



# OHIO DEPARTMENT OF HEALTH

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Columbus, Ohio 43215

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John R. Kasich / Governor

Theodore E. Wymyslo, M.D. / Director of Health

## MEMORANDUM

To: Injury Prevention Grant Program Applicants

From: Steve Wagner, MPH, JD  
Chief, Division of Prevention and Health Promotion  
Ohio Department of Health

Subject: Notice of Availability of Funds for Injury Prevention Grants  
Competitive Grant – January 1, 2014 to December 31, 2018 Program Period

The Ohio Department of Health (ODH), Division of Prevention, Bureau of Healthy Ohio's Violence and Injury Prevention Program announces the availability of grant funds to support local unintentional injury prevention program activities. The Preventive Health and Health Services Block Grant (PHHSBG)-funded Injury Prevention Projects reflect the commitment of ODH to meet community need with programming implemented at the local level. The goal of this grant program is to reduce unintentional injury and injury-related deaths to Ohioans through the development of comprehensive, multi-faceted, population-based local programs that address risks associated with injury. No grant award will be issued for less than \$30,000 or more than \$80,000 (\$112,000 if supplemental coalition building is included).

To obtain a grant application packet:

1. Go to the ODH website at <http://www.odh.ohio.gov/>
2. From the home page, click on "Funding Opportunities";
3. From the next page, click on "ODH Grants";
4. Next click "Grant Request for Proposals," this will give you a pull down menu with current RFPs by name; and
5. Select and highlight the Violence and Injury Prevention Program RFP and click "Submit." This process invokes Adobe Acrobat and displays the entire RFP. You can either read and/or print the document as desired.

In the application packet you will find:

1. Request for Proposals (RFP) – This document outlines detailed information about the background, intent and scope of the grant, policy, procedures, performance expectations, and general information and requirements associated with the administration of the grant.
2. *Notice of Intent to Apply for Funding (NOIAF)* form – The purpose of this document is to ascertain your intent to apply for available grant funds. Please note: The NOIAF must be submitted no later than Friday, September 6, 2013, which is the date to be eligible for these funds. NOIAF's not received by the due date will not be accepted.

When you have accessed the application packet:

1. Review the RFP to determine your organization's ability to meet the requirements of the grant and your intent to apply.
2. If after reviewing the RFP you wish to submit an application for the grant, complete the *Notice of Intent to Apply for Funding* form in the application packet. Fax or e-mail it to ODH, per the listed instructions and by the indicated due date of Friday, September 6, 2013. The *Notice of Intent to Apply for Funding* form is mandatory, if you intend to apply for the grant.

Upon receipt of your completed *Notice of Intent to Apply for Funding* form, ODH will:

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

Once ODH receives your completed *Notice of Intent to Apply for Funding* form, creates the project number for your organization and finalizes all GMIS 2.0 training requirements, you may proceed with the application process as outlined in the RFP.

Potential applicants are strongly encouraged to attend a Bidder's Meeting to be held on Tuesday, September 3, 2013 at the Ohio Department of Public Safety (1970 West Broad Street, Columbus) in the Motorcycle Training Room from 10:00 AM – 1:00 PM. Applicants may attend in person or via conference call, although in person attendance is recommended. The meeting will provide an opportunity for potential applicants to learn more about the RFP instructions and to ask questions. Additional details will be provided upon receipt of notice of intent to apply for funding (required).

**All applications and attachments are due Tuesday, October 15, 2013.** Electronic applications received after Tuesday October 15, 2013 will not be considered for funding. Faxed, hand-delivered or mailed applications will not be accepted.

All grant applications must be submitted via the Internet, using GMIS 2.0. All organizations are required to attend GMIS 2.0 training. If your organization has not been trained, complete and return the GMIS 2.0 training form by Friday, September 6, 2013.

If you have questions regarding this application, please contact Christy Beeghly at 614-466-2144 or [healthy@odh.ohio.gov](mailto:healthy@odh.ohio.gov).

# NOTICE OF INTENT TO APPLY FOR FUNDING

Ohio Department of Health  
Division of Prevention, Bureau of Healthy Ohio

## Violence and Injury Prevention 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     Hospital     Not-for Profit  
(Check One)                     City Agency         Higher Education

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

**Our agency will attend the Bidder's Meeting on September 3rd?**

- Yes, in person. How many attendees? \_\_\_\_\_
- Yes, via conference call

**Program Focus Area (select one)**

- Unintentional Child/Youth TBI – Supplemental \_\_\_Y\_\_\_N
- Falls Among Older Adults – Supplemental \_\_\_Y\_\_\_N
- Unintentional Prescription Drug Overdose
- Supplemental Coalition Building for Falls and Child Injury Only

**Mail, E-mail or Fax To:**

**Christy Beeghly, MPH, Program Administrator**

Violence and Injury Prevention Program

Ohio Department of Health

246 N. High Street, 8<sup>th</sup> Floor

Columbus, Ohio 43215

**E-mail:** [healthy@odh.ohio.gov](mailto:healthy@odh.ohio.gov)

**Fax:** 614-564-2409

**Notice of Intent to Apply for Funding form must be received by Friday, September 6, 2013**



ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

# OHIO DEPARTMENT OF HEALTH

**DIVISION OF**  
*Prevention*

**BUREAU OF**  
*Healthy Ohio*

*Violence and Injury Prevention Program*  
**REQUEST FOR PROPOSALS (RFP)**  
**FOR**  
**FISCAL YEAR 2014**  
**(01/01/14 – 12/31/18)**

**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 website “ODH Application Gateway” and 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 by the due date indicated in sections D, G, and I 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 website <http://www.odh.ohio.gov>. (Click on “Funding Opportunities” [located under At a Glance]; click on “ODH Grants” and then click on “GAPP”) Please refer to Policy and Procedure updates found on the GMIS bulletin board.

**B. Application Name:** **Injury Prevention Program**

**C. Purpose:** The Preventive Health and Health Services Block Grant (PHHSBG) Injury Prevention Projects reflect the commitment of ODH to meet community need with programming implemented at the local level. The goal of this grant program is to reduce injuries and injury related deaths to Ohioans through the development of comprehensive, multi-faceted, population-based programs at the local level that address the risks associated with unintentional injuries.

For this RFP, applicants must choose from **one** of the following injury focus areas.\*

- **Unintentional child/youth traumatic brain injury (TBI)** including but not limited to the following mechanisms:
  - Bicycle and wheeled sports
  - Falls
  - Pedestrian
  - Sports and recreation
  - Teen driving

*\*Please note: Child passenger safety (CPS) will not be funded under this opportunity as ODH provides CPS funding separately through a regional youth occupant protection grant. Additional child injury mechanisms (e.g., drowning, suffocation, fire/burn) may be addressed if indicated by local data as long as the primary focus is on TBI prevention efforts.*

- **Falls among older adults**
- **Unintentional prescription drug overdose/poisoning**

**Supplemental Funding Opportunity:** Supplemental funding is available for applicants of focus areas 1. (unintentional child/youth traumatic brain injury) and 2. (falls among older adults). See **Appendix D.1** for additional information and instructions for the Supplemental Funding.

**IMPORTANT:** More information about the focus areas will be found in Appendix D. It is strongly recommended that you print and carefully read and review Appendices C-D before you begin the application.

- D. Qualified Applicants:** *All applicants must be a local public or non-profit agency. Applicant agencies must attend or document in writing prior attendance at Grants Management Information System 2.0 (GMIS) training and must have the capacity to accept an electronic funds transfer (EFT). See Appendix A for GMIS 2.0 training form.*

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

1. Applicant does not owe funds in excess of \$1,000 to the ODH.
2. Applicant is not certified to the Attorney General's (AG's) office.
3. Applicant has submitted application and all required attachments by 4:00 p.m. on Tuesday, October 15, 2013. Late applications will not be accepted.

Applicants should 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 should be attached if a potential high need community IS NOT under the jurisdiction of the applicant agency.

All counties/agencies are eligible to apply, however, those with highest need, i.e., those in the 75<sup>th</sup> percentile or higher of injury death and poverty rates, will be given priority and additional weighting in the review process. See Appendix N for information on county need – including injury death and poverty rates – and scoring process. County data are weighted based on the following:

- Estimated number of persons below poverty,
- Percent of county residents living below poverty level (2011) based on U.S. Census data and,
- Number of unintentional injury deaths from priority injuries: child injury ages 1-18, falls among older adults, and prescription drug overdose. See Appendix N for details.

- E. Service Area:** *All funded projects are expected to target high risk populations in their county. Applications may include a single county project area or multiple county project area.*

- F. Number of Grants and Funds Available:**

The source of the funding is the Preventive Health and Health Services Block Grant (PHHSBG). Grants may be awarded for a total amount not to exceed \$750,000.

Eligible agencies may apply for \$30,000 up to the following budget ceilings based on county population:

- Counties with a population of less than 200,000\* may apply for up to a maximum of \$65,000 (\$97,000 if applying for supplemental state coalition building funding – See Appendix D.1).
- Counties with a population greater than 200,000\* may apply for up to a maximum of \$80,000 (\$112,000 if applying for supplemental state coalition building funding – See Appendix D.1).

*\*Per the US Census 2011 Population Estimates (See **Appendix O** for a list of counties ranked by population size.)*

No subgrantee is guaranteed a certain percentage of the total 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.*

- G. Due Date:** All parts of the application must be completed and received by ODH electronically via GMIS or via ground delivery by 4:00 p.m. on Tuesday, October 15, 2013. Applications and required attachments received late will not be considered for review.

Contact Christy Beeghly, 614-466-2144, [healthy@odh.ohio.gov](mailto:healthy@odh.ohio.gov) with any questions. Enter the contact name listed under “Programmatic, Technical Assistance and Authorization for Internet Submission.”

- H. Authorization:** Authorization of funds for this purpose is contained in the *Catalog of Federal Domestic Assistance (CFDA) Number 93.991.* |

- I. Goals:** The consequences of injury can be far reaching and severe. Injury is the leading cause of death and disability to Ohioans age 1 through 44 and the 5<sup>th</sup> leading cause of death for all age groups. More than 6,000 Ohioans are killed each year from injury related causes. Of the millions of Ohioans who survive injuries many suffer long-term consequences, such as permanent disability, time lost from work and family, costly medical expenses and pain and suffering. Injury leads to huge societal costs as well, amounting to billions of dollars annually in health care expenses, lost productivity, rehabilitation and criminal justice system expenses among others. However, injuries largely follow predictable patterns and are therefore, preventable. Common themes identified by the Ohio Commission on the Prevention of Injuries include:

1. Injuries are costly. Injury prevention saves lives and money.
2. Improved injury surveillance efforts and program evaluation is needed.
3. Improved statewide coordination of programs is needed.
4. Injuries disproportionately affect those living in poverty and the young and old.
5. Drugs and alcohol are important risk factors for injury.
6. Policy can be an effective strategy for injury prevention.

The goal of this grant program is to reduce injury and injury related deaths to Ohioans through the development of comprehensive multi-faceted population-based programs at the local level that address the risks associated with unintentional injuries. It is expected that as a result there will be:

- An increase in the capacity of local communities to address the risks associated with leading causes of unintentional injury;
- Development of injury prevention coalitions that involve strong local partnerships between public health and others such as health care, EMS, police, schools, businesses, child care, aging service providers, city planners, etc.

Multi-faceted programs involve a comprehensive approach addressing strategies across a spectrum of prevention to include:

- Community needs assessment and injury surveillance;
- Education/training relative to the risks associated with injury;
- Enactment and enforcement of regulations and policies to reduce injury risks;
- Design and implementation of environmental and social systems to reduce risks;
- Evaluation.

Additional information on focus-area specific strategies and program requirements is provided in Appendices C-D.

**J. Program Period and Budget Period:** The program period will begin January 1, 2014 and end on December 31, 2018. The budget period for this application is January 1, 2014 through December 31, 2014.

**K. Public Health Accreditation Board (PHAB) Standard(s):**

- **Standard 1.1:** Participate in or Conduct a Collaborative Process Resulting in a Comprehensive Community Health Assessment
- **Standard 1.2:** Collect and Maintain Reliable, Comparable, and Valid Data That Provide Information on Conditions of Public Health Importance and On the Health Status of the Population
- **Standard 1.4:** Provide and Use the Results of Health Data Analysis to Develop Recommendations Regarding Public Health Policy, Processes, Programs, or Interventions
- **Standard 3.1:** Provide Health Education and Health Promotion Policies, Programs, Processes, and Interventions to Support Prevention and Wellness

- **Standard 3.2:** Provide Information on Public Health Issues and Public Health Functions Through Multiple Methods to a Variety of Audiences
- **Standard 4.1:** Engage with the Public Health System and the Community in Identifying and Addressing Health Problems Through Collaborative Processes
- **Standard 4.2:** Promote the Community’s Understanding of and Support for Policies and Strategies That will Improve the Public’s Health
- **Standard 6.2:** Educate Individuals and Organizations On the Meaning, Purpose, and Benefit of Public Health Laws and How to Comply
- **Standard 10.1:** Identify and Use the Best Available Evidence for Making Informed Public Health Practice Decisions
- **Standard 10.2:** Promote Understanding and Use of Research Results, Evaluations, and Evidence-based Practices With Appropriate Audiences

**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 PHAB Standards.

1. Public Health Impact Statement Summary - Applicant agencies are required to submit a summary of the proposal to local health districts prior to submitting the grant application to ODH. The program summary, not to exceed one page, must include:
  - a) The Public Health Accreditation Board (PHAB) Standard(s) to be addressed by grant activities:
    - A description of the demographic characteristics (e.g., age, race, gender, ethnicity, socio-economic status, educational levels) 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 PHAB 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 multi-county focus, a statement of support must be submitted from at least one local health district, if available.

## M. Incorporation of Strategies to Eliminate Health and Injury Inequities

### Health and Injury Equity Component

The ODH is committed to the elimination of health and injury inequities. Racial and ethnic minorities and Ohio's economically disadvantaged residents experience health inequities and, therefore, do not have the same opportunities as other groups to be healthy. Throughout the various components of this application (Program Narrative, Objectives, and Work Plan), applicants are required to:

- 1) Explain the extent to which injury disparities and/or injury inequities are manifested within the problem addressed by this funding opportunity. This includes the identification of specific group(s) which experiences a disproportionate burden of injury (This information must be supported by data.);
- 2) Explain how specific social and environmental conditions (social determinants of health) put groups who are already disadvantaged at increased risk for injury inequities; and
- 3) Explain how proposed program interventions will address this problem.

The following section will provide basic framework and links to information to understand health equity concepts.

### Understanding Health Disparities, Health Inequities, Social Determinants of Health & Health Equity:

*Certain groups in Ohio face significant barriers to achieving the best health possible. These groups include Ohio's poorest residents and racial and ethnic minority groups. Health disparities occur when these groups experience more disease, death or disability beyond what would normally be expected based on their relative size of the population. Health disparities are often characterized by such measures as disproportionate incidence, prevalence and/or mortality rates of diseases or health conditions. Health is largely determined by where people live, work and play. Health disparities are unnatural and can occur because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors. Those most impacted by health disparities also tend to have less access to resources like healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as **social determinants of health**. Social determinants are the root causes of health disparities. The systematic and unjust distribution of social determinants resulting in negative health outcomes is referred to as **health inequities**. As long as health inequities persist, those aforementioned 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 programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to the elimination of health inequities.*

For more resources on health equity, please visit the ODH website 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. **The subgrantee agency must be prepared to support 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, for new agencies, will be granted after participation in the GMIS training session. All other agencies will receive their authorization after the posting of the RFP to the ODH website and the receipt of the Notice of Intent to Apply for Funding (NOIAF). Please contact Christy Beeghly, 614-466-2144, [healthyo@odh.ohio.gov](mailto:healthyo@odh.ohio.gov) to whom the applicant agency can contact for questions regarding this RFP.

**Applicant must attend or must document in the NOIAF prior attendance at GMIS training in order to receive authorization for Internet submission.**

**P. Acknowledgment:** An 'Application Submitted' status will appear in GMIS 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. 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 **Tuesday, October 15, 2013.**

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 Services Unit, 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 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). 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 period, written notification, issued under the signature of the Director of Health, or his designee, shall be sent 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. Describe 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 RFP;
  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;
  11. Explicitly identifies specific groups in the service area who experience a disproportionate burden of the diseases, health condition(s); or who are at an increased risk for problems addressed by this funding opportunity; and,
  12. Applicant describes activities which supports the requirements outlined in sections I. thru M. of this RFP.

*[The reviewer scoring sheet and review process is attached in Appendix N.]*

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 RFPs.

**There will be no appeal of the Department's decision.**

- U. Freedom of Information Act:** The Freedom of Information Act (5 U.S.C.552) and the associated Public Information Regulations 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 being an unwarranted invasion of personal privacy will not be disclosed. For guidance regarding specific funding sources, refer to: 45 CFR Part 5 for funds from the U.S. Department of Health and Human Service.

- V. **Ownership Copyright:** Any work produced under this grant, including any documents, data, photographs and negatives, electronic reports, records, software, source code, or other media, shall become the property of ODH, which shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. If this grant is funded in whole, or in part, by the federal government, unless otherwise provided by the terms of that grant or by federal law, the federal funder also shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. No work produced under this grant shall include copyrighted matter without the prior written consent of the owner, except as may otherwise be allowed under federal law.

ODH must approve, in advance, the content of any work produced under this grant. All work must clearly state:

“This work is funded either in whole or in part by a grant awarded by the Ohio Department of Health, [Bureau of Healthy Ohio], [Violence and Injury Prevention Program] and as a sub-award of a grant issued by [the Ohio Department of Health] under the [Preventive Health and Health Services Block Grant], grant award number [3B01DP009042-13S1], and CFDA number 93.991.”

- W. **Reporting Requirements:** Successful applicants are required to submit subgrantee program and expenditure reports. Reports must adhere to the requirements of the ODH GAPP manual. Reports must be received in accordance with the requirements of the ODH GAPP manual and this RFP before the department will release any additional funds.

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

Reports shall be submitted as follows:

1. **Program Reports:** subgrantees Program Reports must be completed and submitted via GMIS or the Subgrantee Performance Evaluation System (SPES), as required by the subgrant program by the following dates:

**1st Quarter, January 1 through March 31 .....April 15, 2014**  
**2nd Quarter, April 1 through June 30 .....July 15, 2014**  
**3rd Quarter, July 1 through September 30 .....October 15, 2014**  
**4th Quarter, October 1 through December 31 ..... January 15, 2015**

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 will not be approved.** All program report attachments must clearly identify the authorized program name and grant number.

**Additional Program Reporting Requirements Include:**

- a. **New Program Coordinator/Director's Meeting:** At least one representative from your agency must attend a New Program Coordinator/Director's meeting to be held in January 2014. The purpose of this meeting is to clarify and provide guidance on required objectives and activities with funded subgrantees early in the grant cycle. There will be information provided on Grants Administration Policies and Procedures (GAPP) including reporting requirements, responding to grant special conditions, budget revisions, etc., as well as program-specific information. Costs associated with attending this meeting are an allowable expense for this grant proposal and should be included in the budget.
- b. **Annual Project Meeting:** At least one representative from your injury prevention program must attend this meeting. The objective for this meeting is to provide technical assistance and an opportunity for sharing successes and barriers in program implementation. Costs associated with attending this meeting are an allowable expense for this grant proposal and should be included in the budget.
- c. **Ohio Injury Prevention Partnership Quarterly Meetings:** The Ohio Injury Prevention Partnership (OIPP) is a statewide group of professionals representing a broad range of agencies and organizations concerned with building Ohio's capacity to address the prevention of injury, particularly related to the group's identified priority areas. The group is coordinated by ODH with funds from the Centers for Disease Control and Prevention (CDC). The OIPP advises and assists ODH and Violence and Injury Prevention Program with establishing priorities and future directions regarding injury and violence prevention initiatives in Ohio. The group convenes quarterly all-day meetings to strengthening and sustains effective injury and violence prevention programs at the state and local level. Costs associated with attending these quarterly meetings are an allowable expense for this grant proposal and should be included in the budget. Attendance and active participation in the OIPP is an expectation of funded projects.

**A letter of acknowledgement must be included indicating permission is granted to travel out-of-county to attend these ODH and OIPP meetings.**

- d. **Success Stories:** In 2000, PHHSBG management and grantees, in collaboration with the Association of State and Territorial Health Officials, agreed states would use Success Stories to increase the visibility, credibility and accountability of the PHHS Block Grant Programs. Success stories are intended to: (1) Replace uniform datasets; (2) Identify public health issues that are funded with Block Grant dollars; (3) Describe the interventions that were carried out to bring about change; (4) Document the impacts that were made using Block Grant funds.

**Submission of at least one Success Story during each year of the grant program period is required.** A 2014 Success Story will be due by your agency before or on December 31, 2014 in a format prescribed by ODH.

For information on how to write a Success Story and for use of a success story builder, go to: <http://www.cdc.gov/injury/SuccessStories/storyBuilder.html>

The following website also has success story examples available:  
<http://www.cdc.gov/injury/SuccessStories/stories.html>

- e. **Annual Site-visit:** Site visits are conducted with subgrantees to assure compliance with ODH program standards and to provide technical assistance to assure continued progress toward program objectives.

*Submission of Subgrantee Program Reports via the ODH's (GMIS or SPES) indicates acceptance of the ODH GAPP.*

- 2. **Periodic Expenditure Reports:** Subgrantee Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

1st Quarter, January 1 through March 31 .....April 15, 2014  
2nd Quarter, April 1 through June 30.....July 15, 2014  
3rd Quarter, July 1 through September 30 .....October 15, 2014  
4th Quarter, October 1 through December 31 ..... January 15, 2015

- 3. **Final Expenditure Reports:** A Subgrantee Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS** by 4:00 p.m. on or before February 15<sup>th</sup>, 2015. 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 Periodic and Final Subgrantee Expenditure reports via the GMIS system 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 list of all equipment purchased in whole or in part with **current** grant funds (Equipment Section of the approved budget) must be submitted via GMIS 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 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.

