



# OHIO DEPARTMENT OF HEALTH

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John R. Kasich/Governor

Richard Hodges/Director of Health

## MEMORANDUM

**Date:** February 29, 2016

**To:** Prospective Injury Prevention Program, Prescription Drug Overdose Prevention Applicants

**From:** Shancie Jenkins, Chief  
Office of Health Improvement and Wellness  
Ohio Department of Health

**Subject:** Notice of Availability of Funds – State Fiscal Year 2016  
July 1, 2016 – August 31, 2019 Program Period

The Ohio Department of Health (ODH), Office of Health Improvement and Wellness (OHIW), Bureau of Health Services (BHS), Violence and Injury Prevention Program (VIIP) announces the availability of grant funds. Funds will be available 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 in the 75<sup>th</sup> percentile and higher will be weighted according to the criteria described within the RFP. The criteria includes number and rate of overdose deaths, along with indicators for prescribing behaviors. Up to five applicants will be awarded, based on review scores and need criteria.

To obtain a grant application packet:

1. Go to the ODH website at <http://www.odh.ohio.gov/>
2. From the home pages, 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 ODH Injury Prevention Program RFP and click "Submit." This process invoke Adobe Acrobat and displays the entire RFP. You can either read and/or print the document as desired.

Please note that all interested parties must submit a Notice of Intent to Apply for Funding (Appendix A) no later than Friday, April 1, 2016. All potential applicants are encouraged to participate in a Bidders Conference Tuesday, March 29 from 1 – 2:30 p.m. that will be held via webinar. The voice access will be available by calling 1-855-405-1648 (toll free) and entering the Meeting ID 65770#. To join the online meeting go to:

<https://odh-ohio.webex.com/odh-ohio/j.php?MTID=m7d18eada29dbca3af61cefc856a504eb>

Meeting Number: 641 170 121

Meeting Password: 9951428

The Bidders Conference will provide an opportunity for interested parties to learn more about the RFP and to ask clarifying questions. Please contact Sara Morman to register (see contact information below).

All applications and attachments are due Monday, May 2, 2016. Electronic applications received after Monday, May 2, 2016 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, complete and return the GMIS 2.0 training form by Friday, April 1, 2016.

If you have questions regarding this application, please contact Sara Morman at (614) 995-1428 or email at [Sara.Morman@odh.ohio.gov](mailto:Sara.Morman@odh.ohio.gov).



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

# **OHIO DEPARTMENT OF HEALTH**

**OFFICE OF**  
*Office of Health Improvement and Wellness*

**BUREAU OF**  
*Health Services*

*Injury Prevention Program, Prescription Drug Overdose Prevention*

**SOLICITATION**

**FOR**

**FISCAL YEAR 2016**

**(07/01/16 – 08/31/19)**

**Local Public Applicant Agencies  
Non-Profit Applicants**

**COMPETITIVE GRANT APPLICATION INFORMATION**

**Revised 6/26/15**

**For grant starts 1/1/2016 and thereafter**

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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 components including an electronic portion submitted via the Internet website “ODH Application Gateway” and various paper forms and attachments. All the required components of a specific application must be completed and submitted by the application due date. **If any of the required components are not submitted by the due date indicated in sections D, G and Q, the entire application will not be considered for review.**

This is a competitive Solicitation; a Notice of Intent to Apply for Funding (NOIAF – Appendix A) must be submitted by Friday, April 1, 2016 so access to the application via the Internet website “ODH Application Gateway” can be established.

**NEW AGENCIES ONLY or if UPDATES are needed:** For non-profit agencies, the NOIAF must be accompanied by proof of non-profit status. Both non-profit and local public agencies must submit proof of liability coverage. Request for Taxpayer Identification Number and Certification (W-9), and Authorization Agreement for Direct Deposit of EFT Payments Form (EFT).

The above mentioned forms are located on the Ohio Department of Administrative Services website at: <http://www.ohiosharedservices.ohio.gov/VendorsForms.aspx>

or directly at the following websites:

- **Request for Taxpayer Identification Number and Certification (W-9),**  
<http://www.irs.gov/pub/irs-pdf/fw9.pdf?portlet=103>
- **Authorization Agreement for Direct Deposit of EFT Payments Form (EFT)**  
<http://media.obm.ohio.gov/oss/documents/EFT+FORM+-+REVISED+01+14+2014.pdf>
- **Vendor Information Form**  
[http://media.obm.ohio.gov/oss/documents/New+Vendor+Information+Form\\_11+15+2013.pdf](http://media.obm.ohio.gov/oss/documents/New+Vendor+Information+Form_11+15+2013.pdf)

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 (OGAPP) manual. This manual must be followed to ensure adherence to the rules, regulations and procedures for preparation of all Subrecipient applications. The OGAPP manual is available on the ODH website:  
<http://www.odh.ohio.gov>.  
(Click on Grant/Contracts, ODH Grants, Grants Administrative Policies and Procedures Manual (OGAPP)) or copy and paste the following link into your web browser:  
<http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/funding%20opportunities/OGAPP%20Manual%20V100-2%20Rev%2010-1-2014.ashx>

Please refer to Policy and Procedure updates found on the GMIS bulletin board.

