATTACHMENTS

- A. Personnel/Position/Percent of Time Devoted to & Paid by Grant, and Function
- B. 2013 Creating Healthy Communities Work Plan

#### APPENDICES

1. Strategies
2. Guidelines for Completing the CHC Work Plan
3. Population-Based Interventions
4. Program Definitions

#### 5. Other Required Documentation:

- The following items or forms must be reviewed and submitted only if there are changes since the last grant application was submitted: **Electronic Funds Transfer (EFT) Form, Internal Revenue Service (IRS) W-9 and Vendor Information Change Form.**
- **Audit:** Sub-grantee agencies are responsible for submitting an audit report. Once an audit is completed, a copy must be sent to ODH via [audits@odh.ohio.gov](mailto:audits@odh.ohio.gov). Reference the GMIS 2.0 Bulletin Board for more information.
- **Civil Rights Review Questionnaire - EEO Survey:** The Civil Rights Review Questionnaire (EEO) Survey is a part of the Application Section of GMIS 2.0. Sub-grantees must complete the questionnaire as part of the application process. This questionnaire is submitted automatically with each application via the Internet.
- **Assurances Certification:** Each sub-grantee must acknowledge the Assurances (Federal and State Assurances for Sub-grantees) form in 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 sub-grantee agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

- **Federal Funding Accountability and Transparency Act (FFATA):** All applicants applying for ODH grant funds are required to complete the FFATA reporting form in GMIS 2.0.
  
- **For Non-Profit Organizations Only:**
  1. **Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations must submit documentation validating current liability coverage. **Attach the current Certificate of Insurance Liability in GMIS 2.0.**
  
  2. **Non-Profit Organization Status:** Non-profit organizations must submit documentation validating current status. If changed, attach in GMIS 2.0 the Internal Revenue Services (IRS) letter approving non-tax exempt status.
  
- **For Non-Government Agencies Only:**
  1. **Declaration Regarding Material Assistance/Non-Assistance to a Terrorist Organization (DMA) Questionnaire:** The DMA must be completed in its entirety to certify that agency has 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 and mailed to ODH. The DMA questionnaire is located at the Ohio Public Safety/Ohio Homeland Security Web site: <http://www.publicsafety.ohio.gov/links/HLS0038.pdf>

**POST SUBMISSION REQUIREMENTS:** Continuation applicants are required to submit sub-grantee program and expenditure reports.

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

Reports shall be submitted as follows:

**Program Reports: Sub-grantee Program Reports must be completed and submitted via GMIS by the following dates:**

- 1<sup>st</sup> Quarter, January 1 – March 31 ..... April 15, 2013
- 2<sup>nd</sup> Quarter, April 1 – June 30 ..... July 15, 2013
- 3<sup>rd</sup> Quarter, July 1 – September 30 ..... October 15, 2013

- a. 4<sup>th</sup> Quarter, October 1 – December 31 ..... January 15, 2014
- b. 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.

**Sub-grantee Expenditure Reports:** Sub-grantee 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, 2013
- 2<sup>nd</sup> Quarter, April 1 – June 30 ..... July 15, 2013
- 3<sup>rd</sup> Quarter, July 1 – September 30 ..... October 15, 2013
- 4<sup>th</sup> Quarter, October 1 – December 31 ..... January 15, 2014

- c.
- d. **Final Expenditure Reports:** A Sub-grantee Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS 2.0** by 4:00 p.m. on or before February 15, 2014. The information contained in this report must reflect the program’s accounting records and supportive documentation. Any cash balances must be returned with the Sub-grantee Final Expense Report. The Sub-grantee Final Expense Report serves as an invoice to return unused funds.