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

1. To advance political or religious points of view or for fund raising or lobbying; 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 (including but not limited to bank fees);
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 website: <http://obm.ohio.gov/MiscPages/TravelRule> then click on OBM Travel Rule.)
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;
22. Medications and direct health care expenditures are unallowable expenses of the PHHSBG.

**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 nine months after the end of the subgrantee's fiscal year.

Subgrantees that 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 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 Services Unit, 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; and,
- 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**

### **Formatting Requirements:**

- Properly label each item of the application packet (ex. budget narrative, program narrative, etc. as instructed in the Appendices).
- Program and Budget narratives must be submitted in portrait orientation on 8 ½ by 11 paper.
- Number all pages (print on one side only).
- Program narrative requirements will be met by completing the Program narrative template (Appendix E). This template shall not exceed 30 pages (**excludes** appendices, attachments, budget and budget narrative).
- Use a 12 point font.
- Forms must be completed and submitted in the format provided by ODH.

The GMIS application submission must consist of the following:

**Complete  
& Submit  
Via Internet**

1. Application Information
2. Project Narrative (See Appendix F)
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. Federal Funding Accountability and Transparency Act (FFATA) reporting form
8. Electronic Funds Transfer (EFT) form (**Required if new agency, thereafter only if banking information has changed.**)
9. 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).**)
10. Public Health Impact Statement
11. Statement of Support from the Local Health Districts
12. Liability Coverage (**Non-Profit organizations only; proof of current liability coverage and thereafter at each renewal period.**)
13. Evidence of Non-Profit Status (**Non-Profit organizations only**)

14. Attachments as required by Program
  - i. Executive Summary and Program Narrative (*Appendix E*)
  - ii. Statement of Intent to Pursue Health Equity (*See Section M.*)
  - iii. Key Personnel Form (*Appendix F*)
  - iv. Methodology Work Plan (*Appendix H*)
  - v. \*Supplemental Methodology Work Plan (*Appendix I*)
  - vi. Demographics Table (*Appendix M*)
  - vii. Letters of support should be saved together as one .pdf and named “*Name\_LOS14*”
  - viii. Letter indicating permission to travel out of county for meetings should be named “*Name\_travelLetter14*”

\*Required only for those applying for supplemental state coalition building funding (See Appendix D.1)

One copy of the following documents must be e-mailed to [audits@odh.ohio.gov](mailto:audits@odh.ohio.gov) or mailed to the address listed below:

**Complete  
Copy &  
E-mail or  
Mail to  
ODH**

1. Current Independent Audit (latest completed organizational fiscal period; **only if not previously submitted**)

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

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

**Complete  
Copy &  
Mail To  
ODH**

1. An original and 3 copies of **Attachments** (non-Internet compatible) as required by program: **NONE**

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

## **II. APPLICATION REQUIREMENTS AND FORMAT**

Access to GMIS, will be provided after GMIS training for those agencies requiring training. All others will receive access after the RFP is posted to the ODH website.

*All applications must be submitted via GMIS. Submission of all parts of the grant application via the ODH’s GMIS system 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 page | 12 | 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, 2014 | to | December 31, 2014 |.

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

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

**Funded projects must employ one full time Injury Prevention Coordinator (no fewer than 1,700 hours per year) whose sole duties are to administer the Injury Prevention Program and related grant activities.** Other sources of funding may be used to meet the requirement; however, this position must spend 100 percent of time on grant-related activities. Projects may not use part-time employees in different job positions to equal one FTE to fulfill this requirement. Documentation demonstrating compliance with this requirement should be provided in Appendix F.

Budget should include funds for travel to:

- a. One day-long meeting for New Project Coordinators/Directors to be held during the first quarter of 2014 in the central Ohio area.
- b. One day-long project meeting to be held during the second or third quarter of the project year in the central Ohio area.
- c. Quarterly (4) Ohio Injury Prevention Partnership (OIPP) meetings.

Applicants should consider including funds in the budget to become a member of the Safe States Alliance. More information about Safe States can be accessed here: <http://safestates.org/>

**CCAs cannot be submitted until after the 1<sup>st</sup> quarter grant payment is issued.**

The applicant shall 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 in GMIS 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 but not to exceed 25 percent of the funds being provided by ODH. 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 Sub-grantees) form within GMIS. This form is submitted as a part of each application via GMIS. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive and any omission of other statutes does not mean such statutes 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.
- D. Project Narrative:**

Complete the program narrative as separate documents using the templates found in **Appendix E (Executive Summary and Program Narrative)** and attach in GMIS 2.0. Appendix E, Program Narrative, should be named "*Insert county\_Narrative\_2014*"

**Focus Areas:** Complete the program narrative (Appendix E) choosing from only one of the following focus areas\*:

1. **Unintentional child/youth traumatic brain injury**
2. **Falls among older adults**
3. **Unintentional prescription drug poisoning**

**IMPORTANT:** More information about the focus areas will be found in **Appendix D**. **It is strongly recommended that you print and carefully read and review Appendix C-D before you begin the Program Narrative section.** They contain critical information about the focus areas, required activities and additional instructions to help you complete the application properly.

**Optional Supplemental Funding Opportunity:**

**Applicants of Focus Areas 1 or 2:**

Supplemental funding is available for applicants of focus areas 1 (child injury) and 2 (falls among older adults). An additional \$60,000 (\$32,000 for child injury/\$28,000 for falls) is available for programs to conduct statewide coalition building activities related to unintentional child/youth injury or falls among older adults as an extension of the Ohio Injury Prevention Partnership. The total budget for applicants applying for either focus area 1. or 2. (\$80,000/\$65,000) and the supplemental funding will be \$112,000 for counties >200,000 population and \$97,000 for counties with <200,000 population.

**Supplemental Statewide Coalition Building Funding Only**

Applicants may elect to apply for only the supplemental funding as well. If applicant is applying for both the CIAG and falls coalition facilitation funding, a separate narrative and work plan should be submitted for each. The maximum budget for these applicants would be \$60,000.

**See Appendix D.1 for additional information and instructions for this section.**

1. **Executive Summary:** [Provide an Executive Summary by responding to the template found in Appendix E.]
2. **Description of Applicant Agency/Documentation of Eligibility/Personnel:** Briefly discuss the applicant agency's eligibility to apply by responding to the template in **Appendix E**. *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. 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. Include position descriptions for these staff.*

**3. Problem/Need: Identify and describe the local health status concern that will be addressed by the program by responding to the template in Appendix E.**

*Only restate national and state data if local data is not available. The specific health status concerns that the program intends to address may be stated in terms of injury status (e.g., morbidity and/or mortality) or health system indicators. The indicators should be measurable in order to serve as baseline data upon which the evaluation will be based. Clearly identify the target population.*

*Explicitly describe segments of the target population who experience a disproportionate burden of injury in your community. Include a description of other agencies/organizations also addressing this problem/need by responding to the template found in Appendix E.*

**Sources of Ohio-specific data are listed with hyperlinks in Appendix L.**

**4. Methodology: By responding to the template in Appendix E, identify the program Specific, Measureable, Attainable, Realistic & Time-Phased (SMART) process, impact, or outcome objectives and activities.** Indicate how they will be evaluated to determine the level of success of the program. If health disparities and/or health inequities have been identified, describe how program activities are designed will address these issues. Complete a methodology work plan to identify program objectives and activities and the start and completion dates for each by completing the Methodology Work Plan (Appendix H).

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

**F. Federal Funding Accountability and Transparency Act (FFATA) Requirements:** FFATA was signed on September 26, 2006. FFATA requires ODH to report all subgrants receiving \$25,000 or more of federal funds. All applicants applying for ODH grant funds are required to complete the FFATA Reporting Form in GMIS.

All applicants for ODH grants are required to obtain a Data Universal Number System (DUNS) and a Central Contractor Registration Number (CCR) and submit the information in the grant application, Attachment B. For information about the DUNS, go to <http://fedgov.dnb.com/webform>. For information about CCR go to [www.ccr.gov](http://www.ccr.gov).

Information on Federal Spending Transparency can be located at [www.USAspending.gov](http://www.USAspending.gov) or the Office of Management and Budget's website for Federal Spending Transparency at [www.whitehouse.gov/omb/open](http://www.whitehouse.gov/omb/open).

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

- G. Electronic Funds Transfer (EFT) Form:** Print in PDF format and attach in GMIS. **(Required only if new agency; thereafter, only when banking information has changed.)**
  
- H. Internal Revenue Service (IRS) W-9 and Vendor Forms:** Print in PDF format and attach in GMIS. **(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:**
  - 1. Vendor Information Form (New Agency Only), or**
  - 2. Vendor Information Change Form (Existing agency with tax identification number, name and/or address change(s).)**
  - 3. 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 Services Unit, 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.

- I. Public Health Accreditation Board Standards:** Attach in GMIS the PHAB Standards that will be addressed by grant activities.
  
- J. Public Health Impact:** Only for applicants which are not local health departments, attach in GMIS 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 PHAB Standards. If a statement of support from the local health districts is not available, indicate that and submit a copy of the program summary your agency forwarded to the local health district(s).
  
- K. Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations **must** submit documentation validating current liability coverage. Attach in GMIS the Certificate of Insurance Liability **(Non-Profit organizations only; current liability coverage and thereafter at each renewal period.)**

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

**M. Attachment(s):** Attachments are documents deemed necessary to the application that are not a part of the GMIS system. Attachments that are non-Internet compatible must be postmarked or received on or before the application due date. All attachments must clearly identify the authorized program name and program number. All attachments submitted to GMIS must be in one of the following formats: PDF, Microsoft Word or Microsoft Excel. Please see the GMIS bulletin board for instructions on how to submit attachments in GMIS. An original and the required number of copies of non-Internet compatible attachments must be mailed to the ODH, Grants Services Unit, Central Master Files address by 4:00 p.m. on or before (October 15, 2013. |

**The following attachments are required by Program to be attached in GMIS 2.0**

1. Appendix E. Executive Summary and Program Narrative should be named “*Name\_Narrative\_2014*”
2. Statement of Intent to Pursue Health Equity should be named “*Name\_Equity14*”
3. Appendix F. Key Personnel Form should be named “*Name\_Personnel\_14*”
4. Appendix H. Methodology Work Plan should be named “*Name\_Workplan\_14*”.
5. Appendix I. \*Supplemental Coalition Building Methodology Work Plan should be named “*Name\_supplement\_workplan2014*”.
6. Appendix M. Demographics Table should be named “*Name\_Demo*”
7. Letters of support should be saved together as one .pdf and named “*Name\_LOS14*”
8. Letter indicating permission to travel out of county for meetings should be named “*Name\_travelLetter14*”

**III. APPENDICES**

- A. GMIS Training Form
- B. Injury Prevention Background
- C. Required Year 1 Objectives for All Priority Areas
- D. Program Focus Area Application Guidance
- D.1 Supplemental Funding Opportunity – Statewide Coalition Building
- E. Instructions for Executive Summary and Program Narrative Template
- F. Key Personnel Form
- G. Methodology Work Plan Instructions
- H. Methodology Work Plan for Injury Focus Areas
- I. Methodology Work Plan for Supplemental Coalition Building (optional)
- J. Core Competency for Violence and Injury Prevention Professionals
- K. Sources of Ohio-specific Injury Data
- L. Injury Prevention Coalition Representation Ideas
- M. Community Demographics Table
- N. Scoring Criteria and Reviewer Sheet
- O. 2012 County Population Estimates for Determining Budget Ceiling

Ohio Department of Health  
GMIS TRAINING

ALL INFORMATION REQUESTED MUST BE COMPLETED FOR EACH EMPLOYEE FROM  
YOUR AGENCY WHO WILL ATTEND A GMIS 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 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: 1st choice \_\_\_\_\_, 2nd choice \_\_\_\_\_, 3rd choice \_\_\_\_\_

Mail, E-mail, or Fax To: Gail Byers  
Grants Services Unit  
Ohio Department of Health  
246 N. High Street  
Columbus, Ohio 43215  
E-mail: [gail.byers@odh.ohio.gov](mailto:gail.byers@odh.ohio.gov) Fax: 614-752-9783

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

## Injury Prevention Background

The ODH Violence and Injury Prevention Program (VIPP) will be funding population-based projects that can demonstrate a multifaceted and multidisciplinary approach to injury prevention with complimentary evidence-based interventions. Population-based interventions refer to planned and systematic activities which primarily target influential persons, leaders, decision-makers and persons who can facilitate sustainable policies, environmental changes, services, training activities and information for those at risk for injury.

The specific goal of this grant program is to reduce injury and injury related deaths to Ohioans through the development of comprehensive multi-faceted population-based programs at the local level that address the risks associated with unintentional injuries. It is expected that as a result there will be:

- An increase in the capacity of local communities to effectively address the risks associated with leading causes of unintentional injury.
- Development of collaborative programs that involve local partnerships between public health and others such as health care, EMS, police, schools, businesses, day cares, senior centers etc.

Multi-faceted interventions involve a comprehensive approach of strategies including:

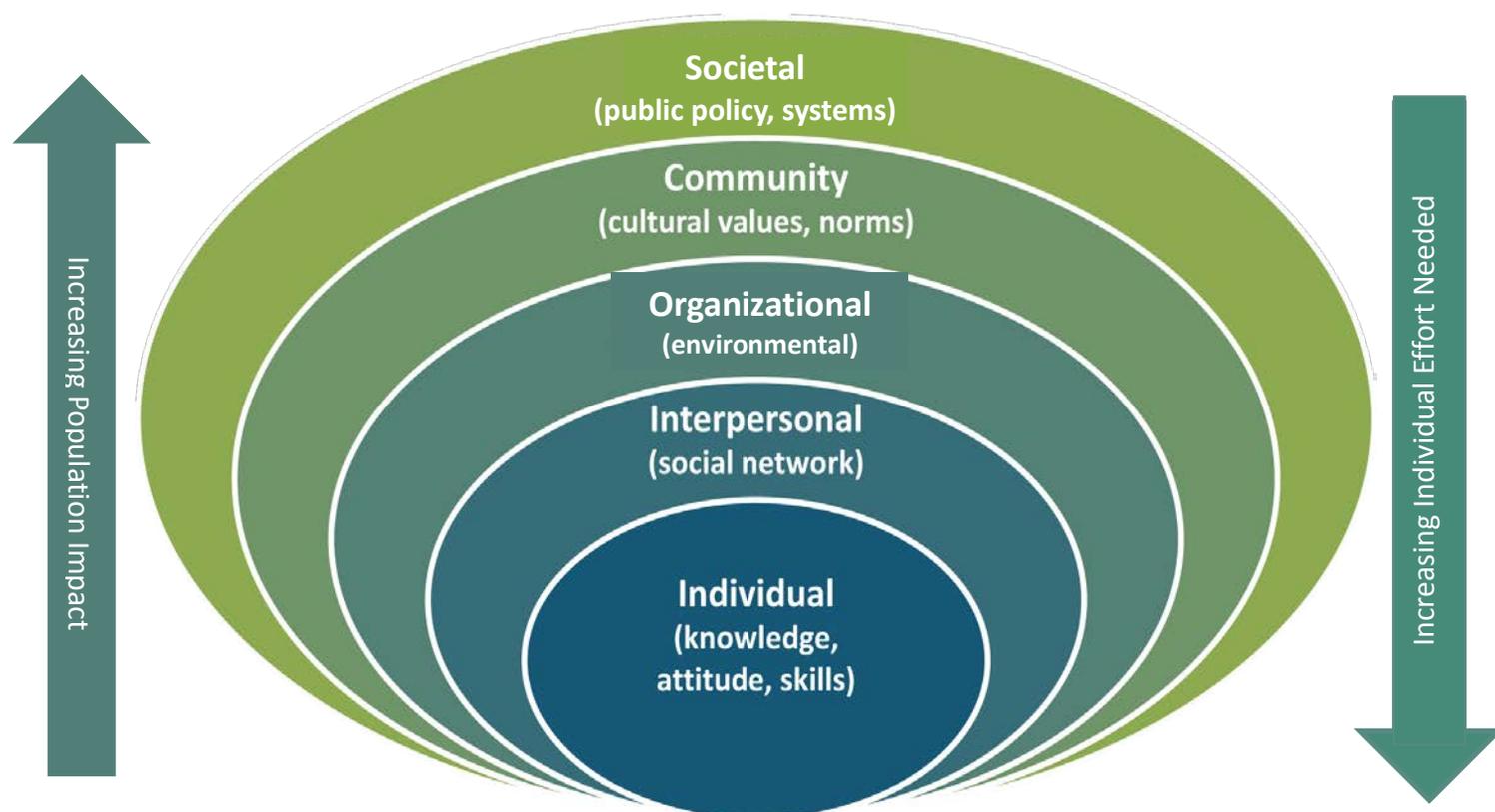
- Community assessment and injury surveillance
- Education/training relative to the risks associated with injury that will extend beyond the project period
- Enactment and enforcement of regulations and policies aimed at reducing injury risks
- Design and implementation of environmental and social systems that will reduce risks
- Evaluation

Sometimes referred to as the “E’s” (i.e., education, environmental strategies, enactment and enforcement of policy, engineering and evaluation) of injury prevention, injury prevention strategies are most effective when they are conducted at multiple levels using multiple interventions. For example, a new helmet ordinance may not succeed unless the community is educated about it through the media, youth norms are changed about helmet use, law enforcement are engaged in developing the policy and supportive of enforcing it, and helmets are provided in low income communities. The overall goal is to make the safe choice easy and the unsafe choice difficult.

### The Socio-Ecological Model

Population-based interventions create change in social systems and environmental conditions at the community level that will influence and support individual behavior change. The socio-ecological model presented below is included to reinforce a multi-faceted perspective in examining injury risks. Prevention strategies should include a continuum of activities that address multiple levels. This approach is more likely to sustain prevention efforts over time than any single intervention. These activities should be developmentally and culturally appropriate.

## Socio-Ecological Model



**Individual** - The first level identifies biological and personal history factors that increase the likelihood of being injured. Some of these factors are age, education, income, substance use, or personal history. Prevention strategies at this level are often designed to promote attitudes, beliefs, and behaviors that ultimately prevent injury. Specific approaches may include education, promote safety device use and life skills training.

**Interpersonal** - The second level examines close relationships that may increase the risk of experiencing injury. A person's closest social circle-peers, partners and family members-influences their attitudes, behavior and contributes to their range of experience. Prevention strategies at this level may include parent contracts and peer programs designed to reduce risk-taking behavior, foster problem solving skills, and promote healthy relationships.

**Organizational Environments** - The third level explores the settings, such as schools, workplaces, and neighborhoods, in which behavior occurs and seeks to identify the characteristics of these settings that are associated with injury. Prevention strategies at this level are typically designed to impact the climate, processes, and policies in a given system. Social norm and social marketing campaigns are often used to foster community climates that promote safety.

### Community Environments

The fourth level examines the social environment including community values, norms that reinforce behaviors and patterns, as well as the physical environment that may reduce or increase an individual's injury risk, often without their awareness.

**Societal** - The last level looks at the broad societal factors that help create a climate in which unsafe behaviors or environments are encouraged or inhibited. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society and may lead to health/safety disparities. An example may be a community setting in which older, poorly maintained housing contributes to more fire-related injuries and deaths or a low income community where access to safe play spaces is limited and children must play in or near busy urban streets, leading to more pedestrian-related injury and deaths. While these factors can be more difficult to impact, they will continue to impact safety and injury on a larger scale than any safety programs targeting individual or interpersonal levels only.

### Spectrum of Prevention:

Funded injury prevention interventions should address interventions across a “Spectrum of Prevention”. The *Spectrum* identifies multiple levels of intervention and encourages people to move beyond the perception that prevention is just about teaching healthy and safe behaviors. The *Spectrum's* six levels for strategy development is a framework for a more comprehensive understanding of prevention. These levels are complementary and when used together produce a synergy that results in greater effectiveness than would be possible by implementing any single activity. At each level, the most important activities related to prevention objectives should be identified. As these activities are identified, they will lead to interrelated actions at other levels of the *Spectrum*. For more information, visit [http://www.preventioninstitute.org/index.php?option=com\\_jlibrary&view=article&id=105&Itemid=127](http://www.preventioninstitute.org/index.php?option=com_jlibrary&view=article&id=105&Itemid=127).

Successful injury prevention projects include activities and interventions that span the spectrum of prevention, with most focus on the upper tiers of the model. The lower tiers should support changes at the upper tiers. Strategies that focus on the upper tier of the model are often considered “passive” intervention strategies because they do not require behavior change and may protect the community without their awareness. Standards requiring airbags in motor vehicles and impact-absorbing playground surfacing are examples of passive injury prevention strategies. Like a vaccine, they protect individuals from injury without any action on the part of the individual benefitting from the strategy.

## The Spectrum of Prevention



~Prevention Institute, August 1999

Applicants are encouraged to develop work plans that address all levels of the Spectrum, with more effort being spent on the upper tiers of the spectrum.

### **Evidence of Effectiveness of Proposed Interventions:**

Interventions must be evidence-based or have an evidence-informed approach supported by ongoing evaluation to determine effectiveness. See the following web sites for a range of evidence-based interventions. Additional focus-area specific resources are provided in the focus area sections.