- B. **Application Name:** ***Injury Prevention Program, Prescription Drug Overdose Prevention***

- C. **Purpose:** [The purpose of this funding is to advance and evaluate comprehensive state-level interventions for preventing prescription drug overuse, misuse, abuse, and overdose. Interventions of priority address drivers of the prescription drug overdose epidemic, particularly the misuse and inappropriate prescribing of opioid pain relievers. The goal of this funding is for awardees to implement prevention strategies to improve safe prescribing practices and prevent prescription drug overuse, misuse, abuse, and overdose. In addition, the

grant program should enhance and empower local community interventions by deploying and coordinating intensive prevention efforts in high-burden communities and working with local entities to disseminate analyses of prescribing and overdose trends. |

- 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 (GMIS) training and must have the capacity to accept an electronic funds transfer (EFT). If an applicant agency needs GMIS training prior to the establishment of access to the application, then a GMIS training form must be submitted (Appendix B). State who is eligible to apply. Indicate whether local public and/or non-profit agencies can apply.* |

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

1. Applicant does not owe funds to ODH and has repaid any funds due within 45 days of the invoice date.
2. Applicant has not been certified to the Attorney General's (AG's) office.
3. Applicant has submitted application and all required attachments by **4:00 p.m. on Monday, May 2, 2016.** |

- 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 (e.g., county, city, or township) or, census tracts, census block groups, census block.* |

- F. Number of Grants and Funds Available:** | *The source of the funding is the Centers for Disease Control and Prevention (CDC) Prescription Drug Overdose Prevention for States. The entire project period is July 1, 2016 to August 31, 2019. Up to five grants will be awarded. Funding will be based on the following criteria: county population; prescribing behaviors; and overdose fatalities. Eligible agencies may apply for \$30,000 up to the following budget ceilings.*

This first program year will span 14 months from 7/1/2016 – 8/31/2017. Funding for the first program year will not exceed \$675,000.

\* Counties with a population less than 200,000\* may apply for a maximum of \$105,000.

\* Counties with a population greater than 200,000\* may apply for a maximum of \$130,000.

\* Multi-county projects with a combined population size exceeding 150,000\* may apply for a maximum of \$135,000.

Continuation program years will span 12 months on the following schedule: Year 2 (9/1/2017 – 8/31/2018); Year 3 (9/1/2018 – 8/31/2019). Funding for continuation years will not exceed \$475,000.

\* Counties with a population less than 200,000\* may apply for a maximum of \$65,000.

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

\* Multi-county projects with a combined population size exceeding 150,000\* may apply for a maximum of \$95,000.

\*Per the US Census 2014 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.*

*Allotments will be established in GMIS by ODH.*

- G. Due Date:** All parts of the application, including any required attachments, must be completed and received by ODH electronically via GMIS or via ground delivery—by **4:00 p.m. by Monday, May 2, 2016**. Applications and required attachments received after this deadline will not be considered for review.

Contact Jolene Defiore-Hyrmer, 614-644-0135, or Jolene.dhyrmer@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 Amended Substitute House Bill        and/or the *Catalog of Federal Domestic Assistance (CFDA) Number* 93.996.

- I. Goals:** The consequences of prescription drug overdose can be far reaching and severe. Every five hours, an Ohioan dies from an unintentional drug overdose. Like the nation, Ohio has experienced a dramatic increase in unintentional drug overdose deaths in the past decade; from 1999 to 2012, these fatalities increased over 440% in Ohio. Ohio’s rates are among the highest in the country, with 18.2 unintentional overdose fatalities per 100,000 people in 2013, and have surpassed motor vehicle crashes as the leading cause of injury-related death in Ohio since 2007.<sup>2</sup> Abuse of prescription opioids has been driving this epidemic; opioid overdoses accounted for 7,929 deaths between 2001 and 2012, of which 5,360 were due to prescription opioids. In 2012, more than a third of unintentional overdose deaths in Ohio involved prescription opioids and two-thirds of fatal overdoses involved any opioids, more than any other substance. There have been more deaths in Ohio from prescription opioids than from cocaine, heroin, and marijuana combined. The effects of this prescription drug overdose (PDO) epidemic reach beyond lost lives. Unintentional drug overdoses accounted for \$2.0 billion in medical costs and lost productivity in Ohio in 2012.<sup>2</sup> Prescription opioid abuse is also related to increases in heroin use and fatal heroin overdoses. According to a 2014 CDC MMWR, heroin use is increasing among those reporting nonmedical use of prescription opioids.<sup>3</sup> Ohio heroin overdose deaths increased from 16% of all drug overdose deaths in 2008 to 35.5% in 2012.<sup>2</sup> Many prescription opioid users have switched to heroin due to its lower price and increased availability. Evidence shows a strong relationship between the increase in exposure to prescription opioids and fatal unintentional overdoses: as the number of grams distributed to retail pharmacies increases, the death rate also increases.<sup>2</sup> Ohio has seen a 643% increase in the amount of prescription opioid grams per 100,000 people distributed to retail pharmacies across the state from 1997 to 2011. From 2010 to 2012, the number of pills per capita increased from 66.3 to 66.9 pills per Ohio resident, although this number decreased to 65.3 in 2013 due to successful interventions.<sup>4</sup> Ohio is also one of the top prescribing states for painkillers in the country; in 2012, there were 100 painkiller prescriptions per person, making it the 12th highest prescribing state of opioid pain relievers in the US.<sup>5</sup> Higher opioid prescribing rates are associated with higher rates of overdose deaths. The following factors have contributed to the increased availability of opioids available and the subsequent rise in opioid overdose in Ohio: overprescribing by physicians due to changes in clinical pain management guidelines in the late 1990s; aggressive marketing by pharmaceutical companies of new, extended-release prescription

opioids to physicians; direct marketing to consumers; rises in substance abuse; illegal online “pharmacies;” improper storage and disposal of medications; medication diversion; and “doctor shopping” by consumers. Ohio has a growing substance abuse population and was formerly home to several “pill mills,” or high-volume pain clinics that prescribed or directly dispensed unscrupulously, often to clients with no medical need for prescription opioids.<sup>1</sup> However, state legislation passed in 2011 has successfully shut down many of these “pill mills” by requiring licensure of pain clinics. The goal of the proposed approach is to reduce PDO fatalities in Ohio by targeting opioid prescribers and communities at high risk for prescription drug abuse in the highest burden counties. Specifically, ODH proposes to improve the state PDMP system (OARRS); to increase its use among prescribers; to build the capacity of high-burden counties to address the PDO epidemic through various community-based initiatives; and to evaluate the effects of recent legislation on opioid prescribing behaviors across the state.