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

**ATTACHMENT A: Personnel/Position/Percent of Time Devoted to & Paid by Grant, and Function**

**No Change from 2012 Application**

<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 new staff person on this grant.**

**\*\*\* Attach a Position Description for each new person on the grant.**

## ATTACHMENT B: 2013 CREATING HEALTHY COMMUNITIES WORK PLAN

Agency \_\_\_\_\_ Grant # \_\_\_\_\_ Priority Community \_\_\_\_\_ County Served \_\_\_\_\_

**Type of Objective:**      \_\_\_\_\_ Community                      \_\_\_\_\_ Health Care                      \_\_\_\_\_ School                      \_\_\_\_\_ Worksite  
    \_\_\_\_\_ Nutrition/Obesity                      \_\_\_\_\_ Physical Activity                      \_\_\_\_\_ Tobacco

**Name of Strategy from Appendix 2:** \_\_\_\_\_

*Copy Additional Pages*

Long Term Objective:						
Program Impact Objective:						
Impact Evaluation Indicator:						
4 <sup>th</sup> Quarter Only: Has this Impact Objective been met? (Please indicate Yes/No, if No explain):						
# of Process Objectives:		# of Process Objectives Met:				
What is the Outcome of the Policy, System, or Environmental Change from this Impact Objective?						
Process Objectives	Related Activities	Agency or Person Responsible	Specific Dates for Each Activity		Evaluation Measures	Progress/Steps
			Start	End		
1.						Q1-
						Q2-

						Q3-
						Q4-
2.						Q1-
						Q2-
						Q3-
						Q4-
3.						Q1-
						Q2-
						Q3-
						Q4-
4.						Q1-
						Q2-
						Q3-
						Q4-

## **APPENDICES**

## APPENDIX 1: Strategies

### **Healthy Eating & Active Living– Choose 2**

#### **Food Access**

- Increase/Improve Availability of Healthier Food and Beverage Choices in Public Service Venues/Worksites
  - Schools
    - Salad Bars
  - After-School Programs
  - Child Care Centers
  - Community Recreational Facilities
  - City and County Buildings
  - Prisons
  - Juvenile Detention Centers
  - Food Banks/Pantries
  - Healthy Food Options at Meetings
  - Provide a variety of beverage options that are competitively priced and recommended by the Dietary Guidelines for Americans
  - Make clean, potable water available
- Improve Geographic Availability of Fresh Food in Underserved Areas
  - Increasing Number of Supermarkets
  - Community Gardens
  - Farmer’s Markets/Double Up Programs
  - Urban Agriculture Policies
- Improve Availability of Purchasing Foods from Farms
  - Farm-to-Institution
  - Farmer’s Markets
  - Farm Stands
  - Community-Supported Agriculture

#### **Healthy Food and Beverage Support**

- Restrict Availability of Less Healthy Foods and Beverages in Public Service Venues/Worksites
  - Standards for Types of Foods Sold
  - Restricting Access to Vending Machines
  - Nutrition Policies for Vending Machines
  - Restricting Availability of Sugar-Sweetened Beverages
  - Banning Snack Foods and Food as a Reward in the Classroom
    - Schools
    - After-School Programs
    - Child Care Centers
    - Community Recreational Facilities
    - City and County Buildings
    - Prisons

- Juvenile Detention Centers
- Institute Smaller Portion Size Options in Public Service Venues/Worksites
  - Policies that Limit the Portion Size of Entrees Served in Facilities Owned and Operated by Local Jurisdiction
    - Schools
    - After-School Programs
    - Child Care Centers
    - Community Recreational Facilities
    - City and County Buildings
    - Prisons
    - Juvenile Detention Centers
- Sugar-Sweetened Beverages
  - School and Child Care Facility Ban SSB and Limit Portion Size of 100% Juice
  - Make clean, potable water readily available in public places, worksite and recreation areas
- Increase Support for Breastfeeding
  - Worksite Support for Breastfeeding
    - Breastfeeding Employees have Access to Breastfeeding Facilities
    - Employees are Trained in Supporting Breastfeeding Customers
- Required Physical Activity in Schools/Increase Amount of Physical Activity in PE Programs
  - School District Policies Increasing Required PE for all students
  - School District Policies Requiring Students to be Physically Active during PE
- Increase Opportunities for Extracurricular Physical Activity
  - Shared Use Agreements
  - New/Repair of Playgrounds
  - Intramural Activities/Physical Activity Clubs for Students including those with Disabilities
- Reduce Screen Time in Public Service Venues
  - Policy Limiting Screen Time for Child Care Facilities
- Enhance Infrastructure Supporting Bicycling
  - Shared-Use Paths and Bike Lanes
  - Workplace/School Biking Improvements
  - Bike Rental/Use
- Support Locating Schools within Walking Distance of Residential Areas
  - Policies Supporting Locating New Schools, Repairing or Expanding Existing Schools within Easy Walking or Biking Distance of Residential Areas
  - Safe Routes to School
- Enhance Personal Safety in Areas where Persons are or could be Physically Active
  - Vacant or Abandoned Lots
- Enhance Traffic Safety in Areas where Persons are or could be Physically Active
  - Complete Streets
- Develop and implement physical activity strategies that fit into people’s daily routines-- strategies that are most effective when tailored to specific interests and preferences