- <http://www.thecommunityguide.org>
- [http://ctb.ku.edu/en/promisingapproach/Databases\\_Best\\_Practices.htm](http://ctb.ku.edu/en/promisingapproach/Databases_Best_Practices.htm)
- [http://www.preventioninstitute.org/spectrum\\_injury.html](http://www.preventioninstitute.org/spectrum_injury.html)
- <http://www.cdc.gov/transportation/recommendation.htm>
- <http://www.convergencepartnership.org>
- <http://www.healthyagingprograms.org>
- <http://preventioninstitute.org/component/jlibrary/article/id-267/127.html>

### **Examples of Injury Prevention Strategies for Population-based Programs**

Examples of population-based interventions include:

- A. Injury Surveillance and Community Needs Assessment** – an activity which detects and monitors local and statewide conditions or incidents contributing to morbidity and mortality. For example, collecting and disseminating injury data from EMS, hospitals, or school systems or collecting data on pedestrian hazards in specific locations.

Essential Elements:

1. Predetermine a plan for using data collected (e.g. sharing with appropriate groups, policy development, creating interventions, etc.)
2. Use standard case definitions and variables.
3. Use reliability and validity testing to confirm adequacy of data collection instrument.
4. Use appropriate sample size for data collection.
5. Establish a system of Quality Assurance.
6. Establish a protocol for assuring confidentiality of data.
7. Adhere to a data collection time table.
8. Disseminate results.

#### **Injury Prevention Examples:**

- By December 2014, “agency” will establish an electronic injury surveillance system for fall-related injuries among older adults (ages 65+) occurring in Madison township.
- By December 2014, “agency” will publish a report of data collected and analyzed through the new injury surveillance system and present the results to school administrators.
- By July 2014, “agency” will produce a summary report based on data collected by the PTA to identify high risk pedestrian locations on children’s routes to school at six local elementary schools in Safesteps, Ohio.

- By December 2014, “agency” will establish an injury surveillance system to capture sports-related traumatic brain injuries occurring to youth ages 0 to 18 years in Sportington County.
- By December 2014, “agency” will improve the percentage of injuries e-coded in Safe-T County from 50% to 80% by:
  - Creating factsheets for hospital coders to show the percentage of injuries in respective hospitals that are e-coded, uses of e-coded injury data for planning prevention efforts and resources for improved e-coding.
  - Conducting a brief needs assessment of coders on what tools would assist them in improving injury coding such as creating an e-coding cheat sheet for coders that includes commonly occurring injuries and the desired e-codes.
  - Inviting coders to participate on coalition and provide a presentation to coalition members on data coding.
  - Drafting and mailing a brief letter to ER physicians and nurses describing the importance of carefully documenting the circumstances of injuries in the medical record and including case examples of the desired level of detail (e.g., circumstances, location, how the injury occurred, etc.). The letter will include an invitation to participate on the IP coalition too.

B. **Policy Enactment (Adoption) and Enforcement** – an activity which relates to steps taken or facilitated by program staff to bring about development or change of policy. For example, the implementation of a school return-to-learn policy or a local bicycle helmet ordinance.

Essential Components:

1. Document need for policy adoption activities through quantitative or qualitative data.
2. Educate critical decision-makers or intermediaries about the burden of injury and evidence-informed strategies to address it.
3. Policy to be adopted should reflect best practices in related fields.
4. Identify support and involvement of stake holders within agreed upon timeline.
5. Identify/adhere to existing legal/organizational protocols for instituting policies.
6. Qualitative data indicates proposed policies are acceptable to priority segment of the population.
7. Use promotional activities to inform the community and stakeholders once new policies are adopted and implanted.
8. Identify and review enforcement measures to assure adopted policies are maintained.
9. Evaluate impact of policies adopted.

**Injury Prevention Examples**

- By December 2014, “agency” will create a factsheet about bicycle-related injury in Safestreeets OH and the effectiveness of helmet policies requiring children younger than 18 years to wear a helmet when riding a bicycle, skateboard, scooter .... on public streets, in parks, etc. ...
- By June 2014, “agency” will promote enforcement of the new helmet ordinance by meeting with the chief or a lead representative of all law enforcement agencies.
- By December 2014, “agency” will determine the effectiveness of the new local helmet ordinance by evaluating pre/post helmet observation studies.
- By December 2014, “agency” will facilitate adoption of helmet policies for youth who ride bicycles to school in four schools in ABCtown, OH.

- By December 2014, three hospitals in NoFallCounty, OH will implement hospital discharge policies for older adults who have fallen to include referrals to appropriate aftercare (e.g., Matter of Balance, Tai Chi, home safety programs, physical therapy, etc.).
- By December 2014, “Agency” will integrate training on appropriate pain management into Fairview Hospital’s continuing education requirements for all prescribers.
- By December 2014, 5 hospital EDs will adopt the Ohio Emergency and Acute Care Opioid and Other Controlled Substances Prescribing Guidelines.
- By December 2014, “Agency” will educate key school decision-makers in 5 high schools about Ohio’s GDL and gain commitment to implement CDC’s Parents are the Key Campaign in Safedrive, OH.
- By December 2014, “Agency” will increase GDL enforcement by sharing injury data on teen driver deaths to law enforcement leadership in Safestreeets, OH.
- By December 2014, Agency will educate key decision-makers in 3 high schools about the risk of multiple TBI’s, the importance of return-to-learn policies and the components of a model return-to-learn policy.

C. **Environmental, Engineering and Systems Change** – an activity which relates to steps taken or facilitated by program staff to bring about changes in the county environment or community or organizational systems. For example, identification and intervention related to high risk areas or activities.

Essential Elements:

1. Document need for environmental and systems change
2. Use a predictor or feasibility study or data, which indicates what it will take to involve the target population or stakeholders.
3. Use local partners/collaborators to establish consensus regarding an effective environmental change.
4. Document adequate financial and stakeholder support (including coalition involvement).
5. If support is not available, activities should include raising awareness, enhanced research of the proposed system change, and/or social marketing intervention.
6. Plan to inform and promote the environmental change among the target population.
7. Show evidence of segments already responding to the proposed environmental change (early adopters)
8. Plan for ongoing maintenance of environmental systems change (institutionalization).

**Injury Prevention Examples:**

- By December 2014, “Agency” will implement a home safety program available to 750 older adults through partnerships with XYZ EMS Agency.
- By October 2014, the Merrystown Neighborhood Association will have plans and resources to reconstruct the Safestreet Park playground with new equipment and surfacing as determined by status reports and meeting updates.

- By December 2014, “agency” will decrease child safety seat misuse from 85% to 75% in Safetystar County, as measured by misuse forms completed by trained technicians, by establishing and promoting 5 countywide fitting stations.
- By December 2014, “agency” will increase implementation of the STEADI falls risk assessment screening tool in 5 family practices by providing copies of the tool kit and patient education material on falls prevention.
- By December 2014, Sunshine County HD will increase bicycle helmet usage by 10% among youth in Anytown, OH as measured through pre/post helmet observation surveys to be conducted in June 2014 by implementing five new community-based helmet “fitting stations” in fire department stations.
- By December 2014, “agency” will increase seat belt use on tractors from X to X based on pre-post survey of 4H youth ages 10-17 enrolled in the Be Farm Safe course.
- By December 2014, the Pro-Bike Ohio coalition will develop plans and petition the Parks Department to create a new walking/bicycling path.
- By December 2014, “Agency” will produce one set of recommendations for the development of a naloxone distribution program in ZeroODville, OH.
- By December 2014, “Agency” will increase use of OARRS in SafeDoc, OH by gaining commitment from 10 physician practices.

D. **Training** – an activity which relates to steps taken or facilitated by program staff to train individuals to provide services that will extend beyond the project period. For example, facilitate training of appropriately qualified volunteers or resources and training to professionals such as teachers or other community leaders.

Essential Components:

1. Include comprehensive training methodology and a plan that includes goals, learning objectives, behavioral objectives and evaluation component.
2. Use train-the-trainer activities that include best practices, including cultural competency.
3. Plan training activities in cooperation with the priority population.
4. Employ trainees whose background and job responsibilities are appropriate.
5. Understand that training is part of an overall strategy to institutionalize a program.
6. Offer refresher/advanced/support training opportunities as appropriate.

**Injury Prevention Examples**

- By October 2014, “agency” will train representatives from ten local EMS agencies to conduct home safety checks for older adult community members as documented by training evaluations and participant’s signed intent to perform at least two safety checks.
- By July 2014, Sunshine County HD will institute an older adult fall prevention train-the-trainer program among home health care providers by conducting four on-site trainings for home health care agencies.

- By October 2014, 15 school representatives will be trained to conduct basic playground safety checks at middle schools in Faraway County as documented by evaluation forms and their signed intent to perform monthly safety checks of their school's playground.
- By December 2014, "agency" will institute the Be Farm Safe train-the-trainer course at 12 Mason County 4-H clubs as measured by follow-up surveys.
- By December 2014, "agency" will provide training and resources to all pediatricians in Acortown on the TIPP program so they can counsel parents and children about adopting behaviors to prevent injuries.
- By December 2014, "agency" will develop a parent education component on Ohio's GDL law to be offered in collaboration with ABC Driving School.
- By December 2014, "Agency" will create a train-the-trainer kit for office-based practices on the STEADI tool kit and will include resources for patient education and reimbursement options.

E. **Media Advocacy** – the use of mass media to support community organizing to advance a social or public policy initiative/change through the use of editorials, interviews, media events, letters to the editor and/or paid ads. See specific objective for Media Advocacy.

Essential Components:

1. Use media campaigns based on documented need.
2. Clearly define segmental audiences.
3. Media shots should occur often and consistently enough to impact opinions.
4. Develop working relationship with media personnel.
5. Provide information that is accurate, consistent and utilizes credible persons for the delivery of the message.
6. Utilize multiple media channels to shape the message.
7. Develop Media Action Plan prior to the delivery of media activities.
8. Contain an evaluation plan that measures impact of message delivery.
9. Involve members of the target population in designing the media message.

F. **Media Campaigns, Information and Support** – an activity which relates to steps taken by program staff to use the media to inform the public about healthy lifestyles or resources/events available, and enhance primary population based initiatives. For example, PSAs, print articles, billboards/signs, participation in talk shows, radio/TV segments to promote the planned intervention. See specific objective for public awareness campaigns.

Essential Elements:

1. When possible and appropriate, link to community based special events, state or national Health campaigns/initiatives.
2. Use media outlets based on cultural appropriateness.
3. Review campaign messages already developed to ascertain appropriateness for proposed campaign.
4. Pretest for message acceptability and cultural appropriateness.
5. Identify population segments for campaign.

**Media Advocacy/Campaigns - Injury Prevention Examples**

- By May 2014, “agency” will initiate a bicycle helmet social marketing campaign with targeted messages based on focus group results to increase awareness of new helmet ordinance.
- By October 2014, “Agency” will develop a fall prevention media campaign for older adults living alone by partnering with the local XBC TV affiliate’s health liaison, to be released and promoted on National Fall Prevention Awareness Day 2014.
- By September 2014, “Agency” will coordinate a Pedestrian Safety press conference with the local media outlets during “Walk Your Child to School Day 2014”. At the press conference, the following evidence supporting the need to improve pedestrian hazards through sidewalk repairs, improved signage, traffic calming strategies, etc. will be released:
  - a collage of photographs taken by children on their walks to school documenting the pedestrian hazards they navigate each day.
  - a report of pedestrian-related injuries occurring to children walking to school from 2008 – 2009 in Blank Co .
- By October 2014, “agency” will develop a media campaign with acceptable messages for increasing use of helmets among elementary school-aged children while bicycling, skating or skate boarding. Messages will be created through focus groups with target children.
- By December 2014, “agency” will develop a social marketing campaign targeting middle-aged adults on the importance of taking medication as prescribed and the dangers of sharing prescription drugs. Messages will be crafted through use of commercial market research data and piloted in focus groups with affected population.
- By December 2014, “agency” will create a Facebook page for XYZ coalition members to share resources and information related to prescription drug abuse/overdose.
- By December 2014, “agency” will hold a press conference to release annual report on child injuries in Safe-T-town, OH and discuss the need for evidence-based prevention strategies.
- By December 2014, “agency” will issue a press release on annual overdose data and highlight the new pain management prescribing resources available.

## Required Year 1 Activities for All Priority Areas:

### 1. Partnerships, Coalition Building and Coalition Evaluation

Most successful injury prevention approaches require building local partnerships to assure sustainability of the efforts. All funded projects will be responsible for working with a functioning, local coalition comprised of appropriate, multi-disciplinary and representative community stakeholders. Key partners may include, but are not limited to:

- Public health
- School districts
- Communities
- Worksites
- Local transportation agencies
- Housing agencies
- Parks and recreation
- Area Agencies on Aging
- Law enforcement/EMS
- Health care/hospitals
- Coroners
- Media
- Public policy/decision-makers
- Children, youth and families

A list to help generate ideas for coalition membership is included in Appendix L. For all key partners identified in the work plan, a letter of agreement from the partner describing the partnership and responsibilities to carry out the work plan ***must*** be provided with this application.

For projects with existing coalitions, expansion and evaluation of the coalition will be a required year 1 activity. This process is intended to be completed in collaboration with coalition members. A list of recommendations and next steps should be produced and submitted to ODH no later than October 15, 2014. Those next steps should be incorporated into the year 2 work plan to strengthen and enhance the coalition. For those projects establishing new coalitions, the year one activity will be the establishment of a functional coalition dedicated to the prevention of your injury focus area. These projects will be required to evaluate their coalitions during year 2 of the project.

#### **Coalition Building: ODH Required Year 1 Activities:**

##### **For those applicants establishing new coalitions:**

- a. Establish a multidisciplinary coalition comprised of appropriate and relevant key community stakeholders focused on your injury priority area. This includes members from diverse communities including racial and ethnic minority populations. A list of members must be provided to ODH Program Consultant by June 30, 2014.
- b. The coalition should meet at least 4 times before December 31, 2014. Meeting agendas and notes should be developed as evidence of these meetings. Coalition development strategies and meetings should be clearly documented in the process objectives of the year 1 work plan.

##### **For those applicants with existing coalitions:**

- a. Conduct an evaluation of your existing coalition during year 1 using guidance provided by ODH. Evaluation results must be provided to ODH Program Consultant by no later than October 15, 2014.
- b. Expand coalition focused on priority injury topic by at least 3 key stakeholders per year. The coalition should meet in person no less than quarterly. Meeting agendas and notes should be developed as evidence of these meetings. Quarterly meetings should be clearly reflected in the process objectives of the work plan.

## 2. Community Needs Assessment and Evaluation Plan Logic Model Development

All funded projects regardless of previous ODH IP funding must conduct a community needs assessment unless grantee can provide results of community needs assessment which are less than 2 years old and in alignment with ODH guidance. The needs assessment will provide the baseline data that will be used to focus activities on the highest need communities as well as to monitor progress throughout the 5-year funding period.

All funded projects must also develop an evaluation plan logic model by December 31, 2014, The development of the logic model must be conducted in conjunction with the community coalition and will be used to connect activities and inputs to short, intermediate and long-term project outcomes.

### **Community Needs Assessment: ODH Required Year 1 Activities:**

- a. Conduct an in-depth needs assessment of injury and injury prevention needs.** The assessment must use both local injury and risk factor data, as well as input from key community informants (e.g., surveys, focus groups, interviews, etc.) and coalition members (e.g., planning sessions, etc.) to identify community needs and gaps which can be feasibly addressed within the 5-year program funding period. The community needs assessment should also specify groups who are disproportionately impacted by unintentional injury. A copy of the needs assessment results and recommendations should be submitted to ODH by no later than December 31, 2014.

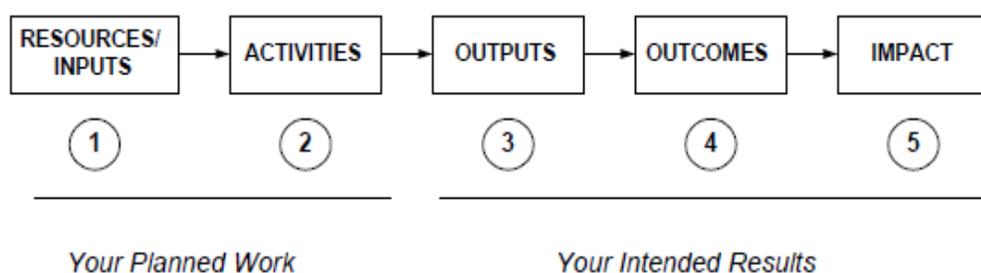
### **The assessment must be accomplished through use of data from at least two sources from 1. and two sources from 2. below:**

1. Relevant **local** injury data (distal measure) including at least 2 sources:
  - Coroner/vital statistics/death data (ODH data warehouse and CDC WONDER have county-level injury death data).
  - Local (county/zip code) hospital discharge: Inpatient and ED data
  - Trauma Registry data
  - EMS data
  - ODPS traffic crash reports
  - VIPP county profiles for selected counties
  - Ohio Mental Health and Addiction Services (OhioMHAS) – State Epidemiological Outcomes Workgroup (substance abuse) data
2. Relevant **local** injury risk behaviors/needs (proximal measure) including at least 2 sources:
  - Focus groups
  - Written or verbal surveys
  - Observations
    - a. Behavioral (e.g., bicycle helmet observations, etc.)
    - b. Environmental (e.g., environmental safety scans, walkability/bikeability checklists, etc.)
    - c. Photo-journaling (e.g., pedestrian intersections, playgrounds, etc.)
  - Census geographies (census tracts, census block groups) where injuries occur at higher rates than the rest of the community (if data are available).
  - Other sources (e.g., local prescription monitoring program data)

Use of data must be logical and tied directly to program goals and objectives. The needs assessment results must be presented to key stakeholders, organization leadership (e.g., health commissioner, hospital trauma management, etc.) partners and coalition members. Both the feasibility and potential impact of evidence-based strategies should be assessed to address local needs. Additional guidance will be provided by ODH to funded projects in year 1.

**b. Develop and submit a 5-year evaluation plan logic model that will serve to monitor progress over the 5-year funding period by December 31, 2014.**

A logic model describes the main elements of an intervention and how they work together to improve health and/or safety in a specific population. This model is often displayed in a flow chart, map, or table to portray the sequence of steps leading to intervention outcomes. It can assist in guiding connecting the dots from activities to long-term outcomes and impacts.



For funded projects, additional technical assistance and information will be provided about the process and format for the logic model. For the purposes of the application, describe the process to be used to develop your needs assessment and logic model and how that will form the basis for your project's evaluation plan. Be sure to include how key stakeholders will be involved in the development of the logic model. The completion of the needs assessment must also be included in your work plan.

**3. Policy, Systems and Environmental Change (PSEC) Strategies:**

PSECs may include ordinances, organizational policies, environmental changes, health care system changes, community-based interventions, regulations, etc. Impacting PSEC goals should be the primary focus of your activities. **Training and education of key stakeholders** and **media advocacy, campaigns, information and support** should be supportive activities for evidence-based PSECs.

Funded projects will describe plans to implement and demonstrate progress on at least 3 PSEC-related strategies.

- **Policy strategies** include steps taken or facilitated by program staff to bring about development of or change in policy. Policy change may include laws, ordinances, organizational policies, regulations, etc.

Local health departments and hospitals have an essential role in ensuring that decision makers and partners have the best available evidence to prevent injuries through active participation in the policy process. For example, programs play an important role in using scientific evidence

and epidemiological data to educate both internal and external decision makers and partners about the injury and violence burden and other related health issues. In addition to educating about the burden or public health problem, health-related organizations also have a role to play in presenting information about evidence based policy interventions when describing strategies to prevent injuries and their consequences. Public health agencies have a role to play in all types (organizational, regulatory, and legislative) of policy initiatives.

The IP subgrants are supported by the Preventive Health and Health Services Block Grant (PHHSBG) from the CDC. Federal funds may not be used directly or indirectly “to favor or oppose any legislation, law, ratification, policy, or appropriation” or “to support or defeat any legislation pending before the Congress or any state legislature”.<sup>1</sup> CDC does not use or allow grantees/contractors/subgrantees to use appropriated funds, directly or indirectly, to lobby any federal or state legislative body. These prohibitions do not impact subgrantees’ ability to communicate through a normal and recognized executive relationship and grantees are allowed to participate in the normal policymaking and administrative processes within the executive branch of their state and local government, if within appropriate boundaries<sup>2</sup>.

Allowable activities related to contact with public policymakers vary by organization; therefore it is important to consult internal agency or organizational rules, state laws, and (where applicable) federal laws to ensure full compliance in addition to consulting your ODH Program Consultant.

#### **Organizational Policy Strategies:**

There are no federal funding prohibitions on participation in organizational policy strategies. Evidence-based organizational policy changes have the ability to impact change by increasing favorable behaviors and decreasing injury. Activities to influence organizational policies and regulations include the following:

- Inform schools, child-care providers, clinicians, or businesses of evidence-based best practices to prevent injury and death that can be incorporated into policy at their specific institutions (e.g., bike-to-school helmet policies, return-to-learn TBI policies for youth, drug-free workplace policies including prescription drug abuse).
- Provide information about evidence-based falls prevention screening practices to health care providers that may be implemented as organizational policies.
- Assess the impact and effectiveness of an existing policy (e.g., referee/coach training on sports-related concussion, removal-from-play, GDL knowledge and enforcement by parents in your community, local bicycle helmet ordinance).
- Encourage schools to implement a policy that supports active transportation for students (pediatric pedestrian education programs, crossing guards, infrastructure grants through SRTS, etc.) in collaboration with the Safe Routes to School program.
- Encourage the adoption of pain management prescribing guidelines for local health care organizations.