**J. Program Period and Budget Period:** The program period will begin July 1, 2016 and end on August 31, 2017. The budget period for this application is July 1, 2016 through August 31, 2017.

**K. Public Health Accreditation Board (PHAB) Standard(s):** Identify the PHAB Standard(s) that will be addressed by grant activities.

**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* | The PHAB standards are available at the following website:

<http://www.phaboard.org/wp-content/uploads/PHAB-Standards-Overview-Version-1.0.pdf>

**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:

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 the 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 point when submitting the program summary with the grant application. If an applicant agency has a regional and/or statewide focus, a statement of support should be submitted from at least one local health district, if available.

**M. Incorporation of Strategies to Eliminate Health Inequities**  
**Health Equity Component (Standard Health Equity Language)**

The ODH is committed to the elimination of health 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 achieve and sustain optimal health. Throughout the various components of this application (e.g., Program Narrative, Objectives) applicants are required to:

- 1) Explain the extent to which health disparities and/or health inequities are manifested within the problem addressed by this funding opportunity. This includes the identification of specific group(s) who experience a disproportionate burden of disease or health condition (this information must be supported by data).
- 2) Explain and identify how specific social and environmental conditions (social determinants of health) put groups who are already disadvantaged at increased risk for health inequities.
- 3) Explain how proposed program interventions will address this problem.
- 4) Link health equity interventions in the grant proposal to national health equity strategies using the GMIS Health Equity Module. These four items should be incorporated into the

grant language in specific areas of the application and not left to the applicant to decide where to insert this information. Also care should be taken to avoid repetition to keep the responses focused and specific.

The following section will provide basic framework, links and guidance to information to understand and apply 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.*

**GMIS Health Equity Module:**

The GMIS Health Equity Module links health equity initiatives in grant proposals to national health equity strategies such as those found in *Healthy People 2020* or the *National Stakeholder Strategy for Achieving Health Equity*. Applicants are required to select the goals and strategies from the module which best reflect how their particular grant proposal addresses health disparities and/or health inequities. Applicants can choose more than one goal and/or strategy.

For more resources on health equity, please visit the ODH website at:

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

**N. Human Trafficking:** The ODH is committed to the elimination of human trafficking in Ohio. If applicable to the subrecipient program, ODH will give priority consideration to those subrecipients who can demonstrate the following:

- a. Victims of human trafficking are included in your agency's target population;
  1. At-risk population
  2. Mental health population

3. Homeless population

- b. Agency promotes the expansion of services to identify and serve those affected by human trafficking.

Applicable  to Prescription Drug Overdose Prevention

**O. Appropriation Contingency:** Any award made through this program is contingent upon the availability of funds for this purpose. **The subrecipient agency must be prepared to support the costs of operating the program in the event of a delay in grant payments.**

**P. 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 Solicitation to the ODH website and the receipt of the NOIAF. Please contact Sara Morman, 614-995-1428, or Sara.Morman@odh.ohio.gov with questions regarding this solicitation.

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

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

**R. Late Applications:** GMIS automatically provides a time and date system for grant application submissions. Required attachments and/or forms sent electronically must be transmitted by the application due date. Required attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before the application due date of **Monday, May 2, 2016 at 4:00 p.m.**

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 (GSU), via the front desk at 246 N. High St., Columbus, Ohio; 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.**

**S. Successful Applicants:** Successful applicants will receive official notification in the form of a Notice of Award (NOA). The NOA, issued over the signature of the Director of the Ohio Department of Health, allows for expenditure of grant funds.

**T. Unsuccessful Applicants:** Within 30 days after a decision to disapprove or not fund a grant application, written notification, issued over the signature of the Director of Health, or his designee, shall be sent to the unsuccessful applicant.

**U. 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, Measureable, Attainable, Realistic & Time-Phased (S.M.A.R.T.) 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 Solicitation;
9. Has demonstrated acceptable past performance in areas related to programmatic and financial stewardship of grant funds;
10. Has demonstrated compliance to OGAPP;
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. Describe activities which support the requirements outlined in sections I. thru M. of this Solicitation.

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

**V. 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; 34 CFR Part 5 for funds from the U.S. Department of Education or, 7 CFR Part 1 for funds from the U.S. Department of Agriculture. |Select only the appropriate reference. |

**W. 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 Health Promotion], [Violence and Injury Prevention Program] and as a sub-award of a grant issued by [the Centers for Disease Control and Prevention] under the [Ohio Prescription Drug Overdose Prevention] grant, grant award number [DOHF24W6F1], and CFDA number [93.136].”

- X. Reporting Requirements:** Successful applicants are required to submit Subrecipient program and expenditure reports. Reports must adhere to the requirements of the OGAPP manual. Reports must be received in accordance with the requirements of the OGAPP manual and this Solicitation; before the department will release any additional funds.

**Note: Failure to ensure 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:** Subrecipients Program Reports must be completed and submitted via GMIS, as required by the subgrant program by the following dates: [The first two months of the project will require monthly reports due August 15, 2016 and September 15, 2016. Subsequently, quarterly reporting will begin with a Quarterly Reporting Form which includes: Quarterly Work Plan Progress Narrative, Annual Success Story, Annual Achievements Summary, Quarterly Task Completion Report. Reporting form due at the close of each quarter of the project period – Quarter 1 – Sept. – Nov, due Dec.15; Quarter 2 December – February, due March 15; Quarter 3 March – May, due June 15; Quarter 4 June – August , due Sept. 15. Annual components of the reporting form due Sept. 15. | Any paper non-Internet compatible report attachments must be submitted to GSU 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.