- Develop and implement strategies that build, strengthen, and maintain social networks to provide supportive relationships for behavior change for physical activity

### **Tobacco-Free Living- Choose 1**

- Smoke-Free Worksite Policies
- Multi-Unit Housing Smoke-Free Policies
- University 100% Comprehensive Tobacco-Free Campus Policies
- School District 100% Comprehensive Tobacco-Free Campus Policies

### **Clinical and Preventive Services- Optional**

- Ounce of Prevention/Pound of Cure trainings
- Chronic Disease/Diabetes Self-Management trainings
- Provide standardized care and advocate for healthy community environments
- Ensure coverage of, access to, and incentives for routine obesity prevention, screening, diagnosis, and treatment
  - Insurers and employers include incentives in individual and family health plans for maintaining healthy lifestyles.
- Encourage healthy weight gain during pregnancy and breastfeeding
  - Health care providers adopt, implement and monitor policies that support healthy weight gain during pregnancy and the initiation and continuation of breastfeeding.
- Perform routine screening regarding overconsumption of sugar - sweetened beverages and counseling on the health risks associated with consumption of these beverages.

## APPENDIX 2: Guidelines for Completing the CHC Work Plan

Impact and Process Objectives must be written in SMART (Specific, Measurable, Achievable, Relevant, and Time) 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** -It specifies a time by which the objective will be achieved. When will the event or change occur?

1. **Long Term Objective:** Complete one (1) long term objective for each of the three (3) settings.

An example of a long term objective for the school setting is: By December, 2014, 100 percent of the schools in the priority 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, attitudes 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 priority populations.
- A generic format for a system outcome objective is:  
By *(date)*, *(system)* will *(specify how system will change)* as measured *(by how much)* and evaluated by *(how you will determine that the desired change has occurred)*.

*Example: By June 20, 2013 one school district will adopt a policy to provide daily physical activity for all K-8 buildings as evidenced by the district's daily schedule.*

*Example: By October 30, 2013 one new community garden will be created near a subsidized housing project as evidenced by the gardener's log of produce.*

*Example: By December 31, 2013 50 percent of the four family practice offices will utilize the Ounce of Prevention program with their pediatric (0-6 years) patients as evidenced by the parent survey results.*

*Example: By December 31, 2013 three (3) community churches will implement policies to make healthy foods available during church-related functions as evidenced by the observation surveys at the monthly potlucks.*

*Example: By October 30, 2013 two (2) worksites will adopt a 100 percent tobacco-free campus policy as evidenced by observation surveys at sporting events.*

### **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, new resources/facilities available in the community, practices adopted, 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. Outcome Evaluation**

Identify the ultimate outcome for the policy, systems, and environmental change that occurs for each Impact Objective. These outcome evaluations should address the behavior changes that occur as a result of your intervention. The impact should be measurable through data collected throughout the year(s).