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<sup>1</sup> Lobbying of Federal or State Legislative Bodies Memo. June 11, 2003. (Document cites the following two laws: Federal Law 18 USC 1913 and The Department of Health and Human Services Appropriation Act, 2003 (Pub. L. 108-7). Retrieved from <http://pgo.cdc.gov/pgo/webcache/Regulations/Lobbying%20of%20Federal%20or%20State%20Legislative%20Bodies%20Memo%206-11-03.pdf>

<sup>2</sup> CDC Implementation of Anti-Lobbying Provisions. Retrieved from: [http://www.cdc.gov/od/pgo/funding/grants/Anti-Lobbying\\_Restrictions\\_for\\_CDC\\_Grantees\\_July\\_2012.pdf](http://www.cdc.gov/od/pgo/funding/grants/Anti-Lobbying_Restrictions_for_CDC_Grantees_July_2012.pdf).

- Provide technical assistance to school systems to develop and implement a policy that supports onsite school enforcement of the evidence-based components of an existing GDL state law (emphasis on number of passengers in car, distracted driving, and seatbelt use while on campus).
- **Systems or Environmental Change Strategies** are steps taken or facilitated by program staff to bring about changes in the county environment or community or organizational systems. Change may occur to the physical (grab bars in homes) or social environment (e.g., norms about bicycle helmet/safety equipment use) or may result in changes in procedure (e.g., education of health care providers about reimbursement for falls risk assessment screenings) to improve safety. For example:
  - Encourage bicycle trails and walking routes that separate pedestrians/cyclists from motor vehicle traffic.
  - Participate in community efforts to improve physical activity by ensuring that safety is considered as environments are altered.
  - Partner with bicycle shops to offer free or low cost helmets with bicycle/wheeled sports purchases as an in-kind contribution to your coalition. Train staff on proper helmet fitting.
  - Work with EMS/Fire stations to offer bicycle helmet fitting stations, in addition to child safety seats.
  - Provide injury data on unsafe pedestrian crossings and work with city engineers to improve signage and walkability.
  - Provide model hospital discharge policies requiring follow-up falls risk assessment screening and intervention for older adults.
  - Assist law enforcement agencies in acquiring drug drop boxes to collect excess medications in the community.
  - Share data and work with local emergency departments to encourage adoption of the Ohio emergency department opioid prescribing guidelines and patient handout.

#### 4. PSEC Supportive Strategies:

**PSEC Supportive Activities** are intended to support, implement and promote policy, systems and environmental changes. These activities include steps taken or facilitated by program staff to ensure that services will extend beyond the project period.

- **Training** – Training efforts should support and enhance the other PSEC categories across the spectrum of prevention. Steps taken or facilitated by program staff to train individuals to provide services that will extend beyond the project period will be supported. For example:
  - recruiting and training instructors for health education programs to incorporate injury prevention education,
  - training health professionals on appropriate falls prevention screening techniques and reimbursement methods;
  - training school personnel on TBI and the importance of adherence to the removal-from-play law;

- incorporating a parent education component on the importance of enforcing the GDL into driver training school curriculum;
- training a network of lay coaches to lead A Matter of Balance fall prevention sessions, working with local senior centers to implement Tai Chi: Moving for Better Balance courses;
- training health care providers about prescription drug abuse and the availability of prescribing guidelines;
- **Media Advocacy, Information and Campaigns** – Media and social media can be cost-effective methods of reaching the focus population with your message. For example, when a new bicycle helmet ordinance is implemented, it is critical that the community is aware of the change or the policy will not be effective. Alternatively, informing the community that bicycle helmets are effective in preventing head injury through media or social media is not likely to be effective in changing behavior unless there is a new policy or another effort such as a helmet giveaway event to recognize a national event such as “Wear-your-helmet to school” day. Strategies should work at multiple levels and be complimentary. Media strategies should be used to help advance, promote and/or support other PSEC strategies to enhance their effectiveness.
- **Resource/Facility Availability** Strategies include 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., screening, brief intervention and referral to addiction treatment (SBIRT) services, bicycle helmet fitting stations, making recreation centers available before/after school for youth to provide a safe play spaces.

### **Direct Education/Services**

Other supplemental activities including **direct** education/services and individual programs should be kept to a minimum of grant-related effort. These activities must enhance and complement primary activities, but are not meant as stand-alone initiatives. Please refer to the following additional focus-area specific guidance to assist in completion of your project narrative and work plans.

## INJURY PREVENTION GRANT RFP PROGRAM FOCUS AREAS

Applicants must select only 1 focus area. Only one application per agency will be reviewed. Follow the instructions for the focus area for which you are applying:

- Unintentional child/youth traumatic brain injury (TBI)
- Falls among older adults
- Prescription drug overdose/poisoning

Funded projects will:

- Be population-based and address strategies across the spectrum of prevention.
- Use evidence-informed strategies.
- Be data driven and address high risk groups.
- Demonstrate strong local collaboration and effective partnerships to address injury.
- Contain a strong evaluation component including process and outcome measures.

### Focus Area 1: Unintentional Child/Youth Traumatic Brain Injury Prevention

**Number of Awards:** Up to four; awards will be determined by review scores and need criteria.

**Eligibility:** Local health departments and non-profit agencies. Program Focus Area 1 is designed to address areas of the state with the greatest unintentional injury death rates among Ohioans aged 1-18. While all counties are eligible to apply, due to the very limited available funding, counties with poverty rates and fatal youth injury rates in the 75<sup>th</sup> percentile or higher will be weighted according to the criteria described in Appendix N. Communities may provide additional community-based data to demonstrate a compelling local need for reviewers to consider including those groups which are disproportionately impacted by the focus area.

**Background:** Unintentional injuries remain the leading cause of death and disability for children and youth in Ohio. Most unintentional injuries are preventable.

- On average, 280 Ohio youth die each year from unintentional injury. The leading causes of unintentional injury-related death among children/youth are motor vehicle traffic (including pedestrian and bicycle), poisoning, drowning, fire/burn and suffocation, although these vary by specific age groups.
- On average each year, more than 1,950 inpatient hospitalizations and 166,000 ED visits among Ohio children aged 14 and younger are due to injury.
- The leading causes of injury-related hospitalization are unintentional falls, motor vehicle traffic, struck by/against, poisoning and other land transportation.
- Among Ohio teens aged 15 to 19, motor vehicle traffic accounts for nearly three-fourths (73 percent) of the unintentional injury deaths.
- Male youth are at greater risk for most injuries.
- Injury death rates for young (<14 years) black children are disparately high in comparison to rates for young white children, specifically for fire/burn, drowning, suffocation and pedestrian-related injury death.
- A comprehensive burden of injury report was completed by the VIPP in 2012. Additional detailed data can be found in that report at: <http://www.healthyohiprogram.org/vipp/data/burden.aspx>

- Special reports devoted to child injury and traumatic brain injury can be found at:  
<http://www.healthyohiprogram.org/en/vipp/data/childdata.aspx>

**Data Driven Injury Mechanism:** Funded projects will be data-driven and focus on the leading causes/mechanisms (i.e., falls, sports and recreation-related TBI, bicycle and pedestrian safety, teen driving, etc.) of child/youth unintentional traumatic brain injury or established injury risk factors (e.g., observed low bicycle helmet use) in the applicant community. **At least one focus of the program must be on TBI prevention;** however, additional child injury topics may be included as well if indicated by local data and year one needs assessment process.

*Note: Child passenger safety (CPS) projects will not be funded through this application as ODH funds CPS through another funding mechanism. Pedestrian/bicycle and recreational vehicle safety projects are acceptable if indicated by local data. Teen driving projects are acceptable if your agency is not receiving funding from the Ohio Department of Public Safety for these activities.*

**Addressing Disparities:** Funded projects will describe and address disparities in unintentional child/youth TBI rates as identified in the applicant community. Available data sources are referenced above and available in Appendix L.

**Objectives and Activities:** Applicants must develop SMART objectives in each of the following categories. *Please note that programs have the entire project period (5 years) to accomplish all long-term outcome objectives but all objectives must be included in this application.* Follow the instructions in **Appendices E (Program Narrative template), G. (Methodology Work Plan Instructions) and H. (Methodology Work Plan)** and complete carefully.

- 1. Coalition Building and Coalition Evaluation:** See ODH Required Year 1 Activities for all Grantees in Appendix C
- 2. Community Needs Assessment and Evaluation Plan Logic Model Development:** See ODH Required Year 1 Activities for all Grantees in Appendix C
- 3. Policy, Systems and Environmental Change –** Applicants will identify at least 3 PSEC-related activities to pursue in year one. These may be modified based on the results of the year 1 community needs assessment and prioritized by the coalition in terms of importance and feasibility. A prioritized list of PSEC strategies must be presented to ODH in the year 2 continuation application.
- 4. PSEC Supportive Activities –** See Appendices B-C

**Evidence-based Strategies:** Funded projects will use evidence-based PSEC strategies, including promising practices. In the **Program Narrative section of Appendix B**, you must specify a research-based source that validates the strategy(ies) you have selected. Following are several sources that describe evidence-based strategies for child/youth injury prevention and will help you complete this section. Innovative applications of evidence-based strategies are also encouraged.

- **CDC National Center for Injury Prevention and Control**
  - **National Action Plan for Child Injury Prevention**  
<http://www.cdc.gov/safechild/NAP/index.html>
  - **TBI Prevention** <http://www.cdc.gov/traumaticbraininjury/prevention.html>
  - **Heads Up: Concussion in Youth Sports Training Materials**  
<http://www.cdc.gov/concussion/sports/index.html>

- **Teen Driving:** [http://www.cdc.gov/Motorvehiclesafety/Teen\\_Drivers/index.html](http://www.cdc.gov/Motorvehiclesafety/Teen_Drivers/index.html)
- **Children’s Safety Network**
  - **Recommendations by topic area** <http://www.childrensafetynetwork.org/injurytopic>
  - **Promoting Bicycle Safety for Children: Strategies and Tools for Community Programs** [http://www.childrensafetynetwork.org/sites/childrensafetynetwork.org/files/CSNBikeSafety\\_brochure.pdf](http://www.childrensafetynetwork.org/sites/childrensafetynetwork.org/files/CSNBikeSafety_brochure.pdf)
- **Pedestrian and Bicycling Information Center** <http://www.bicyclinginfo.org/>
- **Policy Statements of the American Academy of Pediatrics, Committee on Injury, Violence and Poison Prevention – Helmet Policy Statements**
  - <http://pediatrics.aappublications.org/search?fulltext=helmets&submit=yes&tocsectionid=From+the+American+Academy+of+Pediatrics&tocsectionid=American+Academy+of+Pediatrics>
- **Ohio Youth Bicycle Helmet Ordinance Toolkit** <https://sites.google.com/site/ippaag/helmet-toolkit>
- **Children’s Hospital of Philadelphia – Teen Driving** <http://www.teendriversource.org/>

**Collaboration and Integration of Activities:** Funded programs should work collaboratively with other ODH-funded programs, including, but not limited to the following. Include documentation of these collaborations or planned collaborations as appropriate in the *Coalitions and Partnerships* section of **Program Narrative in Appendix E.**

- **Creating Healthy Communities grants –**
  - In funded counties, chronic disease/obesity prevention projects may be addressing the “built-environment” to encourage healthy behaviors and physical activity via environmental, engineering and systems change. Injury prevention expertise is needed to achieve environments that are as safe as possible. These collaborations provide many opportunities for injury prevention programs and leveraging of funding (e.g., playground updates, bicycle paths and walking trails, better pedestrian signage and cross walks) to accomplish a shared mission/goal.
  - In return, IP projects should be mindful of the healthy eating goals of their nutrition/obesity prevention partners when selecting incentives for community campaigns (e.g. “You’ve been caught” bicycle helmet enforcement campaigns could use healthy food choices, incentives for physical activity or other items) and meetings.
- **County Child Fatality Review (CFR) Board** - CFR Board representatives should be included on your injury prevention coalition to share their data and recommendations. Funded projects should assist in the development and dissemination of CFR injury prevention-related recommendations.
- **Healthy Homes** – Where available, IP programs should work in collaboration with local child lead/healthy homes programs to share expertise and resources on injuries in and around the home and home safety strategies.
- **Help Me Grow (HMG)** – IP programs should work collaboratively with local HMG programs to share expertise and resources on injuries to young children and injury prevention strategies.
- **Tobacco Prevention** – IP programs may help disseminate second-hand smoke and quit line information to parents of young children, especially related to home and car exposure.

**Provide assurance that all activities and publications adhere to the ODH Infant Feeding and Infant Safe Sleep policies.** [http://www.odh.ohio.gov/odhprograms/cfhs/cf\\_hlth/cfhs1.aspx](http://www.odh.ohio.gov/odhprograms/cfhs/cf_hlth/cfhs1.aspx)

## Program Focus Area 2: Falls Among Older Adults

**Number of Awards:** Up to 3; number of awards will be determined by review scores and need criteria.

**Eligibility:** Local health departments and non-profit agencies. Program Focus Area 2 is designed to address areas of the state with the greatest fall-related injury death rates among older adults. While all counties are eligible to apply, due to the very limited available funding, counties with poverty rates and falls among older adults death rates in the 75<sup>th</sup> percentile or higher will be weighted according to the criteria described in Appendix N. Communities may provide additional community-based data to demonstrate a compelling local need for reviewers to consider.

**Background:** Falls are particularly harmful to older adults. Falls and fall-related injury seriously affect older adults' quality of life and present a substantial burden to the Ohio health-care system. They easily surpass all other mechanisms of injury as a cause of ED visits, hospitalizations and death for older adults.

- Falls among older adults have reached epidemic proportions and rates continue to rise. On average, an older adult falls in Ohio every 2 minutes resulting in an emergency department visit every 8 minutes, 2 hospitalizations per hour and 3 deaths per day.
- Fall death rates among older Ohioans have increased 163 percent from 2000 to 2011, and will continue to increase as the baby-boomers skew population dynamics.
- Older adults account for a disproportionate share of fall-related injury. In 2011, persons 65 and older accounted for 83% of fatal falls, while they represented only 14% of the overall Ohio population.

For this reason, the injury prevention program will provide funding to local programs that seek to reduce the burden of injury related to falls among older adults. Additional state and county-level data are available at: <http://www.healthyohiprogram.org/vipp/data/fallsdata.aspx>

**Objectives and Activities:** Applicants must develop SMART Objectives for each of the following areas. *Please note that programs have the entire project period (five years) to accomplish all outcome objectives, but all objectives must be included in the application.* Follow the instructions in **Appendices E., Program Narrative template** and **H. Methodology Work Plan** and complete carefully.

1. **Coalition Building and Coalition Evaluation:** See ODH Required Year 1 Activities for all Grantees in Appendix C.
2. **Community Needs Assessment and Evaluation Plan Logic Model Development:** See ODH Required Year 1 Activities for all Grantees in Appendix C.
3. **Policy, Systems and Environmental Change (PSEC) Strategies-** may include ordinances, organizational policies, environmental changes, health care system changes, community-based interventions, regulations, etc. See Appendix B and strategies listed below. Applicants must identify at least 3 PSEC-related activities to pursue in year one. These may be modified based on the results of the year 1 community needs assessment and prioritized by the coalition in terms of importance and feasibility. A final prioritized list of PSEC strategies must be presented to ODH in the year 2 continuation application.
4. **PSEC Supportive Strategies:**
  - **Training and Education of Key Stakeholders** such as health care providers, aging service providers

- **\*Media Advocacy, Campaigns, Information and Support - National Falls Prevention Awareness Day:** Funded fall prevention projects will engage in at least one activity annually related to National Falls Prevention Awareness Day in September (usually observed the first day of fall) to support the Ohio Older Adults Falls Prevention Coalition's activities. National and Ohio toolkits will be available to support awareness efforts. Applicants must include a description of these activities in the Program Narrative (Appendix E) and the Methodology Work Plan (Appendix H).  
<http://www.healthyohioprogram.org/vipp/oafpc/fallsawareness.aspx>

**Evidence-based Strategies:** The objectives and activities proposed in your work plan must be based on best-available evidence. Effective fall prevention programs for older adults follow a **multi-factorial approach** and **\*must include all three of the following components within your objectives.** These strategies may be applied in many different settings and ways (e.g., policy, systems, environment, training, etc.) and applicants must select the best combination of strategies and settings for your local community.

- **Improve falls risk assessment screenings (i.e., CDC STEADI Toolkit)**  
<http://www.cdc.gov/homeandrecreationalafety/Falls/steady/index.html> ) - Comprehensive falls risk assessment by a health professional. Projects should consider innovative uses of the STEADI toolkit in primary and other health-related settings. Some strategies include, but are not limited to the following:
  - Incorporate (components of) STEADI/falls risk assessment tools in patient-centered medical homes and other health care and aging services settings.
  - Collaborate with health care providers to incorporate falls risk indicators in electronic health records (EHRs).
  - Educate health care providers about potential reimbursement methods for conducting falls risk assessments.
  - Evaluate health data to track patient referrals and outcomes related to key indicators such as annual vision exams and medication reviews.
  - Encourage follow-up prescriptions for other evidence-based strategies such as balance/exercise programs and home safety modifications.
- **Balance and Mobility (Exercise-based Interventions)** - Increasing access to evidence-based balance and physical activity (PA) opportunities including but not limited to *Tai Chi: Moving for Better Balance* or other Tai Chi courses adapted for fall prevention, *Matter of Balance* and *Stepping On*. (Budgets may include expenses related to training in these courses). It is expected that the Project Coordinator will work to increase access to strength, balance and mobility programs for older adults; but should not be primarily responsible for teaching the courses. Collaboration with Area Agencies on Aging, hospitals, parks and recreation centers, YMCAs, senior centers, etc. are encouraged to develop a cadre of community instructors.  
[http://www.cdc.gov/HomeandRecreationalSafety/Falls/compendium/1.0\\_exercise.html](http://www.cdc.gov/HomeandRecreationalSafety/Falls/compendium/1.0_exercise.html)
- **Home Modifications (Home Safety)** - Projects will increase access to home safety/home modification resources for older adults as most falls occur in/around the home environment. Projects may conduct train-the-trainer sessions on conducting home safety assessments for older adults. Community resources such as EMS providers, senior services and home health care providers may be engaged and trained to conduct home safety assessments and implement needed modifications. CDC has home safety checklists and descriptions of Home Modification Interventions at:  
[http://www.cdc.gov/HomeandRecreationalSafety/Falls/compendium/2.0\\_home.html](http://www.cdc.gov/HomeandRecreationalSafety/Falls/compendium/2.0_home.html)

- **Other evidence-based prevention strategies or promising practices.** If other strategies are selected, applicant must clearly demonstrate the evidence (see below) supporting the intervention.

Funded projects will use evidence-based strategies, including promising practices. In the **Program Narrative** section of **Appendix E.**, applicant must specify an evidence-based source that validates the strategy(ies) selected. Following are several sources that describe evidence-based strategies for preventing falls among older adults and will help you complete this section.

#### **CDC Fall Prevention Activities and Tools:**

- **STEADI (Stopping Elderly Accidents, Deaths & Injuries)** Tool Kit for Health Care Providers. The STEADI Tool Kit is based on a simple algorithm (adapted from the American and British Geriatric Societies' Clinical Practice Guideline). It includes basic information about falls, case studies, conversation starters, and standardized gait and balance assessment tests (with instructional videos). In addition, there are educational handouts about fall prevention specifically designed for patients and their friends and family.  
<http://www.cdc.gov/homeandrecreationalafety/Falls/steady/index.html>
- **Exercise-Based Fall Prevention Interventions**  
[http://www.cdc.gov/HomeandRecreationalSafety/Falls/compendium/1.0\\_exercise.html](http://www.cdc.gov/HomeandRecreationalSafety/Falls/compendium/1.0_exercise.html)
- **Preventing Falls: What Works A CDC Compendium of Effective Community-based Interventions from Around the World** - This compendium, designed for public health practitioners and community-based organizations, describes 14 scientifically tested and proven interventions.  
[http://www.cdc.gov/ncipc/preventingfalls/CDCCompendium\\_030508.pdf](http://www.cdc.gov/ncipc/preventingfalls/CDCCompendium_030508.pdf)
- **Preventing Falls: How to Develop Community-based Fall Prevention Programs for Older Adults** This "how to" guide is designed for community-based organizations who are interested in developing their own effective fall prevention programs.  
[http://www.cdc.gov/ncipc/preventingfalls/CDC\\_Guide.pdf](http://www.cdc.gov/ncipc/preventingfalls/CDC_Guide.pdf)

#### **Multi-factorial and Physical Activity Programs for Fall Prevention**

[http://www.stopfalls.org/grantees\\_info/files/Multi\\_factorial.pdf](http://www.stopfalls.org/grantees_info/files/Multi_factorial.pdf)

#### **National Council on Aging – Center for Healthy Aging – Fall Prevention**

<http://www.ncoa.org/improve-health/falls-prevention/>

#### **State Fall Prevention Resources:**

- **Ohio**
  - **Violence and Injury Prevention Program**  
<http://www.healthyohiprogram.org/vipp/falls/fallsolder.aspx>
  - **Ohio Older Adult Falls Prevention Coalition and State Plan**  
<http://www.healthyohiprogram.org/vipp/oafpc/oafpc.aspx>
- **Wisconsin** Fall Prevention Programs – Stepping On and Sure Step  
<http://www.dhs.wisconsin.gov/health/InjuryPrevention/FallPrevention/index.htm>
- **California** Fall Prevention Center of Excellence  
<http://www.stopfalls.org/>

### **Program Focus Area 3: Unintentional Prescription Drug Poisoning/Overdose**

**Number of Awards:** Up to 3; number of awards will be determined by review scores and need criteria.

**Eligibility Criteria:** Program Focus Area 3 is created to address areas of the state with the greatest fatal drug overdose rates. While all counties are eligible to apply, due to the very limited available funding, counties with poverty rates and fatal overdose rates in the 75<sup>th</sup> percentile and higher will be weighted according to the criteria described in Appendix N. Communities may provide additional community-based data to demonstrate a compelling local need for reviewers to consider.