*Submission of Subrecipient Program Reports via GMIS indicates acceptance of the OGAPP.* |

**New Program Coordinators/Directors Meeting:** At least one representative from your agency must attend a new program coordinators meeting to be held at a date TBD. The purpose of this meeting is to clarify and provide guidance on required objectives and activities with funded sub grantees early in the grant cycle. There will be information provided on Grants Administration Policies and Procedures (GAPP) including reporting requirement, 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.

**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.

**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 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 strengthen and sustain effective injury and violence prevention programs at the state and local level. Costs associated with attending these meetings are an allowable expense for this grant proposal and should be included in the budget. Attendance and active participation in the OIPP is a

requirement of funded projects.

2. **Subrecipient Reimbursement Expenditure Reports:** Subrecipients can choose monthly or quarterly reimbursement (expenditure report submission) from ODH (please check the reimbursement type on the attached NOIAF). Please note that no changes can be made to the reimbursement type once the project numbers have been established in GMIS. Subrecipient Monthly Reimbursement Expenditure Reports **must** be completed and submitted via GMIS by the following dates:

<i>Period</i>	<i>Report Due Date</i>
<i>January 1 – 31, 2016</i>	<i>February 10, 2016</i>
<i>February 1 – 29, 2016</i>	<i>March 10, 2016</i>
<i>March 1 – 31, 2016</i>	<i>April 10, 2016</i>
<i>April 1 – 30, 2016</i>	<i>May 10, 2016</i>
<i>May 1 – 31, 2016</i>	<i>June 10, 2016</i>
<i>June 1 – 30, 2016</i>	<i>July 10, 2016</i>
<i>July 1 – 31, 2016</i>	<i>August 10, 2016</i>
<i>August 1 – 31, 2016</i>	<i>September 10, 2016</i>
<i>September 1 – 30, 2016</i>	<i>October 10, 2016</i>
<i>October 1 – 31, 2016</i>	<i>November 10, 2016</i>
<i>November 1 – 30, 2016</i>	<i>December 10, 2016</i>
<i>December 1 – 31, 2016</i>	<i>January 10, 2017</i>

Subrecipient Quarterly Reimbursement Expenditure Reports **must** be completed and submitted via GMIS by the following dates: **(please see example below)**

<i>Period</i>	<i>Report Due Date</i>
<i>Sep. 1, 2015 – Nov. 30, 2015</i>	<i>Dec. 15, 2015</i>
<i>Dec. 1, 2015 – Feb. 28, 2016</i>	<i>March 15, 2016</i>
<i>March 1, 2016 – May 31, 2016</i>	<i>June 15, 2016</i>
<i>June 1, 2016 – Aug. 31, 2016</i>	<i>Sep. 15, 2016</i>

*Note: Obligations not reported on the final monthly or 4<sup>th</sup> quarter expenditure report will not be considered for payment with the final expenditure report.*

3. **Final Expenditure Reports:** A Subrecipient 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 Oct. 5, 2017. The information contained in this report must reflect the program's accounting records and supportive documentation. Any cash balances must be returned with the Subrecipient Final Expense Report. The Subrecipient Final Expense Report serves as an invoice to return unused funds.

***Submission of the Monthly/Quarterly and Final Subrecipient Expenditure reports via the GMIS system indicates acceptance of OGAPP. Clicking the "Approve" button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of OGAPP 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 subrecipient Final Expenditure Report. At least once every two years, inventory must be physically inspected by the Subrecipient. 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 within GMIS. This link is viewable only after the issuance of the subrecipient's first payment. The 30 day time period, in which the subrecipient must respond to special conditions will begin when the link is viewable. Subsequent payments will be withheld until satisfactory responses to the special conditions or a plan describing how those special conditions will be satisfied is submitted in GMIS.

**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;
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. Contributions to a contingency fund;
6. Entertainment;
7. Fines and penalties;
8. Membership fees -- unless related to the program and approved by ODH;
9. Interest or other financial payments (including but not limited to bank fees);
10. Contributions made by program personnel;
11. Costs to rent equipment or space owned by the funded agency;
12. Inpatient services;
13. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building;
14. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
15. Travel and meals over the current state rates (see OBM website: <http://obm.ohio.gov/MiscPages/Memos/default.aspx> for the most recent Mileage Reimbursement memo.)
16. Costs related to out-of-state travel, unless otherwise approved by ODH, and described in the budget narrative;
17. Training longer than one week in duration, unless otherwise approved by ODH;
18. Contracts for compensation with advisory board members;
19. Grant-related equipment costs greater than \$1,000, unless justified in the budget narrative and approved by ODH;
20. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants;

**Subrecipients will not receive payment from ODH grant funds used for prohibited purposes. ODH has the right to recover funds paid to Subrecipients for purposes later discovered to be prohibited.**

**Z. Client Incentives and Client Enablers:**

Client incentives are **an unallowable cost.** The following client incentives are allowed.

Client Enablers are ~~an unallowable cost.~~ The following client enablers are allowed.

Recipients of incentives must sign a statement acknowledging the receipt of the incentive and agreeing to the purpose(s) of the incentive. Subrecipients are required to maintain a log of all client incentives and enablers purchased and distributed. These files must be readily available for review during your programmatic monitoring visit.

- AA. Audit:** Subrecipients currently receiving funding from the ODH are responsible for submitting an independent audit report. Every subrecipient will fall into one of two categories which determine the type of audit documentation required.