*Example: Sales of fresh fruits and vegetables increased by 25% at Little Joe's corner market.*

*Example: 15% more students walked or biked to school at Lakewood Middle School due to the SRTS program.*

## 5. 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, 2013, 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, 2013, 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, 2013, 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. Organize a Wellness Committee.
- d. Complete Worksite Assessment tool for baseline data.
- e. Identify area the worksite team wants to start developing strategies and policies to improve.
- f. Provide technical assistance and resources to worksite as they progress.
- g. Assist in developing policy.
- h. Assist with policy implementation.
- i. Evaluate the impact of the policy on the employees.

Sample 4: By August 30, 2013 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.
6. **Related Activities**, specific name of Agency/Person Responsible, Specific beginning and ending dates throughout the year, and Evaluation Measures.
7. **Agency or Person Responsible**  
Identify the person(s) and/or agency (ies) responsible for each activity.
8. **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.

**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:

- **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
- **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.
- **Questions/surveys/questionnaires/interviews**
  - Paper-pencil tests
  - Face-to-face interviews
  - Phone interviews
  - Focus groups
  - Key opinion leaders input
  - Community forums
  - Survey Monkey

9. **Progress/Steps:**

Complete the “Progress/Steps” column for each Process Objective in the Work Plan with the Quarterly Report. This will show the development of your Impact Objective throughout the year. It is to be submitted quarterly with the “Success Stories” and “Data Summary.”

### APPENDIX 3: 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 CHC 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.

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

## APPENDIX 4: 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.
- **Collective Impact**- Alignment of many organizations toward a common goal makes impact greater than any individual agency.
- **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.
- **Evaluation Plan** - A written document describing the overall approach or design that will be used to guide an evaluation. It includes what will be done, how it will be done, who will do it, when it will be done, why the evaluation is being conducted, and how the findings will likely be used.
- **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 Care Setting**- In the context of CHC, the health care setting is defined as any setting where a provider of health services or health information practices. The following are considered health care settings:
  - Hospitals/health systems
  - Clinics
  - Community clinics
  - WIC offices
  - Local public health
  - Migrant health services
  - Community Health Worker Service Agencies
  - Student Health Services
- **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. These groups include, but are not limited to, racial/ethnic minorities; people with severe and persistent mental illness; people with low socio-economic status; lesbian, gay, bisexual, and transgender populations.
- **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-Risk Populations**- High risk populations are groups of individual that experience negative disparities in the social determinants of health, quality of life, and/or health outcomes. Examples of disparities related to race, ethnicity, economic status, age, sex, sexual orientation, disability and geographic location.
- **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.**
- **Ordinance**- In the CHC context, an ordinance is a formally-adopted law, rule or regulation that is enacted by the governing body of a city or county and affects tobacco use and exposure, physical activity, and/or nutrition.
- **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.
- **Policy Strategies**- A policy strategy may be a law, ordinance, resolution, mandate, regulation, or rule (both formal and informal). Examples are laws and regulations that restrict smoking in public buildings and organizational rules that provide time off during work hours for physical activity. Subtypes of policies include:
  - **Public Policy**: A set of agreements about how government shall address societal needs and spend public funds that are articulated by leaders in all

three branches of government and embedded in many different policy instruments (e.g., ordinances and resolutions).

- Organizational Policies: A set of rules and understandings that govern behavior and practice within a business, nonprofit or government agency.
- Regulatory Policies: Rules and regulations created, approved, and enforces by governmental agencies, generally at a federal or state level.
- **Priority 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*)
- **Program Evaluation**—The systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future program development.
- **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/>).
- **Risk Factors**- Risk factors are habits or characteristics that increase the likelihood of developing chronic diseases. In the CHC context, risk factors are tobacco use and exposure, physical activity, nutrition and healthy weight/healthy behavior.
- **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.
- **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.
- **Worksite Setting**- A worksite is defined by a location, permanent or temporary, where an employee performs work or work related activities. Worksite facilities include lunchrooms, restrooms, break rooms, and vehicles used for work, and parking facilities. If specified, it can also include the grounds around the worksite. The following are examples of the worksite setting:
  - Offices

- Manufacturing plants
- Retail
- Food service
- Transportation
- Wholesale
- Agriculture
- Construction
- Health care (employees)