**Background:** Drug overdoses have reached epidemic levels in Ohio.

- In 2007, unintentional drug poisoning became the *overall leading cause of injury death* in Ohio, surpassing motor vehicle traffic and suicide, the second- and third-leading causes of injury death respectively.
- From 1999 to 2011, Ohio's death rate due to unintentional drug poisonings increased more than 350 percent. There were 327 fatal unintentional drug overdoses in 1999 growing to 1,765 annual deaths in 2011.
- The death rate increases are largely driven by overdoses from prescription pain medications (opioids) and use of multiple drugs. Prescription opioids have been associated with more overdoses than any other prescription or illegal drug including cocaine and heroin combined. Multiple drug use is also a major contributing factor to the epidemic. In 2011, at least 71 percent of all unintentional overdoses involved multiple drugs.

For these reasons, the Ohio VIPP is funding projects to address prescription drug poisoning/overdose. Additional Ohio and county-level data are available:

<http://www.healthyohioprogram.org/vipp/data/rxdata.aspx>

**Data-driven Approach:** Programs should be data driven and address groups at highest risk. For example, Ohio's death data reveal that adults aged 25-54 are at the highest risk for fatal overdose.

**Recommended Resources:** The following resources will provide background information on this issue and how other states are addressing it.

***Description of the Problem/Data:***

- **CDC Vital Signs:**
  - ***Prescription Painkiller Overdoses, July 2013***  
<http://www.cdc.gov/vitalsigns/PrescriptionPainkillerOverdoses/>
  - ***Prescription Painkiller Overdoses in the U.S., November 2011***  
<http://www.cdc.gov/vitalsigns/PainkillerOverdoses/>
  - ***Use and Abuse of Methadone as a Painkiller, July 2012***  
<http://www.cdc.gov/vitalsigns/MethadoneOverdoses/index.html>
- ***Ohio Drug Overdose Data, Ohio Department of Health, Violence and Injury Prevention Program***  
<http://www.odh.ohio.gov/sitecore/content/HealthyOhio/default/vipp/data/rxdata.aspx>

- *Hall AJ, Logan JE, Toblin RL, et al. Patterns of abuse among unintentional pharmaceutical overdose fatalities. JAMA 2008;300(22):2613-20.* <http://jama.ama-assn.org/cgi/content/full/300/22/2613>
- *Centers for Disease Control and Prevention. Unintentional poisoning deaths--United States, 1999-2004. MMWR 2007;56(5):93-6.* <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5605a1.htm>
- *Fingerhut, LA. Increases in Poisoning and Methadone-related Deaths: United States 1999-2005. Health E-Stat (NCHS). February 2008.* <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/poisoning/poisoning.htm>

#### **Strategies and Potential Solutions:**

- **State Laws on Prescription Drug Misuse and Abuse, July 2012** This new CDC resource offers an overview of seven types of state laws to prevent the misuse and abuse of prescription drugs and highlights which U.S. states have enacted them. This inventory provides a picture of some of the legal and regulatory strategies states are using to address the epidemic. <http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/laws/index.html>
- **Prescription Drug Overdose: State Health Agencies Respond.** Association of State and Territorial Health Officials (ASTHO) Report, 2008. <http://stacks.cdc.gov/view/cdc/5339/>
- **Preventing Overdose, Saving Lives: Strategies for Combating a National Crisis.** Drug Policy Alliance. March 2009. <http://www.drugpolicy.org/docUploads/OverdoseReportMarch2009.pdf>
- **Drug Abuse in America: Prescription Drug Diversion.** Trend Alert: Critical Information for State Decision-makers. The Council of State Governments. April 2004. <http://www.csg.org/pubs/Documents/TA0404DrugDiversion.pdf>

#### **National Meeting Presentations:**

- **"State Strategies for Preventing Prescription Drug Overdoses"** <http://www.safestates.org/displaycommon.cfm?an=1&subarticlenbr=204>
- **"Promising Legal Responses to Epidemic of Prescription Drug Overdoses in US"** <http://safestates.org/displaycommon.cfm?an=1&subarticlenbr=203>

**Approved Program Activities:** Projects must address primary prescription drug overdose/poisoning prevention. Activities may be related to expanding access to substance abuse treatment, such as screening/referral, but may not include direct service provision of treatment, and must address other prevention strategies such as:

- Overdose prevention (identification of high risk individuals and targeted messages/interventions such as naloxone distribution to prevent overdose)
- Prescription drug diversion prevention through education of and collaboration with health care providers and law enforcement.
- Collaboration with health care providers to address appropriate prescribing and patient education, and use of the prescription drug monitoring program (OARRS) for controlled substances.

- Social marketing and/or community education initiatives to address using prescription drugs appropriately and as prescribed. Campaigns may also address proper storage and disposal of prescription drugs.

**Objectives and Activities:** Applicants must develop SMART Objectives for each of the following areas. *Please note that programs have the entire project period (five years) to accomplish all outcome objectives, but all objectives must be included in the year 1 application.* Follow the instructions in **Appendices E., Program Narrative template** and **H. Methodology Work Plan** and complete carefully.

1. **Coalition Building and Coalition Evaluation:** See ODH Required Year 1 Activities for all Grantees in Appendix C.
2. **Community Needs Assessment and Evaluation Plan Logic Model Development:** See ODH Required Year 1 Activities for all Grantees in Appendix C.
3. **Policy, Systems and Environmental Changes-** include ordinances, organizational policies, health care system changes, environmental changes, community-based interventions, regulations, etc.
4. **PSEC Supportive Activities:**
  - **Training and Education of Key Stakeholders** such as health care providers, aging service providers
  - **Media Advocacy, Campaigns, Information and Support**

Required objectives for population-based areas are described below as are examples of other approved program activities. The required and other objectives must be included in the **Program Narrative template (Appendix E)** and the **Methodology Work Plan (Appendix H)**.

1. **Coalition Building Objective:** See Appendix C for required Year 1 activities for all IP grantees.

**A coalition must be developed and maintained including, but not limited to, the following members:** health department, coroner's office, law enforcement/criminal justice, substance abuse/mental/behavioral health, physician/prescriber from private practice, physician/prescriber from local ED, hospital representative, pharmacist/toxicologist, pain management specialist (if available), survivor of prescription drug abuse in recovery. This group must meet at least four (4) times per year. The coalition should include members that encompass the county/multi-county area for which you are applying for funding.

**If you have an existing coalition, you must conduct an evaluation of the coalition during year 1. See Appendix C for guidance.**

2. **Community Needs Assessment and Program Evaluation Plan Logic Model Development:**

**See Appendix C for required Year 1 activities for all IP grantees.** In addition to the community needs assessment and program evaluation logic model development, drug overdose subgrantees must develop a SMART Objective related to the following activities:

**Develop (or maintain) a county or multi-county Poison Death Review (PDR) program** (based on Child Fatality Review model) to identify the circumstances surrounding the deaths to inform prevention.

**\*Required Activities:**

- **Convene a PDR Committee:** The reviews should be conducted by representatives from the coalition. The coroner's office will assist in the identification of cases and accessing

prescription history reports. Additional stakeholders and potential data owners (e.g., treatment centers, law enforcement, health care providers, etc.) will be invited to participate in the review of cases in a confidential setting.

Resource: **Ohio Child Fatality Review Program** and materials

<http://www.odh.ohio.gov/odhPrograms/cfhs/cfr/cfr1.aspx>

- **Enter 2014 PDR data into ODH-provided database** from death certificates, coroner reports, autopsy, toxicology, prescription monitoring program (Ohio Automated Rx Reporting System) and other data as available (e.g., medical records, law enforcement/criminal records, substance abuse or mental health information). The database will contain the drugs involved in the death, circumstances of death (e.g., witnessed, EMS called, etc.) and any other available and informative details of the decedent's history (e.g., history of substance abuse treatment), that may inform future prevention efforts.
- **Provide ODH with a written summary of de-identified PDR data to ODH and coalition members.**

**\*Applicants must include a letter of support from the county coroner ensuring access to coroner data and prescription monitoring program data from the State Board of Pharmacy's Ohio Automated Rx Reporting System (OARRS). Coroners may access these data in the course of investigating a drug overdose death.**

### 3. Policy, Systems and Environmental Change (PSEC) Strategies:

#### Resources:

- **State Laws on Prescription Drug Misuse and Abuse, July 2012** This new CDC resource offers an overview of seven types of state laws to prevent the misuse and abuse of prescription drugs and highlights which U.S. states have enacted them. This inventory provides a picture of some of the legal and regulatory strategies states are using to address the epidemic. <http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/laws/index.html>
- **National Alliance for Model State Drug Laws** <http://namsdl.org/>

**\*Required:** Applicants will identify at least 3 PSEC-related activities to pursue in year one. These may be modified based on the results of the year 1 community needs assessment and prioritized by the coalition in terms of importance and feasibility. A final prioritized list of PSEC strategies must be presented to ODH in the year 2 continuation application. Additional guidance will be provided.

#### Examples of Policy Strategies:

- Educate about HB 93 (pain clinic licensure)- Current information regarding implementation of the legislation can be found at the State Medical Board's [Center for Safe Prescribing](#):
- Develop colleges/university campus policies regarding PDA/O or ensure the inclusion of PDA in peer programs addressing alcohol/drug use; implement policies to educate faculty and staff; include information about PDA in orientation courses.
- Encourage hospitals to adopt policies requiring education of staff and patients about PDA/O. (e.g., Fairfield Medical Center).

- Encourage adoption of pain management policies in health care systems that include alternate therapies in addition to prescription opioids.
- Promote drug-free workplace policies that include abuse/misuse of prescription drugs and promote access to treatment as needed.
  - New Jersey – Partnership for a Drug Free New Jersey - [http://www.drugfreenj.org/drugs\\_overview/](http://www.drugfreenj.org/drugs_overview/)
- Prescription Fraud statutes – Ohio Revised Code: <http://codes.ohio.gov/orc/2925.22>
- Educate prescribers about State Medical board policy encouraging physicians to co-prescribe naloxone to patients who are at risk for an opioid overdose (see Project DAWN guidelines). Under *Prescriber Resources*: <http://www.med.ohio.gov/>

**Examples of Environment and Systems Change Strategies: At least 1 of the following 3 strategies must be included:**

1. **Promote use of Ohio Automated Rx Reporting System (OARRS) among physicians and prescribers.** <http://www.ohiopmp.gov/Default/default.aspx?height=768&width=1024>  
OARRS is Ohio’s prescription drug monitoring program for controlled substances and can be used to identify and discourage doctor shopping behavior. Efforts should be made to obtain commitment from local physicians to register for OARRS and use it when prescribing controlled substances. This should include educating prescribers about the prescription drug overdose epidemic and providing resources.
2. **Facilitate development and adoption of standardized pain management guidelines in health care settings.**
  - Promote implementation of *Ohio Emergency and Acute Care Facility Opioid and Other Controlled Substances Prescribing Guidelines* <http://www.healthyohioprogram.org/ed/guidelines>
  - Promote new trigger guidelines for patients on high doses of opioids: <http://www.med.ohio.gov/pdf/NEWS/Prescribing%20Opioids%20Guidlines.pdf>
  - Promote State Medical Board policy encouraging physicians to co-prescribe naloxone to patients who are at risk for an opioid overdose (see Project DAWN guidelines). Under *Prescriber Resources*: <http://www.med.ohio.gov/>
  - Promote adoption of standard opioid prescribing guidelines.
    - Utah: <http://health.utah.gov/prescription/tools.html>
    - Washington: [www.agencymeddirectors.wa.gov](http://www.agencymeddirectors.wa.gov)
  - Provide evidence-base for alternative (non-opioid) pain management strategies.
  - Monitor the [Center for Safe Prescribing](http://www.med.ohio.gov/center_for_safe_prescribing.html) [http://www.med.ohio.gov/center\\_for\\_safe\\_prescribing.html](http://www.med.ohio.gov/center_for_safe_prescribing.html) website for current information on the status of pain management guidelines for Ohio.
3. **Encourage development or expansion of naloxone education and distribution programs.**  
The VIPP is interested in expanding access to naloxone programs in Ohio. Naloxone education and distribution projects are a promising practice to prevent prescription opioid-related overdose among high risk individuals. Applicants may consider conducting a feasibility study of a local naloxone education and distribution program or expansion of an existing one to EDs or treatment facilities.

**Naloxone Program Examples and Resources:**

- Network for Public Health Law:  
[http://www.networkforphl.org/\\_asset/qz5pvn/network-naloxone-10-4.pdf](http://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf)
- Preventing Overdose, Saving Lives: Strategies for Combating a National Crisis. Drug Policy Alliance.  
<http://www.drugpolicy.org/docUploads/OverdoseReportMarch2009.pdf>
- Ohio –Project DAWN  
<http://www.healthyohiprogram.org/vipp/drug/ProjectDAWN.aspx>
- Naloxone Program Case Studies - <http://harmreduction.org/issues/overdose-prevention/tools-best-practices/naloxone-program-case-studies/>

**Other Environmental Strategies:**

- Encourage adoption of Screening, Brief Intervention and Referral to Treatment (SBIRT) programs for prescription substance abuse in emergency departments and physicians' offices.
- Promote court-based drug treatment programs as an alternative to incarceration. <http://www.nadcp.org/learn/what-are-drug-courts>

**4. PSEC-Supportive Activities:**

Training health care providers (HCPs) including physicians, dentists, nurses, pharmacists, physicians' assistants, etc. about the growing problems associated with prescription drugs, particularly prescription opioids is an important component of a prevention effort. These efforts can focus on any of the approved training and education strategies listed below and use of any existing tools/resources or development of your own.

**Required: Applicants must include at least 2 PSEC-supportive strategies related to health care provider education for year one.**

**Resources:** *Prescription Pain Medication Management and Education* existing tools:

- Utah: <http://health.utah.gov/prescription/tools.html>
- Washington: [www.agencymeddirectors.wa.gov](http://www.agencymeddirectors.wa.gov)

**Training and Education Strategies:**

- Use train-the-trainer strategies in which coalition members assist in HCP education efforts. Recruit providers to educate others of their same profession.
- Coordinate continuing education offerings for HCPs related to the following topics.
- Coordinate HCP education and training at other planned continuing education sessions (e.g., trainings, meetings, seminars) related to the following topics.

**HCP Education/Training Topic Areas:**

- Dangers of prescribing multiple medications, especially multiple central nervous system (CNS) depressants, specifically opioids, sedatives, anxiolytics and muscle relaxants, and anti-depressants (OSAMRADs) simultaneously.
- Recognizing substance misuse/abuse.
- Local resources for substance abuse treatment.
- Available resources for opioid prescribing, dosing, etc.

- Use of clinical opioid prescribing guidelines for acute and chronic pain. (e.g.,
- *Ohio Emergency and Acute Care Facility Opioid and Other Controlled Substances Prescribing Guidelines* <http://www.healthyohioprogram.org/ed/guidelines>).
- New trigger guidelines for patients on high doses of opioids: <http://www.med.ohio.gov/pdf/NEWS/Prescribing%20Opioids%20Guidelines.pdf>
- State Medical Board policy encouraging physicians to co-prescribe naloxone to patients who are at risk for an opioid overdose (see Project DAWN guidelines). Under *Prescriber Resources*: <http://www.med.ohio.gov/>
- Use of pain management contracts.
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Ohio laws related to prescription drug fraud.

**Patient Education: Train HCPs to educate patients receiving controlled substances about:**

- Importance of taking medication as prescribed.
- Potential for addiction with opioids and benzodiazepines.
- Dangers of sharing medication.
- Dangers of taking multiple medications, especially multiple central nervous system (CNS) depressants simultaneously.
- Recognizing signs of an overdose and how to respond.
- Alternative pain management strategies.
- Local resources for substance abuse treatment.
- *Ohio Emergency and Acute Care Facility Opioid and Other Controlled Substances Prescribing Guidelines Patient Handout* <http://www.healthyohioprogram.org/ed/guidelines>
- Promote use of evidence-based guidelines for opioid dosing and prescribing:
  - *Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: an educational pilot in Washington State to improve care and safety with opioid treatment* <http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf>
  - *Utah Prescription Pain Medication Management and Education*: <http://health.utah.gov/prescription/tools.html>
- Promote use of clinical guidelines for chronic and/or acute pain management.
  - *Utah Prescription Pain Medication Management and Education*: <http://health.utah.gov/prescription/tools.html>
- Promote use of contracts with pain patients among HCPs.
- Engage pharmacists to participate in these efforts.

**Media Advocacy, Campaigns, Information and Support Strategies;**

- Use multiple local media outlets to disseminate written and verbal campaign materials (newspaper articles, TV/radio PSAs, Facebook/Twitter, movie theaters, etc.) to advance other PSEC strategies.
- Identify credible local spokespeople (e.g., physician, pharmacist, coroner, law enforcement, survivor of prescription drug abuse, family member, etc.) to respond to media inquiries and help disseminate/promote campaign messages.

- Disseminate media toolkits containing state and local data, sample article template, call to action information, prevention information, sample campaign materials, contact information, resource list, etc.
- Conduct a press conference to raise awareness of the extent of the problem locally.
- Disseminate existing Prescription for Prevention Campaign brochures/pamphlets addressing:
  - Importance of taking medication as prescribed
  - Dangers of sharing medication and taking multiple medications
  - Resources

## **OPTIONAL Supplemental Funding Opportunity**

### **Statewide Coalition Building for Injury Prevention**

An additional \$60,000 is available for two (2) funded projects (\$32,000 for CIAG/\$28,000 for falls coalition) to coordinate and administer statewide activities as described below as an extension of the Ohio Injury Prevention Partnership (OIPP).

- **Coordinate the statewide Child Injury Action Group (CIAG) and its subgroups** composed of key state and local stakeholders and decision-makers who have the ability to impact policies related to child health and safety (*only Focus Area 1. Unintentional Child/Youth Injury Prevention applicants*)
- **Coordinate the statewide Falls Prevention Coalition** focusing on the older adult population to include all key representatives from statewide agencies and organizations, e.g., the aging network. (*only Focus Area 2. Falls among Older Adults applicants*)

**\*Applicants who apply for focus areas 1 and 2 may also apply for the supplemental funding. Applicants may apply for only the supplemental funding as well if they apply for both the Falls and CIAG.** If applicant is applying for both funding for facilitation of both groups, a separate narrative and work plan should be submitted for each.

#### **Required activities:**

- Continue to recruit appropriate new members for falls among older adults/CIAG:
  - Contact members by phone and in writing (mail/email) to invite them to join.
  - Prepare written materials/invitations to explain the purpose of the initiatives.
  - Create orientation materials for new and potential members containing group mission/vision statement and goals, current list of members, background information on injury area, OIPP Member Agreement, recent meeting minutes, etc.
- For CIAG, will serve as coordinator, to include all activities described herein, for at least 2 CIAG subcommittees.
- Coordinate no fewer than quarterly meetings in conjunction with OIPP meetings. At least four meetings must be planned and conducted by December 31, 2014. Develop agenda, coordinate meeting logistics and copy meeting materials.
- Coordinate quarterly planning and strategic plan coaching sessions for members using expert facilitator that meets the following criteria:
  - expertise in and demonstrated success in the field of public health advocacy and coaching;
  - 5+ years of working with public health partners, including working with public-private state coalitions and state health departments;
  - demonstrated experience working with public health coalitions

*\*ODH can assist funded projects by providing list of qualified, potential contractors upon request.*

- In conjunction with expert facilitator, coordinate updates of CIAG/falls state plans as needed to respond to changing opportunities and accomplishments to date. Plans should extend toward December 31, 2018.

- In conjunction with expert facilitator, conduct an evaluation of the coalition membership and structure. Present results of evaluation with recommendations and next steps to ODH by October 1, 2014. Develop a recruitment plan and propose structure changes based on results for year 2.
- Facilitate meetings or work with meeting facilitator to prepare for meetings and plan agenda. Compile meeting minutes and send to ODH within 30 days after the meetings.
- Communicate with members in between meetings to ensure adequate support to group chairs and progress is occurring. Respond to requests for information from members.
- Represent Falls among Older Adults Coalition or Child Injury Action Group at statewide meetings.
- Maintain regular communication with ODH VIPP staff.
- Provide quarterly website content updates for the ODH Falls among Older Adults Coalition or CIAG webpages. Meeting minutes, presentations, meeting schedule, etc. should be provided to the VIPP website contact, and updates must be provided no less than quarterly.
- Deliver statewide action plans, recommendations and updates from the respective group to ODH VIPP.
- Coordinate implementation of updated state action plans with recommendations related to falls among older adults or child/youth injury prevention policy. Funded entities will be expected to be active participants in implementing state plans through a variety of strategies (e.g., developing and reviewing annual action plans for progress, offering mini-grants, identifying members to be responsible for key components of plans, structuring coalition for success, recruiting and identifying committee chairs, planning conference calls as needed, cultivating coalition leadership, etc.).
- Plan and coordinate **one instate training activity** that engages key partners and members in implementing the state plan or some portion of the state plan. (CIAG should be policy-focused). Training must include building capacity of group members related to state plan activities. A subgroup of the respective groups should be formed to assist in planning the training, setting objectives, choosing speaker(s)/topic area(s), etc.
  - For **Child Injury Prevention Group**, the training should include but not be limited to regional/statewide representatives of key governmental and non-governmental agencies; media outlets; HMOs/MCOs; hospital/trauma/medical centers; injury prevention and research, academia, public health, Safe Kids Coalitions; medical/professional organizations (e.g., pediatrics, family medicine); and other stakeholders (e.g., businesses, insurance companies, etc.).
  - For **Falls among Older Adults**, the training should include but not be limited to regional/statewide representatives of key governmental and non-governmental agencies; media outlets,; HMOs/MCOs; hospital/trauma/medical centers; aging network service providers; public health, injury prevention, academia, medical/professional organizations (e.g., geriatrics); and other stakeholders (e.g., businesses, insurance companies, etc.).
- Provide quarterly and annual reports of statewide coalition building activities containing information in format requested by ODH.