Subrecipients that expend \$750,000 or more in federal awards per fiscal year are required to have a single audit which meets OMB's Federal Uniform Administrative Requirements. The subrecipient must submit, 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 no later than nine months after the end of the Subrecipient's fiscal year. 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's Federal Uniform Administrative Requirements.

Subrecipients that expend less than the \$750,000 threshold require a financial audit conducted in accordance with Generally Accepted Government Auditing Standards. The Subrecipient must submit a copy of the audit report, the auditor's management letter, and a corrective action plan (if applicable) within 30 days of the receipt of the auditor's report, but no later than nine months after the end of the Subrecipient's fiscal year. **The financial audit is not an allowable cost to the program.**

Once an audit is completed, a copy must be sent via e-mail to [audits@odh.ohio.gov](mailto:audits@odh.ohio.gov) or to the ODH, Grants Services Unit, (GSU) within 30 days. Reference: OGAPP and OMB's Omni Circular Federal Uniform Administrative Requirements regarding Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.

**Subrecipient 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.

## **AB. Submission of Application**

### **Formatting Requirements:**

- Properly label each item of the application packet (e.g., Budget Narrative, Program Narrative).
- Each section should use 1.5 spacing with one-inch margins.
- 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 should not exceed 15 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:

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

1. Application Information
2. Project Narrative
3. Project Contacts
4. Budget
  - Primary Reason
  - Funding
  - Justification
  - Personnel
  - Other Direct Costs
  - Equipment
  - Contracts
  - Compliance Section
  - Summary
5. Civil Rights Review Questionnaire
6. Assurances Certification
7. Federal Funding Accountability and Transparency Act (FFATA) reporting form
8. Change request in writing on agency letterhead **(Existing agency with tax identification number, name and/or address change(s).)**
9. Health Equity Module
10. Public Health Impact Statement Summary (non-health department only)
11. Statement of Support from the Local Health Districts (non-health department only)

Attachments as required by Program: |

- a. Executive Summary and Program Narrative (Appendix G)
- b. Key Personnel Form (Appendix H)
- c. Methodology Work Plan (Appendix J)
- d. Community level data (Appendix N)
- e. Letters of support should be saved together as one .pdf named "County Name\_LOS 2016"
- f. Letter indicating permission to travel out of county for meetings should be named "County Name\_Travel Letter 2016" |  
One copy of the following document(s) 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

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

## II. APPLICATION REQUIREMENTS AND FORMAT

GMIS access will be provided to an agency after it has completed the required ODH sponsored training. Agencies who have previously completed GMIS training will receive access after the Solicitation 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 OGAPP. Submission of the application signifies authorization by an agency official and constitutes electronic acknowledgment and acceptance of OGAPP 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   Y   of the Solicitation 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. (A budget justification example can be found on GMIS).
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 |July 1, 2016 to |August 31, 2017|.

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 original fully executed contracts on file. A completed "Confirmation of Contractual Agreement" (CCA) must be submitted via GMIS for each

contract once it has been signed by both parties. All contracts must be signed and dated by all parties prior to any services being rendered and must be attached to the CCA section in GMIS. The submitted CCA and attached contract must be approved by ODH before contractual expenditures are authorized. **CCAs and attached contracts cannot be submitted until the first quarter grant payment has been issued.**

Please refer to the memorandum issued by the Director on November 26, 2013 Subject: Contracts. The memorandum was posted on the GMIS Bulletin Board on November 27, 2013.

The applicant shall itemize all equipment (**minimum \$1,000, unit cost value**) to be purchased with grant funds in the Equipment Section.

**3. Indirect (Facilities and Administration): Note to Applicant- please select one of the 3 options that apply.**

Use the indirect cost rate included in the agency's Indirect Cost Rate Agreement as negotiated with and approved by the cognizant federal funder. If the applicant chooses this option, then the agreement must be submitted in GMIS as an attachment to the application

If the subrecipient has not executed a federally approved Indirect Cost Rate Agreement, the subrecipient may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely.

Base the budget solely upon direct costs.

For further information please see section B2.10 of OGAPP.

**4. Compliance Section:** 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.*

**C. Assurances Certification:** Each subrecipient must submit the Assurances (Federal and State Assurances for subrecipients) 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 subrecipient agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

**D. Project Narrative:**

**1. Executive Summary:** *Complete the Executive Summary and Program Narrative as directed in Appendix F and attach in GMIS 2.0. Appendix F, Program Narrative should be named "County\_Narrative\_2016."*

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

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(s) that will be addressed by the program. 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 health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which the evaluation will be based. Clearly identify the target population.

*Explicitly describe segments of the target population who experience a disproportionate burden for the health concern or issue; or who are at an increased risk for the problem addressed by this funding opportunity.*

*Include a description of other agencies/organizations, in your area, also addressing this problem/need.*

- 4. Methodology:** [In narrative form, identify the program goals, 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 to address these issues. Complete a program activities timeline to identify program objectives and activities and the start and completion dates for each. ]

**E. Civil Rights Review Questionnaire - EEO Survey:** The Civil Rights Review Questionnaire Survey is a part of the Application Section of GMIS. Subrecipients 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 subrecipients 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), register in SAM.gov and submit the information in the grant application. For

information about the DUNS, go to <http://fedgov.dnb.com/webform>. For information about System for Award Management (SAM) go to [www.sam.gov](http://www.sam.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. Public Health Impact:** Applicants that are not local health departments are to attach in GMIS the statement(s) of support from the local health district(s) regarding the impact of your 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 that your agency forwarded to the local health district(s).

**H. Attachment(s):** Attachments are documents which are not part of the standard GMIS application but are deemed necessary to a given grant program. All attachments must clearly identify the authorized program name and program number. All attachments submitted to GMIS must be attached in the "Project Narratives" section and 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. Attachments that are non-Internet compatible must be postmarked or received on or before the application due date. An original and the required number of copies of non-Internet compatible attachments must be mailed to the ODH, Grants Services Unit, Central Master Files address by **4:00 p.m. on or before May 2, 2016**.