### **Application Instructions:**

Provide a separate methodology, work plan (Appendix E) and budget narrative justification for this section and include in GMIS 2.0.

**Program Narrative/Methodology:**

In a separate file attachment, provide a brief (no more than 12 double-spaced pages, 12 point font) narrative description of proposed plans to coordinate the statewide coalition.

- Describe any current or past involvement in CIAG or falls coalition activities.
- Describe plans to continue recruitment and orientation of new and diverse members to the coalitions, including subcommittees for CIAG.
- Describe plans for quarterly meeting facilitation.
- Describe plans to evaluate coalition membership and structure.
- Describe process for contracting with expert meeting facilitator to evaluate and update state plans and conduct coaching sessions for subcommittees as needed. Describe how you will ensure that deliverables by contractors are achieved? What method (e.g., sole source, competitive bid) will be used to select a contractor?
- Describe how you will ensure that state plan activities are being implemented.
- Describe plans to conduct an instate training/forum that engages key partners in implementing the state plan, or portions of the state plan updated in 2014.
- Describe other plans and activities related to statewide coalition building for Falls among Older Adults Prevention or Child/Youth Injury Prevention.

**Methodology Work Plan** – Use the work plan format in *Appendix I* (final page). Outline specific activities and detail a timeline for the completion of activities.

**Budget Narrative Justification** – Include a *detailed* budget narrative justification outlining proposed costs in each of the following categories. Follow budget justification instructions in Sections II and III.

- **Personnel and fringe** – Include anticipated personnel costs related to these activities.
- **Other Direct Costs** Include anticipated supplies, copying/printing, training costs, etc.
- **Travel** (instate and out-of-state)
- **Equipment**
- **Contractual** – Include costs associated with a professional facilitator if needed (up to \$10,000).

Include this budget justification in the same file as the main budget justification and submit per budget instructions in Section II and III.

**Attachments:** Create new files for this section. Label the file attachments in GMIS 2.0 as follows:

1. “Insert County\_supplement\_narrative2014”
2. “Insert County\_supplement\_workplan2014”
3. Budget justification will be included in main budget justification. See instructions in Section II.B.

***Required attachment should be named "Insert county\_Narrative\_2014"  
and attached in GMIS 2.0***

## **Instructions for Executive Summary and Program Narrative Template**

A Word version of required attachments will be available to applicants once the RFP is posted on the ODH website. A web link where documents may be downloaded will be sent to all potential applicants who complete and submit the Notice of Intent to Apply for Funding. Contact [HealthyO@odh.ohio.gov](mailto:HealthyO@odh.ohio.gov) for information.

- Complete this form for the required Executive Summary and Program Narrative section.
- Copy and paste into a new document and save as "*Name\_Narrative\_2014*".
- Include your responses beneath each of the questions/statements in the order specified in this document. Respond to each bullet point individually as requested. The Review Scoring Sheet will closely follow this format.
- Attach completed Appendix E., labeled: "*Name\_Narrative\_2014*" in GMIS 2.0 per system instructions.

## **Program Narrative Template**

### **1. Executive Summary**

The Executive Summary must be limited to one page. It should be submitted on a separate page, but in the same electronic file as the remainder of the Program Narrative. The Executive Summary will be used for legislative and public inquiries about programs.

- Describe the injury problems that the program will address.
- Provide justification for why these injury problems were chosen. What planning factors lead to the decision to propose this project?
- List program goal(s) and objectives.
- Briefly describe:
  - Who the project will be serving, including demographics.
  - Location of project activities (e.g., schools, community, worksite, healthcare).
  - Role of your partners/coalition.
- Describe how the project will be evaluated.
- State the total funds that are being requested and how they will be primarily used.

## **Program Narrative**

### **2. Description of Applicant Agency and Documentation of Eligibility:**

#### **Eligibility**

- Briefly discuss the applicant agency's eligibility to apply. Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program.

### **Experience in and Capacity to Address Injury Prevention**

- Briefly summarize any existing injury prevention efforts managed by your agency related to the focus area chosen.
- Provide information on other sources of grant and local funding your agency has for existing injury prevention activities. Describe how this funding will be used to expand upon or address other areas, and not supplant current funding sources.
- Describe other experience by your agency in managing and conducting injury prevention programs. If none, briefly describe experience in managing and conducting another population-based public health program.

### **Personnel**

- **Funded projects must employ one full time staff (no fewer than 1,700 hours per year) assigned as the Injury Prevention Coordinator whose sole duties are to administer the Injury Prevention Program and related grant activities.** Provide documentation that demonstrates compliance with this requirement on the **Key Personnel Form - Appendix F**.
- List all personnel who will be directly involved in program activities and working on the grant on **Appendix F**. 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. Attach position description and resumes in attachment section of GMIS 2.0 for all relevant program staff. Provide position descriptions for any new positions to be created.
- How many program staff within your agency work on injury prevention-related efforts?

### **Hiring and Training**

- Describe plans for hiring and staff training as necessary to implement the project. Describe on-going training activities as appropriate. Include details about the type of training routinely provided to new staff. Include a statement here to ensure that all involved program staff will have experience or receive training in concepts of population-based injury prevention and control.
- Applicants should demonstrate that staff have experience or will be trained in the **Core Competency Areas for Violence and Injury Prevention Professionals** (See Appendix J) as defined by the Safe States Alliance/SAVIR National Training Initiative at: <http://www.safestates.org/displaycommon.cfm?an=1&subarticlenbr=41> Describe staff experience with the competency areas and include a training plan below that is consistent with these competency areas. All IP staff must also complete the following Injury Prevention 101 self-study course: <http://www.safestates.org/displaycommon.cfm?an=1&subarticlenbr=259#Injury101> Evidence of course completion will be required of funded projects by the time of the 3<sup>rd</sup> quarter report deadline (October 15, 2013). Please describe plans to assure that staff are working toward achieving the Core Competency Areas. Resources for training are provided at <http://www.safestates.org>. Budget may include costs associated with staff training related to the

core competency areas.

- Is (or will) your agency/staff (become) a member(s) of Safe States Alliance?  
<http://www.safestates.org> Yes \_\_\_\_ No \_\_\_\_

#### **Contracts**

- If any objectives of the grant are to be implemented through a contract, include background information about the contracting agency or individuals, if known. Include all work to be conducted through contracts in the methodology. If contracts are to be determined, they will need to be pre-approved by ODH before contract initiation.

#### **Capacity to Address Disparities**

- 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.

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

*Use this section to identify and describe the local health status concern that will be addressed by the program. Do not restate national and state data.*

#### **Description of the Injury Problem**

- Describe the injury problems that the program will address. Include descriptions of local injury rates and related injury risk factors.
- Provide support as to why this is a problem in your community at this time (include local data, not just national and state data). Describe any primary (self-collected, needs assessment, etc.) and secondary (existing) data that describes the problem and justifies the need for your program.

#### **Disparities**

- Explicitly describe segments of the target population who experience a disproportionate burden of the local injury rates (this information must correlate with the Statement of Intent to Pursue Health Equity Strategies).

#### **Planning Process**

- Indicate if a needs assessment has been completed within the past two years. Provide a brief summary of the needs assessment process. Describe how this process was used in determining the injury problem(s) chosen.

#### **Existing Programs and Gaps in Programming**

- Include a description of other agencies/organizations also addressing this problem/need.
- Describe potential gaps in injury prevention programs and services in the community. How will the proposed project fill these gaps?

**Barriers**

- Describe any barriers/anticipated barriers in implementing injury prevention activities and strategies for overcoming these issues.

**4. Methodology Narrative**

Include a narrative description of your project methodology including your overall goal in this section as instructed. **Refer to Appendix C-D to complete this section.** In addition to the Program Narrative, applicants must also provide an annual plan by completing **Appendix G. Methodology Work Plan.**

**Overall Project Description**

- List long-term project outcome objective in SMART format.
  - Describe how program activities will address injury disparities in your community. Disparities may be based on race/ethnicity, sex, socio-economic status, geography, sexual orientation, age etc.
  - Provide rationale for why the particular strategies and activities to be used are appropriate to the community.
  - Describe the setting(s) or location(s) for your proposed activities; i.e., community, school-based, worksite, healthcare.
  - Describe the evaluation measures that will be used to determine the overall success of the program. Describe impact measures as well as process/activity-level measures.
  - The objectives and activities in your work plan should be evidence-based. Include a description of the evidence-based strategies you have selected and rationale for why these were chosen. Include a reference that validates the effectiveness of the strategies. Refer to **Appendix D. Program Focus Areas** for further instruction and sources of evidence-based injury prevention strategies.
- 1. Coalition Building and Partnerships and Coalition Evaluation** - Each injury prevention project is required to develop an injury prevention coalition or expand an existing one through this grant in order to implement their other objectives. Additionally, existing coalitions must be evaluated during year 1. See **Appendix C.** for additional guidance.
- List Coalition Building SMART Impact Objective:
  - Do you have an existing coalition or will you be developing a new one?

If **EXISTING**, complete this section:

- Describe your injury prevention coalition/partnerships. Include a description of the structure including leadership (e.g., Chair, co-chairs, executive committee, etc.) and other committees. **Attach a list of coalition members or proposed coalition members with representing agencies.** Attach a copy of any existing bylaws or governance documents.
- Describe coalition members from diverse communities including racial and ethnic minority populations.
- Describe changes to your coalition over the past year (e.g., has it grown or become smaller, has the structure or leadership changed, have the changes been positive or provided challenges). Describe any concerns or challenges you have faced in further developing and growing your coalition. How have you addressed these challenges?
- Describe the role of key coalition members and partners related to your project activities. Attach a letter of support from each key partner.
- Describe planned coalition activities and initiatives during 2014.
- Describe plans to evaluate your coalition in year 1. Resources are available at: **Coalitions Work** <http://coalitionswork.com/resources/tools/> and **Power Prism**: <http://www.powerprism.org/coalition-building-maintenance.htm>

If **NEW**, complete this section:

- Describe plans to develop your community injury prevention coalition. Describe recruitment efforts, organizations to be contacted and potential coalition structure.
- Describe plans to recruit coalition members from diverse communities including racial and ethnic minority populations.
- Describe the proposed role of key coalition members and partners related to your project activities. Attach a letter of support from each key partner.
- Describe planned coalition activities and initiatives during 2014.

## 2. **Community Needs Assessment, Injury Surveillance, and Development of Logic Model–**

Projects will be data-driven and seek to improve the collection of injury data and injury risk factor information.

- List Community Needs Assessment SMART Program Impact Objective:
- Describe results of any assessments used to plan the proposed strategies (e.g., behavior observations, pretest evaluations, attitude surveys, etc.). Describe any continuing

assessment activities for 2014. Describe how these data will be used to evaluate activities at the end of the project period.

- Describe plans to conduct a community needs assessment to identify community readiness and gaps in services/programs in the first 12-months.
- Describe any primary (data collection) or secondary (e.g., analysis, linkage, etc.) surveillance activities and use of injury data (e.g., reports) in your proposed project. Describe how data will be obtained and used to support other project initiatives.
- Describe any planned activities related to improving the quality and/or use of local fatal and non-fatal injury data.
- Describe the process that will be used to develop a program evaluation logic model during year 1 (specific guidance will be provided by ODH in year 1; but reviewers need information on the process.). Describe any experience with logic model development. Include a description of how your coalition or key members of your coalition will be engaged in this process.

### **3. Policy, Systems and Environmental Change (PSEC) Strategies: (See Appendices C and D for Program Requirements)**

- List PSEC SMART Impact Objectives
- Describe plans related to policy development, adoption, implementation or enforcement activities. These may be organizational policies (e.g., school or workplace), ordinances, regulations or system changes. Describe which coalition members/partners will be engaged in this effort, what settings will be affected and how the efforts will be evaluated.
- Describe proposed environmental and systems change interventions and how they will lead to achievement of outcomes and goals. Describe which coalition members will be engaged in this effort, how disparities will be addressed, what settings (community, school, worksite, healthcare) will be affected and how the efforts will be evaluated.
- Describe examples of any previous successes in this area for your community or agency.
- What methods will be used to engage key stakeholders and decision-makers in order to ensure project success? Who are the anticipated opponents to the changes? Describe activities to engage opponents in order to understand their perspectives and provide information/education?
- Describe strategies to promote enforcement and education of any new policies or laws to increase their effectiveness.
- What systems will be developed, enhanced, improved, changed, etc. to reduce injury risk factors.
- Provide available evidence that the proposed strategies are effective.

- How will you evaluate the effectiveness of these efforts?

#### **PSEC Supportive Strategies:**

- List PSEC Supportive Strategy Program Impact Objective:

#### **Training and Education Strategies (See Appendix D for Focus Area-specific Requirements)**

- Describe any proposed training and education strategies. Describe which coalition members will be engaged in this effort, how disparities will be addressed, what settings will be affected and how the efforts will be evaluated.
- Describe the intermediary populations (influential and credible persons, leaders, decision-makers, professionals) that will be targeted to achieve goals. For example, if you wish to increase bicycle helmet use among children, describe the population (e.g., physicians, teachers, EMS providers, child care center staff, etc.) you will train/educate to do this.
- What health behavior strategies/theories (e.g., improving self-efficacy of older adults to be physically active) are proposed to change knowledge, attitudes and/or behavior? What evidence exists that your strategy will be effective?
- How will you evaluate the effectiveness of these efforts?

#### **Media Advocacy, Campaigns, Information and Support, including Social Marketing Campaigns**

- If a media strategy is selected... Describe available “media” outlets in your community and how you plan to use them to accomplish proposed activities, e.g., traditional media (newspapers, radio, TV); social media (websites, facebook); and other (movie theater previews, buses, yard signs, community events, sporting events, etc.).
- Describe planned media strategies/campaigns including the proposed audience. Describe which coalition members will be engaged for in effort, how disparities will be addressed, what settings will be affected and how the efforts will be evaluated.
- How will messages be tailored for your proposed audience?
- How will the media be used to elevate “injury” as a significant public health threat among your target population?

#### **Other PSEC-Supportive Strategies (e.g., Resource/Facility Availability)**

- Provide a detailed description and justification for the selection of other strategies.

#### **Evaluation Plan:**

Describe how program impact objectives will be evaluated. A logic model will be required by the end of year 1 and additional technical assistance will be provided by ODH regarding its development. Describe how coalition will be involved in development of logic model. Describe how this will be accomplished and

which key stakeholders/coalition members will be engaged.

**Sustainability Plan:**

Sustainability means ensuring that an effort or change is lasting. It does *not* necessarily require securing additional funding for a program that would otherwise end, although leveraging funding can be an effective sustainability strategy. Sustainability can be achieved by changing individual, organizational, system or institutional policies, practices, norms, attitudes, etc.

Include a description of how you will sustain injury prevention activities in your county if funding is no longer available through ODH.

Include a description of how additional funding or inkind contributions may be leveraged through use of the ODH IP grant funds. Please be as specific and detailed as possible.

**Required attachment should be named “Insert county\_Personnel\_2014”  
and attached in GMIS 2.0 Narrative Section**

**KEY PERSONNEL FORM**

**Only list changes in Personnel and include their resumes.**

Funded projects must employ one staff person (no fewer than 1,700 hours per year) assigned as the Injury Prevention Coordinator whose primary duties are to administer the Injury Prevention Grant and related grant activities. Other sources of funding may be used to meet this requirement; however, this position must spend 100% of time on injury prevention grant-related activities. Projects may *not* use two or more part-time employees to meet this requirement.

Complete this section to demonstrate compliance with this program requirement and to list other program staff. Attach resumes and position descriptions in GMIS 2.0 as needed. Position descriptions should be included for all new positions.

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

Personnel/Position	% of Time Devoted to Grant	% of Time Paid by Grant	Function of Position	Qualifications or Desired Qualifications of Project Personnel.*

## Methodology Work Plan Instructions

Use these instructions to complete the enclosed Methodology Work Plan (Appendix H).

**Objectives must be written in SMART (Specific, Measurable, Achievable, Relevant, and Time-Framed) format and emphasize population-based interventions. See Appendices B-D for information on population-based interventions.** Visit [http://www.cdc.gov/phcommunities/resourcekit/evaluate/smart\\_objectives.html](http://www.cdc.gov/phcommunities/resourcekit/evaluate/smart_objectives.html) for additional guidance and SMART Objectives templates.

1. **Long Term Outcome Objective:** Complete at least one (1) long term outcome objective for each category (Coalition Building, Needs Assessment, PSEC, PSEC-Supportive Strategies). An example of a long term objective is: By December, 2018, 20% of older adults in Anytown, OH will be screened for falls risk and referred to appropriate follow-up care.
2. **Program Impact Objectives**
  - Complete a separate Work Plan page for each program impact objective.
  - Program impact objectives should have an annual timeframe and build logically toward the long term outcome objective.
  - 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.
  - Specify the immediate effect the program has on the targeted behaviors or on the influential environmental conditions. They focus on improvement of knowledge, attitudes, skills, and behaviors as well as organizational and environmental changes which promote safe and healthy behavior. They are more global and long range than process objectives.

### Components of **SMART** Objectives

<b>By When?</b>	Time frame in which the change is expected to occur.
<b>What?</b>	Action or changes in behavior, health practice, or system to be achieved.
<b>Who?</b>	Group of people or systems expected to change.
<b>Where?</b>	Location of the activity.
<b>How Much?</b>	Extent of the change to be achieved.

- A generic format for an Impact Objective is:  
By (date), (system) will (specify how system will change) in (where) as measured or evaluated by (how you will determine that the desired change has occurred).
- Measurable objectives use action verbs such as ‘establish,’ ‘enact,’ ‘train,’ ‘adopt,’ ‘commit,’ ‘increase,’ ‘reduce,’ ‘institute,’ or ‘organize.’

**Example:** *By December 31, 2014, 50 percent of the eight family practice offices in ABC Community will be using components of the STEADI falls prevention screening toolkit.*

**Example:** *By December 31, 2014, 20 new physicians will have registered for OARRS prescription monitoring program and agreed to incorporate OARRS checks for patients using and requesting prescription pain medication.*

**Example:** By October 30, 2014, two (2) schools will adopt a campus helmet policy for students who bike to school.

### 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 at risk for falling and have scheduled 80 percent of them for follow-up visits and referrals to community-based falls prevention programs such as Tai Chi: Moving for Better Balance and Matter of Balance.

### 4. Justification for Intervention:

Provide the underlying behavioral change theory, community organization theory, best available research evidence or evidence-base to justify selection of intervention.

### 5. Location:

Describe the community setting or location for the intervention.

### 6. Injury Disparities:

Describe how each activity will address the safety/injury disparities in the applicant community.

### 7. Outcome Evaluation

Identify the ultimate outcome for the PSEC 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:** Helmet use increased by 25% as evidenced by pre/post policy observations on school property.

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

**Example:** 40% more older adults screened for falls risk are active participants in Tai Chi: Moving for Better Balance

**Example:** OARRS prescription monitoring program usage increased by 20% among physicians in "X" county.

### 8. Process Objectives and Related Activities

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. Activities should logically connect and follow from process objectives.

**Sample 1:** By October 31, 2014, 80 percent of office staff in four family practice offices will be trained on the STEADI toolkit, current guidelines for falls prevention screening, and reimbursement codes related to falls risk assessment screening.

**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 STEADI Tool Kit.
- f. Follow up with offices regarding use of STEADI and any changes in practice behaviors.

**Sample 2:** By December 31, 2014, the IP Program will assist the X School district in establishing a return-to-school policy for students who have experienced a TBI.

**Activities:**

- a. Educate hospital staff on the importance of hospital discharge planning for older adults experiencing a fall-related injury.
- b. Provide technical assistance and model language to implement policy.
- c. Provide model language and other supportive materials including discharge patient education materials.
- d. Request and measure hospital discharge data on falls and repeat falls to determine progress.

**Sample 3:** By December 31, 2013, the IP Program will facilitate the development of one bicycle helmet policy in three community settings.

**Activities:**

- a. Complete a helmet usage observation survey to identify communities or settings with low helmet use.
- b. Collaborate with coalition partners to identify a minimum of three settings willing to develop a helmet use policy.
- c. Schedule meeting with organization leadership (e.g., Human Resources, Business Department and Occupational Health Nurse, principal/nurse, etc.) to review benefits of helmet usage.
- d. Identify area the worksite team wants to start developing strategies and policies to improve.
- e. Provide technical assistance and resources (e.g., data, stories) as they progress.
- f. Assist in developing policy.
- g. Assist with policy implementation and promotion
- h. Evaluate the impact of the policy by observing helmet usage post intervention.

**Complete the methodology work plan (Appendix H) for each program Population-based Objective and provide at least one Impact Objective for each of the following:**

1. Coalition Building and Coalition Evaluation
2. Community Needs Assessment and program Evaluation Logic Model completion (objective must be completed within first 12-months)
3. Policy, Systems and Environmental Change Strategies
4. PSEC Supportive Strategies
  - Training and Education
  - Media Advocacy, Campaigns, Information and Support

You have 5 years to complete your long term objectives; however all must be included in your initial application. Provide a detailed 12-month work plan.

Applicants must include required activities for each focus area in the population-based areas. Review **Appendices C-D** for additional guidance on required activities for all grantees (C.) and by focus area (D.).

**9. Person and Agency Responsible**

Identify the person and agency responsible for completing the activities.

**10. Timeline – Start and end date**

Assign a timeline including start and end dates for each process objective; state the time period (in dates) when the activity will take place.

**11. Priority Population**

List the populations - intermediate (influential and credible persons, leaders, decision-makers, professionals) and ultimate (children/older adults) that will be targeted to achieve objectives.

**12. Activities**

Provide activities describing how the **Population-based Impact Objective** will be achieved. You must provide at least one activity to meet each program **population-based impact objective**.

**13. Evaluation Measures for Success**

Describe how the activities will be evaluated for success. Describe the method for ensuring that each activity has been completed, e.g. survey data, number of providers trained, focus group results, etc. The method should be well thought out and specific evaluation tools completed before the project begins.

**Complete the work plans (Appendix G) for each area, save all objectives in one file and name “insert county name\_Workplan\_2014”. Attach in GMIS 2.0.**

**Required attachment should be named "Insert county\_Workplan\_2014" and attached in GMIS 2.0  
Methodology Work Plan**

Agency Name: \_\_\_\_\_ GMIS# \_\_\_\_\_

Select Injury Focus Area:  Older Adult Falls Prevention  Prescription Drug Abuse and Overdose  Child/Youth TBI Prevention

**Population-based Strategy #1: Coalition Building and Partnerships**

<b>A. Long-term Objective:</b> Write "SMART" impact objective(s) for your plan that address the priority focus area and target population
<b>Program Impact Objective:</b>
<p><b>Spectrum of Prevention: (Check all that apply)</b></p> <p><input type="checkbox"/> Policy <input type="checkbox"/> Organizational Practices <input checked="" type="checkbox"/> <u>Coalitions</u> <input type="checkbox"/> Provider Education <input type="checkbox"/> Community Education* <input type="checkbox"/> Individual Knowledge &amp; Skills*</p> <p>Please note that those strategies focusing on individual knowledge &amp; skills and community education will only be approved if they are supporting the upper levels of the Spectrum. For example, strengthening decision maker (e.g., school leadership) knowledge or skills in support of an organizational change.</p>
<b>Impact Evaluation Indicator(s):</b>

*Instructions:* Please complete all components: related process objective, person and agency responsible, timeline (report in dates only), priority population, related activities and evaluation for success for each program impact objective(s).

Process Objective (Write actual objective or paraphrase)	Person and Agency Responsible	Specific Timeline		Priority Population Ultimate or Intermediate	Related Activities or Steps (Describe the significant activities/steps accomplished for each process objective)	Evaluation Measure (How do you know you are successful?)
		Start Date	End Date			

Process Objective (Write actual objective or paraphrase)	Person and Agency Responsible	Specific Timeline		Priority Population Ultimate or Intermediate	Related Activities or Steps (Describe the significant activities/steps accomplished for each process objective)	Evaluation Measure (How do you know you are successful?)
		Start Date	End Date			

**Population-based Strategy #2: Community Needs Assessment and Logic Model Development**

<b>A. Long-term Objective:</b> Write “SMART” impact objective(s) for your plan that address the priority focus area and target population
<b>Program Impact Objective:</b>
<b>Impact Evaluation Indicator(s):</b>

*Instructions:* Please complete all components: related process objective, person and agency responsible, timeline (report in dates only), priority population, related activities and evaluation for success for each program impact objective(s).

<b>Process Objective</b> (Write actual objective or paraphrase)	<b>Person and Agency Responsible</b>	<b>Specific Timeline</b>		<b>Priority Population</b> Ultimate or Intermediate	<b>Related Activities or Steps</b> (Describe the significant activities/steps accomplished for each process objective)	<b>Evaluation Measure</b> (How do you know you are successful?)
		<b>Start Date</b>	<b>End Date</b>			

**Population-based Strategies #3: Policy, Systems and Environmental Change (PSEC) -**

Provide **at least 3** PSEC-related program impact objectives for your injury focus area for year 1. They may all be related to the same long-term objective. Complete a separate work plan for each program impact objective. Form may be copy/pasted as needed. The following activities may be used to support implementation of larger PSEC strategies and may be included in your PSEC work plan or included in a separate work plan depending on the scope of the activities.

A: Training and Education

B: Media Advocacy, Campaigns, Information, and Support

C: Resource/Facility Availability

<b>Long-term Objective:</b> Write “SMART” impact objective(s) for your plan that address the priority focus area and target population for
<b>Program Impact Objective:</b>
<p><b>Spectrum of Prevention: (Check all that apply)</b></p> <p><input type="checkbox"/> Policy   <input type="checkbox"/> Organizational Practices   <input type="checkbox"/> Coalitions   <input type="checkbox"/> Provider Education   <input type="checkbox"/> Community Education*   <input type="checkbox"/> Individual Knowledge &amp; Skills*</p> <p><b>*Please note that those strategies focusing on individual knowledge &amp; skills and community education will only be approved if they are supporting the upper levels of the Spectrum. For example, strengthening decision maker (e.g., school leadership) knowledge or skills in support of an organizational change.</b></p>
<b>Impact Evaluation Indicator(s):</b>
<b>Provide justification for selection of this strategy? (i.e., provide underlying theory of change, best available research evidence or evidence-base for selection of strategy)</b>
<b>Community or location of intervention (Ultimate or Intermediate):</b>
<b>How will this intervention impact injury disparities (i.e., populations disproportionately impacted by injuries) in your community?</b>
<b>What is the intended Outcome of the Policy, System, or Environmental Change from this Impact Objective?</b>

*Instructions:* Please complete all components: related process objective, person and agency responsible, timeline (report in dates only), priority population, related activities and evaluation for success for each program impact objective(s).

Process Objective (Write actual objective or paraphrase)	Person and Agency Responsible	Specific Timeline		Priority Population Ultimate or Intermediate	Related Activities or Steps (Describe the significant activities/steps accomplished for each process objective)	Evaluation Measure (How do you know you are successful?)
		Start Date	End Date			

### Methodology Work Plan – Supplemental Statewide Coalition Building Funding

Agency Name: \_\_\_\_\_ GMIS# \_\_\_\_\_

Supplemental Funding : Ohio Older Adult Falls Prevention Coalition or Child Injury Action Group: \_\_\_\_\_

<b>Long-term Objective: Write “SMART” impact objective(s) for your plan to facilitate and expand the statewide coalition.</b>
<p><b>Program Impact Objective:</b></p> <p><u>1.</u> By October 1, 2014, “Agency” will provide prioritized recommendations for next steps based on an in-depth evaluation of the “CIAG/Falls Coalition’s” membership and function. Recommendations will include recruitment needs and structural changes needed.</p>
<b>Impact Evaluation Indicator(s): List of next steps with timeline will be provided to enhance coalition</b>

*Instructions:* Please complete all components: related activity, timeline (report in dates only), person and agency responsible, health disparities and evaluation for success for each program impact objective(s).

Process Objective (Write actual objective or paraphrase)	Person and Agency Responsible	Specific Timeline		Priority Population  Ultimate or Intermediate	Related Activities or Steps (Describe the significant activities/steps accomplished for each process objective)	Evaluation Measure (How do you know you are successful?)
		Start Date	End Date			

Process Objective (Write actual objective or paraphrase)	Person and Agency Responsible	Specific Timeline		Priority Population Ultimate or Intermediate	Related Activities or Steps (Describe the significant activities/steps accomplished for each process objective)	Evaluation Measure (How do you know you are successful?)
		Start Date	End Date			

**A. Program Impact Objective:**  
 2. By December 31, 2014, "Agency" will update the "older adult falls/child injury" state plans as needed to reflect changing opportunities, challenges and accomplishments.

**Impact Evaluation Indicator(s):**

*Instructions:* Please complete all components: related activity, timeline (report in dates only), person and agency responsible, and evaluation measure success for each program impact objective(s).

Process Objective (Write actual objective or paraphrase)	Person and Agency Responsible	Specific Timeline		Priority Population Ultimate or Intermediate	Related Activities or Steps (Describe the significant activities/steps accomplished for each process objective)	Evaluation Measure (How do you know you are successful?)
		Start Date	End Date			

<p><b>A. Program Impact Objective:</b>  <u>3.</u> By December 31, 2014, “Agency” will update the “older adult falls/child injury” state plans as needed to reflect changing opportunities, challenges and accomplishments.</p>
<p><b>Impact Evaluation Indicator(s):</b></p>

*Instructions:* Please complete all components: related activity, timeline (report in dates only), person and agency responsible, and evaluation measure success for each program impact objective(s).

Process Objective (Write actual objective or paraphrase)	Person and Agency Responsible	Specific Timeline		Priority Population Ultimate or Intermediate	Related Activities or Steps (Describe the significant activities/steps accomplished for each process objective)	Evaluation Measure (How do you know you are successful?)
		Start Date	End Date			

## Core Competency Areas for Violence and Injury Prevention Professionals

Detailed learning objectives for each of the core competencies can be found at:

Safe States Alliance/SAVIR National Training Initiative at

<http://www.safestates.org/displaycommon.cfm?an=1&subarticlenbr=41>

- Ability to describe and explain injury and/or violence as a major social and health problem.
- Ability to access, interpret, use and present injury and/or violence data.
- Ability to design and implement injury and/or violence prevention activities.
- Ability to evaluate injury and/or violence prevention activities.
- Ability to build and manage an injury and/or violence prevention program.
- Ability to disseminate information related to injury and/or violence prevention to the community, other professionals, key policy makers and leaders through diverse communication networks.
- Ability to stimulate change related to injury and/or violence prevention through policy, enforcement, advocacy and education.
- Ability to maintain and further develop competency as an injury and/or violence prevention professional.
- Demonstrate the knowledge, skills and best practices necessary to address at least one specific injury and/or violence topic (e.g. motor vehicle occupant injury, intimate partner violence, fire and burns, suicide, drowning, child injury, etc.) and be able to serve as a resource regarding that area.

Source: Safe States Alliance <http://safestates.org/>

### OHIO-SPECIFIC INJURY DATA

- **Ohio Violence and Injury Prevention Program – Burden of Injury In Ohio (Selected County Injury Profiles)** <http://www.healthyohioprogram.org/vipp/data/burden.aspx>
- **Ohio Department of Health Information Warehouse - State and county-level data** <http://dwhouse.odh.ohio.gov/>
- **WISQARS** (Web-based Injury Statistics Query and Reporting System) - Customized reports of state and national injury-related data. <http://www.cdc.gov/injury/wisqars/index.html>
- **WONDER** (Wide-Ranging Online Data for Epidemiologic Research) <http://wonder.cdc.gov/mortSQL.html> - State data on underlying cause of death – state and county-level
- **Alcohol Related Disease Impact Software** - Injuries attributable to alcohol - Ohio data available. <http://apps.nccd.cdc.gov/ardi/Homepage.aspx>
- **Ohio Trauma Registry** - Ohio Department of Public Safety [http://ems.ohio.gov/ems\\_datacenter.stm#tog](http://ems.ohio.gov/ems_datacenter.stm#tog)
- **Ohio Child Fatality Review Annual ReportsH** - Ohio Department of Health <http://www.odh.ohio.gov/odhPrograms/cfhs/cfr/cfrrept.aspx>

### OHIO INJURY COST DATA

- **Children's Safety Network** - Fatal injury cost data by state <http://www.childrensafetynetwork.org/state/ohio-cost-data>
- **West Virginia Injury Control Research Center** - Injury hospitalization incidence and costs by state <http://www.hsc.wvu.edu/icrc/AHRQFORM.asp>
- **WISQARS Cost of Injury Reports** - <http://wisqars.cdc.gov:8080/costT/>

### OCCUPATIONAL INJURY DEATHS IN OHIO

- **Census of Fatal Occupational Injury** - Ohio Data Reports <http://www.bls.gov/iif/oshstate.htm#OH>
- **Census of Fatal Occupational Injury** - Data Query <http://www.bls.gov/iif/home.htm>

### MOTOR VEHICLE TRAFFIC CRASH DATA

- **Ohio Traffic Crash Data** - Ohio Department of Public Safety - **local data available** <https://ext.dps.state.oh.us/crashstatistics/CrashReports.aspx>
- **FARS** (Fatal Analysis Reporting System) - NHTSA - Fatal vehicle crash data on public roadways - Ohio data available <http://www-fars.nhtsa.dot.gov/QueryTool/QuerySection/SelectYear.aspx>

### OHIO CRIME DATA

- **OIBRS** (Ohio Incident Based Reporting System) - Ohio Department of Public Safety - Ohio and **county-level** data <http://www.crimestats.ohio.gov/>

### BEHAVIOR RISK FACTOR DATA

- **OYRBS** (Ohio Youth Risk Behavior Survey) - Ohio Department of Health [http://www.odh.ohio.gov/odhPrograms/chss/ad\\_hlth/YouthRsk/youthrsk1.aspx](http://www.odh.ohio.gov/odhPrograms/chss/ad_hlth/YouthRsk/youthrsk1.aspx)
- **BRFSS** (Behavioral Risk Factor Surveillance Survey) - CDC <http://www.cdc.gov/brfss/index.htm>

### SUBSTANCE ABUSE DATA

- **State Epidemiological Outcomes Workgroup – Ohio Department of Mental Health and Addiction Services** - Ohio Department of Health – <http://www.odadas.ohio.gov/SEOW/>

## INJURY PREVENTION COALITION IDEAS

This list is presented to help you generate some ideas on coalition representation. Some may not be appropriate for your program.

Potential Partners/Coalition Members	Appropriate for project (Y/N)	Available in community (Y/N)	Contact person/notes
<b>County/City Health Department</b>			
Maternal & Child Health Staff (e.g., WIC programs, Help Me Grow)			
Adolescent Health/Youth Violence Staff			
Older adult programs			
Other, specify			
<b>Other City/County Agencies</b>			
Emergency Preparedness/Health Department			
Children & Family Services – Jobs and Family			
Law Enforcement Agency			
Other County/City Agency (specify)			
Area Agency on Aging/County Aging Organization			
Emergency Medical Services (EMS)/Fire Department			
<b>Local Officials</b>			
Mayor's Office			
City/County Administration			
County Health Director/Commissioner			
Other High Profile County Official (specify)			
Transportation officials			
<b>Hospitals/Health Care</b>			
Emergency Room Nurses/Trauma Center Manager			
Community Outreach/Education Programs			
EMS Coordinator			
Insurance Providers			
Occupational therapists/physical therapists			
Poison Control Center staff			
Pediatricians/Osteopathic physicians/Geriatricians/Trauma surgeons			
<b>Schools</b>			
School Nurses			
School Safety Officer			
Administrators			
Teachers			
Students/student groups			
Parent Teacher Organizations			

Potential Partners/Coalition Members	Appropriate for project (Y/N)	Available in community (Y/N)	Contact person/notes
<b>Business</b>			
Insurance providers/agents			
Related business agenda (e.g., bicycle helmets, car seats, home safety equipment, etc.)			
Businesses willing to provide in-kind donations (e.g., food, mailing, printing, communications, etc.)			
<b>Community-Based Organizations</b>			
Youth Serving Organizations (specify)			
Mental Health			
Substance Abuse Prevention Organizations			
Orgs. Serving Marginalized Communities (e.g., poverty)			
Child and Family First Council			
Orgs. Serving Migrant Farm Workers			
Community Health Centers			
Faith-based Organizations			
Community/Service Organizations (e.g., Jaycees, Federation of Women’s Clubs, Junior League, etc.)			
Child Care Centers			
Community Centers (e.g, Jewish Community Centers/YMCA/YWCA)			
Others, specify			
<b>Colleges &amp; Universities</b>			
University/College			
Community College			
Technical/Art Schools			
<b>Advocacy Groups</b>			
AAA			
Other, specify			
<b>Racial/Ethnic Underserved</b>			
African American			
Hispanic/Latino			
Asian Pacific Islander and Native American			
Persons with Disabilities			
Rural			
Low socio-economic status			
Gay, Lesbian, Bi-sexual & Transgender (GLBT)			
<b>Others (please specify)</b>			

Required attachment should be named *"Insert county\_Demographics"* and attached in GMIS 2.0

## Community Demographics Table

Complete the following table for your target "community" using the following sources and attach in GMIS 2.0 as *"Insert County\_Demographics"*. Use county-level data if more specific (e.g., city) information is not available.

Sources: Information can be found at the following sites:

1. U.S. Census Factfinder at <http://www.census.gov/2010census/>
2. Ohio Department of Development, County Profiles  
[http://development.ohio.gov/reports/reports\\_countytrends\\_map.htm](http://development.ohio.gov/reports/reports_countytrends_map.htm)

Target Community: City/County \_\_\_\_\_

Zip Code(s) \_\_\_\_\_

Designated Appalachian County Yes \_\_\_\_\_ No \_\_\_\_\_

Demographic	Category	Target Community		Ohio	
		Number	Percent	Number	Percent
<b>2007 Total Population<sup>2</sup></b>	All residents			11,466,917	100%
<b>Gender<sup>1</sup></b>	Male			5,586,499	48.7%
	Female			5,876,904	51.3%
<b>Age<sup>2</sup></b>	Under 6 years			908,264	8%
	6 to 17 years			1,976,877	17.4%
	18 to 24 years			1,056,259	9.3%
	25 to 44 years			3,335,997	29.4%
	45 to 64 years			2,567,648	22.6%
	65 and over			1,508,095	13.3%
	Median Age			36.2	N/A
<b>Race/Ethnicity<sup>1</sup></b>	White			9,630,053	84%
	African American			1,346,290	11.7%
	American Indian and Alaska Native			21,903	0.2%
	Asian			174,382	1.5%
	Native Hawaiian and Other Pacific Islander			3,372	0%
	Other race			109,891	1%
	Two or more races			177,512	1.5%
	Hispanic (may be any race)			273,920	2.4%
<b>Language<sup>1</sup></b>	Speak a language other than English at home			657,311	6.1%

## Community Demographics Tables Continued

Demographic	Category	Target Community		Ohio	
		Number	Percent	Number	Percent
Educational Attainment <sup>2</sup>	No high school diploma			1,262,085	17%
	High school graduate			2,674,551	36.1%
	Bachelor's degree or higher			1,563,532	21.1%
Poverty <sup>1,2</sup>	Individuals below poverty level <sup>1</sup>			1,170,698	10.6%
	Below 50% poverty level <sup>2</sup>			530,076	4.8%
	Families below poverty level <sup>1</sup>			235,026	7.8%
Unemployment	% of Labor Force Unemployed - 2009				10.4%
Income <sup>2</sup>	2006 Per Capita Personal income			\$33,320	N/A
Geography <sup>1</sup>	Urban			<b>8,782,329</b>	<b>77%</b>
	Inside Urbanized Areas			7,311,293	64%
	Inside Urbanized Clusters			1,471,036	13%
	Rural			2,570,811	23%
Land Use (% of Land) <sup>2</sup>	Urban			N/A	9.17%
	Cropland			N/A	45.53%
	Pasture			N/A	7.81%
	Forest			N/A	37.12%
No. Houses (Year Built) <sup>2</sup>	Before 1960		*	2,251,130	47.1%
	1960 to 1979		*	1,44,1421	30.1%
	1980 to March 2000		*	1,090,500	22.8%
Media Resources <sup>2</sup>	Television stations		*	69	N/A
	Radio stations		*	340	N/A
	Daily newspaper stations (circulation)		*	94	N/A
				(3,126,339)	N/A
Health Care <sup>2</sup>	Physicians		*	29,472	N/A
	Hospitals (# beds)		*	177 (44,189)	N/A
	Licensed Nursing Homes		*	1,779	N/A
	Licensed Residential care		*	1,000	N/A
Schools <sup>2</sup>	Public Schools		*	4,043	N/A
	Students		*	1,751,511	N/A
Transportation <sup>2</sup>	Motor Vehicles		*	12,021,879	N/A

\*Calculate % of Ohio for these

**Data Sources:** Information on community indicators and GIS mapping to help identify social determinants of health can found at the Community Commons website: [www.communitycommons.org](http://www.communitycommons.org).

## Application Scoring Criteria and Process

All application materials will first be checked and reviewed by GSU to determine that applicants are eligible (see RFP section I.D.) and all required attachments and information are included. Only complete applications and applications from agencies in compliance with the Grants Application Eligibility Matrix (GAEM) criteria; RFP section I.D.

The injury prevention applications will be reviewed by internal and external injury prevention and public health professionals who are not connected to any of the applicant agencies. Each grant will be reviewed by 3 reviewers, at least one of whom will be external to ODH.

Reviewers will be briefed on the application requirements and provided with a copy of the RFP and all application materials meeting the review criteria. The reviewer scoring sheet is available on the following pages.

### Weighted Scoring:

In addition to the total reviewer scores, county needs will be considered in awarding the IP subgrants through the application of additional weighting for those counties with the highest poverty rates and highest injury fatality rates for falls, child injury and drug overdose to permit these extremely limited resources to be focused on areas with disparate needs.

Those counties in the 75<sup>th</sup> percentile or higher for county poverty rates and for fatal unintentional injury rates for ages 1-18, falls among older adults and unintentional drug overdose will be awarded an additional 5 points in the scoring criteria. The additional weighting will be awarded only if the area for which the application is proposed falls within the 75<sup>th</sup> percentile or higher (e.g., application focuses on falls and county is within the 75<sup>th</sup> percentile for fatal falls among older adults). 10 points will be awarded if the county falls within the 75<sup>th</sup> percentile for both poverty and applicable injury rate.