*A minimum of an original and the indicated number of copies of non-Internet attachments are required. If program requires more copies, then insert the appropriate number.*

### **III. APPENDICES**

- A.** Notice of Intent to Apply For Funding
- B.** GMIS Training Form
- C.** Application Review Form
- D.** Required Year 1 Activities, follows Injury Prevention Background
- E.** Injury Prevention Grant RFP Application Guidance
- F.** Instructions for Executive Summary and Program Narrative Template
- G.** Key Personnel Form
- H.** Methodology Work Plan Instructions
- I.** Methodology Work Plan
- J.** Core Competency for Violence and Injury Prevention Professionals
- K.** Sources of Ohio-specific data
- L.** Coalition Representation ideas
- M.** Community level data
- N.** Scoring Criteria and Reviewer Sheet.
- O.** 2014 County Population Estimates for Determining Budget Ceiling

NOTICE OF INTENT TO APPLY FOR FUNDING

Ohio Department of Health
Office of Health Improvement and Wellness
Bureau of Health Promotion

ODH Program Title:

Violence and Injury Prevention Program

ALL INFORMATION REQUESTED MUST BE COMPLETED.

Reimbursement Type
Monthly OR Quarterly

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 (Check One)
County Agency Hospital Local Schools
City Agency Higher Education Not-for Profit

Applicant Agency/Organization

Applicant Agency Address

Agency Contact Person Name and Title

Telephone Number E-mail Address

Agency Head (Print Name) Agency Head (Signature)

Does your agency have at least two staff members who have been trained in and currently have access to the ODH GMIS system? YES NO

If yes, no further action is needed.

If no, at least two people from your agency are REQUIRED to complete the training before you will be able to access the ODH GMIS system and submit a grant proposal. Complete the GMIS training request form in the Request for Proposal.

The NOIAF must be accompanied by the agency's Proof of Non-Profit status (if applicable); Proof of Liability Coverage (if applicable); Request for Taxpayer Identification Number and Certification (W-9), Authorization Agreement for Direct Deposit of EFT Payments Form (EFT), (New Agency Only) Vendor Information Form. These forms are located on the Ohio Department of Administrative Services website at:

http://www.ohiosharedservices.ohio.gov/VendorsForms.aspx. You can also access these forms at the following websites:

- Request for Taxpayer Identification Number and Certification (W-9), http://www.irs.gov/pub/irs-pdf/fw9.pdf?portlet=103
Authorization Agreement for Direct Deposit of EFT Payments Form (EFT) http://media.obm.ohio.gov/oss/documents/EFT+FORM+-+REVISED+01+14+2014.pdf
Vendor Information Form http://media.obm.ohio.gov/oss/documents/New+Vendor+Information+Form\_11+15+2013.pdf

Forms are only required for NEW AGENCIES or if UPDATES are needed for current agencies. ODH will forward the forms to Ohio Shared Services. FORMS MUST BE RECEIVED BY Friday, April 1, 2016

Mail, E-mail: Sara Morman, Program Manager, 614-995-1428, sara.morman@odh.ohio.gov
Ohio Department of Health Violence and Injury Prevention Program
246 North High Street - 35 E. Chestnut, 5th Floor
Columbus, OH 43215
E-mail: Sara.Morman@odh.ohio.gov

NOTE: NOIAF's will be considered late if any of the required forms listed above are not received by NEW AGENCIES by the due date. NOIAF's considered late will not be accepted.



# OHIO DEPARTMENT OF HEALTH

246 North High Street  
Columbus, Ohio 43215

614/466-3543  
www.odh.ohio.gov

John R. Kasich/Governor

Richard Hodges/Director of Health

## GMIS 2.0 TRAINING FORM

### (Competitive Solicitations ONLY)

*It is mandatory that all new agencies to ODH have at least two people trained in order to apply of a grant. Each Training form must request training for one person. Requests will only be processed when this form has been signed by the Agency Head or Agency Financial Head. The user will receive his/her username and password via e-mail once they have completed the required GMIS Training.*

Agency Name: \_\_\_\_\_ County: \_\_\_\_\_

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.

Employee Name: (no nicknames, please) \_\_\_\_\_ Title \_\_\_\_\_

Agency Address: \_\_\_\_\_  
\_\_\_\_\_

Office Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Agency/Financial Head Signature: X \_\_\_\_\_

(\*Signature of Agency/ Financial Head) \*Required

X \_\_\_\_\_

(\*Printed Name of Agency /Financial Head) \*Required

Requests may be mailed to ODH address or e-mailed to:

**Gail Byers, Processing Team Manager**  
Office of Finance & Information Technology  
246 N. High Street, 4<sup>th</sup> fl.  
Columbus, Ohio 43215  
Phone: 614-644-5728  
[gail.byers@odh.ohio.gov](mailto:gail.byers@odh.ohio.gov)



## Injury Prevention Background

The ODH Violence and Injury Prevention Program (VIPPP) 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:

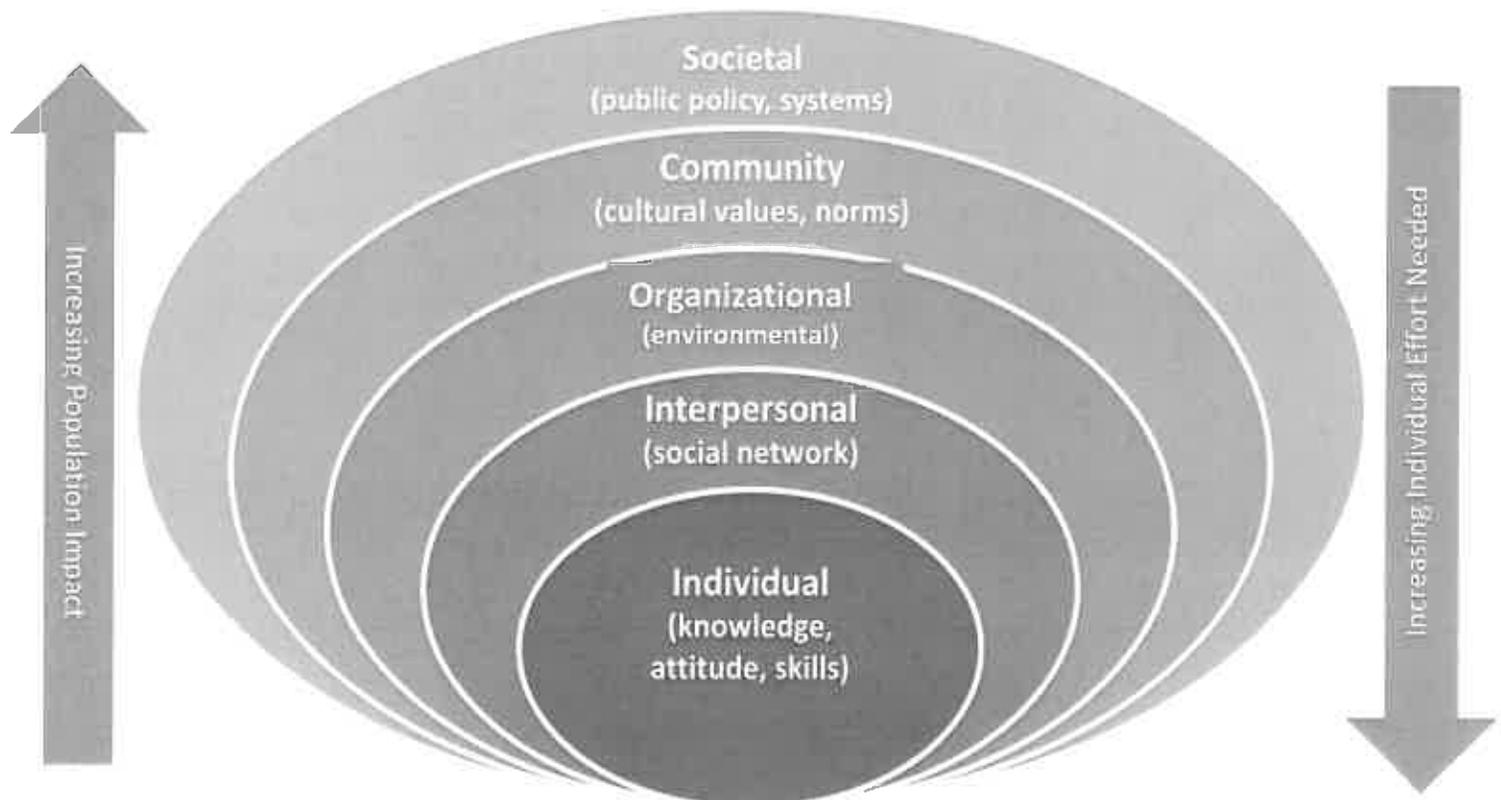
- Community assessment and injury surveillance
- Education/training relative to the risks associated with injury that will extend beyond the project period
- Enactment and enforcement of regulations and policies aimed at reducing injury risks
- Design and implementation of environmental and social systems 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 naloxone distribution site may not succeed unless the community is educated about it through the media, societal norms are changed about addiction, harm reduction, and treatment, and overdose prevention kits are provided to those in need. Additionally, law enforcement and EMS providers can be engaged to carry naloxone and refer friends and families of users to the naloxone distribution site. 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.

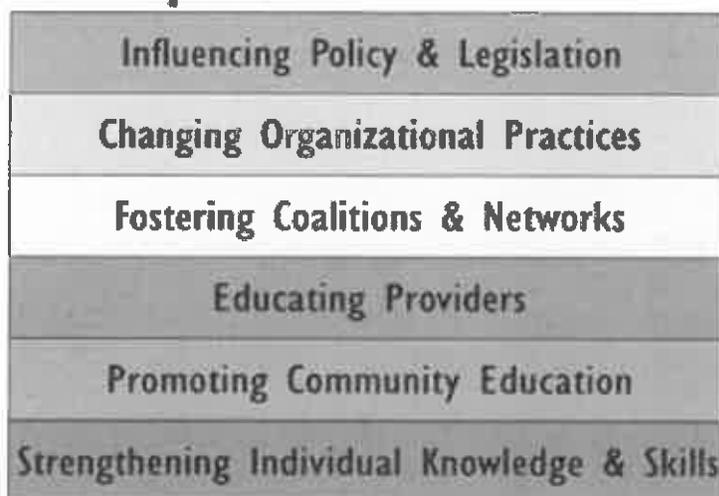
**Societal** - The last level looks at the broad societal factors that help create a climate in which unsafe behaviors or environments are encouraged or inhibited. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society and may lead to health/safety disparities. 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.

## 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.healthysagingprograms.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 August 2016, “agency” will establish an injury surveillance system to capture unintentional drug overdose occurring to in Ohio County.
- By August 2016, “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 law enforcement policy to carry naloxone or a local health system policy to require OARRS checks.