**Average Reviewer Score + Weighted need-based Score (if applicable) = Total Applicant Score**

### Counties in 75<sup>th</sup> Percentile of Injury Death and Poverty Rates\*

Sources: 1. ODH Office of Vital Statistics; 2. US Census Bureau, 2011 SAIPE <http://www.census.gov/did/www/saipe/data/interactive/#view=StateAndCounty>

Unintentional Drug Overdose Deaths 2007-11 <sup>1</sup>		Unintentional Injury Deaths Ages 1-18 2002-11 <sup>1</sup>		Unintentional Fall-related Injury Deaths – Ages 65+ 2007-11 <sup>1</sup>		County Poverty Data <sup>2</sup>		
County of Residence	Rate	County of Residence	Rate	County of Residence	Rate	County	# Living in Poverty	% of County Living in Poverty
BROWN	29.1	HARDIN	39.28	MONTGOMERY	116.72	ATHENS	19,353	35
SCIOTO	28.6	NOBLE	37.53	STARK	89.13	SCIOTO	19,671	26.1
ROSS	25.3	VINTON	37.48	GREENE	84.72	VINTON	3,114	23.5
PIKE	25.1	PAULDING	30.31	ASHLAND	82.49	LUCAS	100,123	23.3
JEFFERSON	24.6	ADAMS	30.09	WOOD	78.95	PIKE	6,376	22.7
ADAMS	23.5	MEIGS	29.25	PUTNAM	76.89	ADAMS	6,310	22.5
MONTGOMERY	23.5	CRAWFORD	29.24	WARREN	75.19	MEIGS	5,236	22.4
TRUMBULL	23.2	DARKE	26.66	HENRY	74.13	HIGHLAND	9,190	21.5
HOCKING	22.1	HIGHLAND	26.37	MONROE	73.64	GALLIA	6,346	21.2
JACKSON	21.0	MERCER	26.12	AUGLAIZE	72.77	MORGAN	3,096	20.9
CLERMONT	20.9	HENRY	26.04	DEFIANCE	71.34	JACKSON	6,668	20.4
CLINTON	18.8			PAULDING	71.25	ASHTABULA	19,891	20.3
PREBLE	18.8			FULTON	70.88	HARDIN	5,854	19.8
LAWRENCE	18.5			WILLIAMS	70.50	GUERNSEY	7,658	19.4
CRAWFORD	18.4			PREBLE	69.81	ROSS	13,914	19.4
HARDIN	17.0			HURON	69.76	ALLEN	19,203	19.2
BUTLER	16.9			WAYNE	69.40	CLARK	25,642	19.1
MAHONING	16.8			SUMMIT	68.96	LAWRENCE	11,684	18.9
VINTON	16.5			DARKE	67.19	MUSKINGUM	15,836	18.9
SHELBY	16.2			LICKING	66.88	CUYAHOGA	233,438	18.8
				LUCAS	65.37	FRANKLIN	216,974	18.8
				CLINTON	63.71	HAMILTON	144,388	18.5
				SANDUSKY	60.66	MONTGOMERY	96,053	18.3
				WYANDOT	60.32			
				UNION	60.29			

**2014 Reviewer Score Sheet**  
**Ohio Department of Health, Division of Prevention and Health Promotion, Bureau of Healthy Ohio**  
**Injury Prevention Program Grants**

Applicant Agency _____	County(s) to Be Served _____	
Applicant Number _____	Requested Budget \$ _____	
Reviewer Name _____	Date _____	
Grant Focus Area(s): <input type="checkbox"/> Unintentional Child Injury <input type="checkbox"/> Falls among Older Adults <input type="checkbox"/> Unintentional Prescription Drug Poisoning		
<b>Overall Scoring Summary</b>		
	<b>Section</b>	<b>Maximum Score</b>
Executive Summary	5	_____
Applicant Agency	25	_____
Problem/Need Statement	25	_____
Methodology Narrative	55	_____
Methodology Work Plan	50	_____
Focus Area Requirements	10	_____
Budget Review	10	_____
<b>Total Score</b>	<b>180</b>	_____
	<b>Minimum score 120 (67%)</b>	
<b>Funding Recommendation:</b>	<b>Y   N</b>	
<b>Technical Assistance or Training Needs</b> (Suggestions for this grantee to strengthen the application)		

<b>Recommended Special Conditions</b> <b>(Reviewer note: please complete last.)</b>	<b>Comments</b>		
<b>Reviewer Note: The word “satisfactorily” is implied in each statement throughout review sheet. Points should be awarded accordingly. Poor quality responses should receive points at the lower end of the scale and high quality at the high end.</b>			
<b>Review by Sections</b>			
<b>Category – 1. Executive Summary (10 points)</b>	<b>Comments</b>	<b>Maximum Score</b>	<b>Reviewer’s Score</b>
<input type="checkbox"/> Describes the injury problems the program will address, including descriptions of local injury rates and related injury risk factors. Provides justification of the injury problems chosen.  <input type="checkbox"/> Includes program goals and objectives.  <input type="checkbox"/> Describes who the project is serving, includes demographics, location of project activities and role of partners/coalitions.  <input type="checkbox"/> Describes how the project will be evaluated.  <input type="checkbox"/> Provides the total funds requested and how they will be used.		1 point  1 point  1 point  1 point	
<b>Total Executive Summary</b>		<b>5 points</b>	

Category – Description of Applicant Agency and Documentation of Eligibility (25 points)	Comments	Maximum Score	Reviewer’s Score
<input type="checkbox"/> Discusses eligibility to apply and summarizes agency’s structure as it relates to this program and as lead agency, how it will manage the program		3 points	
<input type="checkbox"/> Summarizes existing injury prevention efforts; provides information on other sources of funding for existing injury prevention efforts and how this funding will be used to expand other areas; describes other experience by the agency in managing injury prevention programs OR describes the agency’s experience in managing other population-based public health programs.		3 points	
<input type="checkbox"/> Lists all personnel working on the grant on the Key Personnel Form (Appendix F). Includes relationship between program staff members, applicant agency staff members and other partners and agencies they will be working on the grant. Includes number of program staff in agency that work on injury prevention-related efforts		4 points	
<input type="checkbox"/> Includes position description and resumes		3 points	
<input type="checkbox"/> Provides documentation and demonstrates compliance that an individual is 100% dedicated to injury prevention (See Appendix F)	Applicants that do not provide this assurance are not eligible for this funding.	<b>Required</b>	<b>Y N N/A</b>
<input type="checkbox"/> Describes plans for hiring and training staff; includes on-going training and details about the training provided. Includes a statement that ensures all involved program staff will have experience or receive training in concepts of population-based injury prevention and control		4 points	
<input type="checkbox"/> Demonstrates that staff have experience or will be trained in the Core Competency Areas for Injury and Violence Prevention; Includes a training plan that is consistent with the core competency areas (Appendix J).		5 points	
<input type="checkbox"/> Includes background information about contract agency or individuals and all work to be conducted, if applicable		No Score	<b>Y N N/A</b>

Category – Applicant Agency – Continued (25 points)	Comments	Maximum Score	Reviewer’s Score
<ul style="list-style-type: none"> <li><input type="checkbox"/> Describes the capacity of the organization, its personnel or contactors to communicate effectively and convey information in a timely manner that is easily understood by diverse audiences. Includes person of limited English proficiency, those who are not literate, how low literary skills, and individuals with disabilities</li> <li><input type="checkbox"/> THE FACILITIES AND RESOURCES ARE ADEQUATE TO CARRY OUT THE PROJECT OBJECTIVES</li> <li><input type="checkbox"/> QUALIFICATIONS OF STAFF ARE ADEQUATE TO MEET PROJECT’S OBJECTIVES</li> </ul>		<p>3 points</p> <p>No Score</p> <p>No Score</p>	<p></p> <p>Y N N/A</p> <p>Y N N/A</p>
<b>Total Applicant Agency</b>		<b>25 points</b>	
Category – Problem Statement/Need (25 points)	Comments	Maximum Score	Reviewer’s Score
<ul style="list-style-type: none"> <li><input type="checkbox"/> Describes injury problems and includes description of local injury rates and related injury risk factors. Provides support as to why this is a problem in your community and includes data that describes the problem and justifies the need for the program</li> <li><input type="checkbox"/> Explicitly describes segments of the target population who experience a disproportionate burden of local injury rates</li> <li><input type="checkbox"/> Indicates if a needs assessment has been completed within the past two years. Includes a brief summary. Describes how this was used in determining the injury problem chosen</li> <li><input type="checkbox"/> Includes a description of other agencies/organization also addressing this problem/need</li> <li><input type="checkbox"/> Describes potential gaps in services in the community</li> <li><input type="checkbox"/> Describes any barriers in implementing IP activities and strategies for overcoming these issues</li> <li><input type="checkbox"/> PROJECT NARRATIVE DEMONSTRATES THE NEED FOR PROJECT</li> </ul>		<p>5 points</p> <p>5 points</p> <p>3 points</p> <p>3 points</p> <p>5 points</p> <p>4 points</p> <p>No Score</p>	<p></p> <p></p> <p></p> <p></p> <p></p> <p></p> <p>Y N N/A</p>
<b>Total Problem Statement/Need</b>		<b>25 points</b>	



<ul style="list-style-type: none"> <li><input type="checkbox"/> Describe plans to recruit coalition members from diverse communities including racial and ethnic minority populations.</li> <li><input type="checkbox"/> Describes the proposed role of key coalition members and partners related to your project activities. A letter of support from each key partner is included.</li> <li><input type="checkbox"/> Describes planned coalition activities and initiatives during 2014.</li> </ul> <p><b>Community Needs Assessment and Program Evaluation Logic Model Development</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> List Community Needs Assessment SMART Program Impact Objective:</li> <li><input type="checkbox"/> Describe plans to conduct a community needs assessment to identify community readiness and gaps in services/programs in the first 12-months.</li> <li><input type="checkbox"/> Describe results of any assessments used to plan the proposed strategies (e.g., behavior observations, pretest evaluations, attitude surveys, etc.). Describe any continuing assessment activities for 2014. Describe how these data will be used to evaluate activities at the end of the project period.</li> <li><input type="checkbox"/> Describe any primary (data collection) or secondary (e.g., analysis, linkage, etc.) surveillance activities and use of injury data (e.g., reports) in your proposed project. Describe how data will be obtained and used to support other project initiatives.</li> <li><input type="checkbox"/> Describe how data will be used to identify groups who are disproportionately impacted by unintentional injury.</li> <li><input type="checkbox"/> Describe any planned activities related to improving the quality and/or use of local fatal and non-fatal injury data.</li> <li><input type="checkbox"/> Describe the process that will be used to develop a program evaluation logic model during year 1 (specific guidance will be provided by ODH in year 1; but reviewers need information on the process.). Describe any experience with logic model development. Include a description of how your coalition or key members of your coalition will be engaged in this process.</li> </ul>		<p>10 points</p>	
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<p><b>Other PSEC-Supportive Strategies</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Describes strategy in detail.</li> <li><input type="checkbox"/> Provides evidence/justification for the selection of the strategy.</li> <li><input type="checkbox"/> Describes which coalition partners will be engaged and their role in the strategy.</li> </ul> <p><b>Overall Program Methodology</b></p> <p><b>Sustainability Plan:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Includes a sustainability plan/statement for continued program efforts in the event that grant funding is no longer available.</li> <li><input type="checkbox"/> Demonstrates effort will be made to institutionalize changes and/or program policies, practices, norms, attitudes at the organizational or institutional level.</li> <li><input type="checkbox"/> Describes additional program funding will be leveraged through use of ODH IP grant.</li> <li><input type="checkbox"/> PROJECT NARRATIVE DEMONSTRATES HOW ALL PROGRAM OBJECTIVES WILL BE MET IN DETAIL AND MEETS/ADDRESSES THOSE LISTED IN THE RFP (Y/N)</li> <li><input type="checkbox"/> PROPOSED PROJECT METHODOLOGY IS CAPABLE OF ACHIEVING THE PROJECT'S OBJECTIVES (Y/N)</li> </ul>		<p>6 points</p> <p>Y N</p> <p>Y N</p>	
<b>Total Methodology Narrative</b>		<b>55 points</b>	

**Work Plan Review Sheets: 50 Points Total**

Category – 5. Methodology Work Plan – Coalition Building	Comments	Maximum Score	Reviewer’s Score
<p><b>Reviewer Note:</b> Grantee must have 1 objective related to coalition building and coalition evaluation (if they have an existing coalition).</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Impact objectives are population-based and written in <b>SMART</b> (<b>S</b>pecific, <b>M</b>easurable, <b>A</b>chievable, <b>R</b>elevant, and <b>T</b>ime-framed) format such as: By (date),(system), will (specify how system will change) in (where) as measured or evaluated by (how you will determine that the desired change has occurred)</li> <li><input type="checkbox"/> Provides a satisfactory impact evaluation indicator to indicate achievement of impact objectives. <b>Will grantee be able to use indicator to measure achievement of impact objective?</b></li> <li><input type="checkbox"/> Describes how objective will address safety/injury disparities in the applicant community (if applicable).</li> <li><input type="checkbox"/> Describes how the population-based impact and process objectives will be achieved by listing activities in detail (must provide at least <u>one</u> activity to meet each program population based impact objective).</li> <li><input type="checkbox"/> Includes a specific timeline for each activity (e.g., all activities should not say 1/1 – 12/31).</li> <li><input type="checkbox"/> Identifies the person and the agency responsible for completing the activities.</li> <li><input type="checkbox"/> Lists the populations—intermediate (influential and credible persons, leaders, decision makers, professionals) and ultimate (children/older adults) that will be targeted to achieve goals.</li> <li><input type="checkbox"/> Describes how the activities will be evaluated for success.</li> <li><input type="checkbox"/> Includes sufficient detail to describe required activities and demonstrate capacity to successfully perform grant activities.</li> </ul>			
<b>Total Coalition</b>		<b>10 points</b>	

<p align="center"><b>Category – 5. Methodology Work Plan – Community Needs Assessment/Surveillance/Data and Program Evaluation Logic Model Development</b></p>	<p align="center"><b>Comments</b></p>	<p align="center"><b>Maximum Score</b></p>	<p align="center"><b>Reviewer’s Score</b></p>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Describes how the activities will be evaluated for success.</li> <li><input type="checkbox"/> Includes plans to conduct a community needs assessment (unless evidence is provided of one in past 2 years) in year 1.</li> <li><input type="checkbox"/> Includes description of how coalition will be engaged in needs assessment process.</li> <li><input type="checkbox"/> Includes a description of plans to develop program evaluation logic model in year 1.</li> <li><input type="checkbox"/> Impact objectives are population-based and written in <b>SMART</b> format.</li> <li><input type="checkbox"/> Provides a satisfactory impact evaluation indicator to indicate achievement of impact objectives. <b>Will grantee be able to use indicator to measure achievement of impact objective?</b></li> <li><input type="checkbox"/> Describes how objective will address safety/injury disparities in the applicant community (if applicable).</li> <li><input type="checkbox"/> Describes how the population-based impact and process objectives will be achieved by listing activities in detail (must provide at least <u>one</u> activity to meet each program population based impact objective).</li> <li><input type="checkbox"/> Includes a specific timeline for each activity (e.g., all activities should not say 1/1 – 12/31).</li> <li><input type="checkbox"/> Identifies the person and the agency responsible for completing the activities.</li> <li><input type="checkbox"/> Lists the populations—intermediate (influential and credible persons, leaders, decision makers, professionals) and ultimate (children/older adults) that will be targeted to achieve goals.</li> <li><input type="checkbox"/> Includes sufficient detail to describe required activities and demonstrate capacity to successfully perform grant activities.</li> </ul>			
<p align="center"><b>Total Needs Assessment/Surveillance/Data Work Plan</b></p>		<p align="center"><b>10 points</b></p>	

<b>Category – 5. Methodology Work Plan – Policy, Systems and Environmental Changes (PSEC) Strategies and PSEC Supportive Strategies – 30 points</b>	<b>Comments</b>	<b>Maximum Score</b>	<b>Reviewer’s Score</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Includes at least 3 PSEC-related strategies and a work plan for each.</li> <li><input type="checkbox"/> PSEC-Supportive strategies are used to support PSECs.</li> <li><input type="checkbox"/> Objectives are population-based and written in <b>SMART</b> format.</li> <li><input type="checkbox"/> Strategies selected are based in evidence.</li> <li><input type="checkbox"/> Appropriate partners are included to increase likelihood of success.</li> <li><input type="checkbox"/> Provides a satisfactory impact evaluation indicator to indicate achievement of impact objectives. <b>Will grantee be able to use indicator to measure achievement of impact objective?</b></li> <li><input type="checkbox"/> Describes the desired program outcome on the intermediate and/or the ultimate target population.</li> <li><input type="checkbox"/> Describes how objective will address safety/injury disparities in the applicant community (if applicable).</li> <li><input type="checkbox"/> Describes how the population-based impact and process objectives will be achieved by listing activities in detail (must provide at least <u>one</u> activity to meet each process objective).</li> <li><input type="checkbox"/> Includes a specific timeline for each activity (e.g., all activities should not say 1/1 – 12/31).</li> <li><input type="checkbox"/> Identifies person and agency responsible for completing activities.</li> <li><input type="checkbox"/> Lists the populations—intermediate (influential and credible persons, leaders, decision makers, professionals) and ultimate (children/older adults) that will be targeted to achieve goals.</li> <li><input type="checkbox"/> Describes how the activities will be evaluated for success.</li> <li><input type="checkbox"/> Includes sufficient detail to describe required activities and demonstrate capacity to successfully perform grant activities.</li> </ul>			
<b>Total Policy Enactment and Enforcement Work Plan</b>		<b>30 points</b>	

Specific Focus Area Requirements	Comments	Maximum Score	Reviewers Score
<p><b>Unintentional Child TBI Prevention</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Includes at least one focus area on TBI prevention</li> </ul> <p><b>Falls Among Older Adults:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Includes all 3 required strategies:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Increase use falls risk assessment screening</li> <li><input type="checkbox"/> Increase access to exercise/strength/balance courses</li> <li><input type="checkbox"/> Increase access to home safety resources</li> </ul> </li> <li><input type="checkbox"/> Includes National Falls Prevention Awareness Day activities</li> </ul> <p><b>Prescription Drug Overdose:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Includes Poison Death Review</li> <li><input type="checkbox"/> Includes letter of support from Coroner</li> <li><input type="checkbox"/> Includes at least 1 of the following PSEC strategies: increase use of OARRS, increase access to naloxone, promote adoption of standardized pain management guidelines.</li> </ul>		<b>10 points</b>	
<b>Focus Area Requirements</b>		<b>10 points</b>	
Budget Justification	Comments	Maximum Score	Reviewer's Score
<ul style="list-style-type: none"> <li><input type="checkbox"/> Budget justification is logically tied to program objectives and activities.</li> <li><input type="checkbox"/> IS ANY EQUIPMENT REQUESTED NECESSARY TO CARRYOUT PROJECT OBJECTIVES (During Budget Period)</li> </ul>		<p><b>10</b></p> <p><b>Y N</b></p>	

<ul style="list-style-type: none"> <li><input type="checkbox"/> BUDGET JUSTIFICATION PROVIDES DETAILED EXPLANATION OF PROPOSED EXPENSES AND HOW COSTS APPLY TO THE PROGRAM OBJECTIVES (Cost-benefits warrant the grant award)</li>   <li><input type="checkbox"/> REQUESTED EXPENDITURES ARE ALLOWABLE (Personnel, Other Direct Costs, Equipment, Contracts) – <b>Pending GSU Final Approval</b></li>   <li><input type="checkbox"/> ARE COSTS NECESSARY, REASONABLE AND ALLOCABLE <b>Pending GSU Final Approval</b></li> </ul>		<p><b>Y N</b></p> <p><b>Y N</b></p> <p><b>Y N</b></p>	
<b>From program perspective, is Budget Justification reasonable and appropriate?</b>		<b>10 Points</b>	

<b>Additional Comments/Reviewer Notes</b>

## Ohio County Population Estimates, 2012\*

**Citation:** Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2012 **Source:** U.S. Census Bureau, Population Division, May 2013.

County Name	Population						
Adams	28,550	Fairfield	146,156	Licking	166,492	Portage	161,419
Allen	106,331	Fayette	29,030	Logan	45,858	Preble	42,270
Ashland	53,139	Franklin	1,163,414	Lorain	301,356	Putnam	34,499
Ashtabula	101,497	Fulton	42,698	Lucas	441,815	Richland	124,475
Athens	64,757	Gallia	30,934	Madison	43,435	Ross	78,064
Auglaize	45,949	Geauga	93,389	Mahoning	238,823	Sandusky	60,944
Belmont	70,400	Greene	161,573	Marion	66,501	Scioto	79,499
Brown	44,846	Guernsey	40,087	Medina	172,332	Seneca	56,745
Butler	368,130	Hamilton	802,374	Meigs	23,770	Shelby	49,423
Carroll	28,836	Hancock	74,782	Mercer	40,814	Stark	375,586
Champaign	40,097	Hardin	32,058	Miami	102,506	Summit	541,781
Clark	138,333	Harrison	15,864	Monroe	14,642	Trumbull	210,312
Clermont	197,363	Henry	28,215	Montgomery	535,153	Tuscarawas	92,582
Clinton	42,040	Highland	43,589	Morgan	15,054	Union	52,300
Columbiana	107,841	Hocking	29,380	Morrow	34,827	Van Wert	28,744
Coshocton	36,901	Holmes	42,366	Muskingum	86,074	Vinton	13,435
Crawford	43,784	Huron	59,626	Noble	14,645	Warren	212,693
Cuyahoga	1,280,122	Jackson	33,225	Ottawa	41,428	Washington	61,778
Darke	52,959	Jefferson	69,709	Paulding	19,614	Wayne	114,520
Defiance	39,037	Knox	60,921	Perry	36,058	Williams	37,642
Delaware	174,214	Lake	230,041	Pickaway	55,698	Wood	125,488
Erie	77,079	Lawrence	62,450	Pike	28,709	Wyandot	22,615

**Note:** The estimates are based on the 2010 Census and reflect changes to the April 1, 2010 population due to the Count Question Resolution program and geographic program revisions. All geographic boundaries for the 2012 population estimates series are defined as of January 1, 2012. Additional information on these localities can be found in the Geographic Change Notes (see <http://www.census.gov/popest/about/geo/changes.html>). For population estimates methodology statements, see <http://www.census.gov/popest/methodology/index.html>.