#### **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 August 2016, “Agency” will promote enactment of policy for local law enforcement agencies to carry naloxone.
- By August 2016, “Agency” will integrate training on appropriate pain management into Fairview Hospital’s continuing education requirements for all prescribers.
- By August 2016, 5 hospital EDs will adopt the Ohio Emergency and Acute Care Opioid and Other Controlled Substances Prescribing Guidelines.
- By August 2016, “Agency” will educate key school decision-makers in 5 high schools about Ohio’s naloxone distribution laws and gain commitment to implement availability of naloxone at high schools in Savelives, OH.
- By August 2016, “Agency” will educate one local health care system leadership on the need for a policy to require education of staff on how to prevent, identify, and treat opioid addiction.

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 August 2016, “Agency” will produce one set of recommendations for the development of a naloxone distribution program in ZeroODville, OH.
- By August 2016, “Agency” will increase use of OARRS in SafeDoc, OH by gaining commitment from 10 physician practices.
- By August 2016, “Agency” will increase available drug take-back programs and drop boxes within NoODs, OH.

- 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 August 2016, “Agency” will train health care providers in local health care practices on the use of OARRS.
- By August 2016, “Agency: will train health care providers on the use of appropriate prescribing practices.
- By August 2016, “Agency” will train health care providers about how to prevent, identify and treat opioid addiction.
- By August 2016, “Agency” will educate local law enforcement on the importance of carrying naloxone.

- 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 August 2016, “agency” will support implementation of a marketing campaign provided by state agencies at the local level.
- By August 2016, “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 August 2016, “agency” will create a Facebook page for XYZ coalition members to share resources and information related to prescription drug abuse/overdose.
- By August 2016, “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 August 2016, “agency” will issue a press release on annual overdose data and highlight the new pain management prescribing resources available.

## Required Year 1 Activities:

### 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 M. 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 August 31, 2017. 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 May 31, 2017.
- b. The coalition should meet at least 4 times before August 31, 2017. 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:**

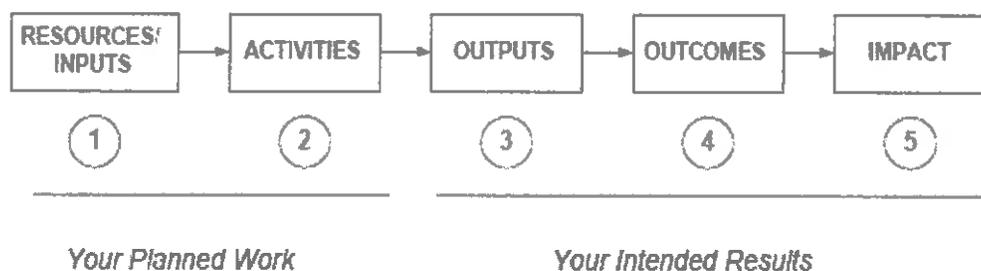
- a. Conduct an evaluation of your existing coalition during year 1 using guidance provided by ODH. Evaluation results must be provided to ODH Program Consultant by no later than August 31, 2017.
- b. Expand coalition focused on priority injury topic by at least 3 key stakeholders per year. The coalition 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. Data & Evaluation:

All funded projects must conduct evaluation and data surveillance activities in the form of establishment of baseline data for specified outcomes; a revised evaluation plan logic model; development of a community immediate response action plan; and development of a poison death review by August 31, 2017.

**Required: Revise the 3-year evaluation plan logic model that will be submitted with application and serves to monitor progress over the 3-year funding period by August 31, 2017.**

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, submit a logic model. During year 1, the logic model can be revised based on technical assistance and feedback from ODH Program Consultant.

**Required: Establish baseline data for the following outcomes:**

### Short-term –

- Percentage of those prescribing opioids and benzodiazepines in the last 90 days in Ohio that have requested a patient report within the past month
- Percentage of those prescribing opioids in the last 90 days in Ohio who have requested a patient report within the past month. (Also include delegate's requests)
- Percentage of those prescribing opioids in the last 90 days in Ohio who are registered with OARRS.

### Intermediate –

- Decrease opioid distribution in doses per capita
- Decrease benzodiazepines distribution in doses per capita
- Decrease the number of persons receiving prescriptions at or above 80 MME/day
- Decrease number of individuals exhibiting doctor shopping behavior
- Increase in hospitals implementing ED prescribing guidelines
- Increase in primary care settings implementing acute pain guidelines

For the purposes of the application, include the short and intermediate outcomes in your logic model and as part of your evaluation measures in your work plan. During year 1, ODH will provide technical assistance to counties to determine their baseline for these outcomes. Please see the Ohio Department of Health Prescription Drug Overdose Prevention Logic Model in Attachment P as

an example.

**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 2016 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:**

<http://www.pharmacy.ohio.gov/Documents/Pubs/Special/OARRS/Coroner%20Use%20of%20the%20Ohio%20Automated%20Rx%20Reporting%20System.pdf>

**Please note: Relevant information relating to a decedent's prescription history must be included as part of the coroner's report or obtained by the coroner. PDR participants may not have access to the decedent's OARRS report.**

**Develop a local immediate community response action plan** for the purpose of mobilizing immediate local efforts to respond to EpiCenter anomalies when overdose visits to emergency departments and urgent care centers increase in their community. EpiCenter is Ohio's statewide syndromic surveillance system used by state and local public health agencies to detect, track and characterize health events. The system has traditionally been used to monitor pandemic influenza, outbreaks, environmental exposures and potential bioterrorism in real-time. EpiCenter gathers de-identified information on patient symptoms and automatically alerts public health when an unusual pattern or trend is occurring. The system was recently enhanced to include the ability to identify anomalies when overdose visits increase within a county in an effort to provide local health departments with more timely information to respond to appropriately. The purpose of syndromic

surveillance is to act as a catalyst for action among local partners (i.e. first responders aware of increase in overdoses, and provided with additional naloxone; law enforcement informed of increase overdoses and provided with naloxone, etc.) and source for situational monitoring for acute illness events. For the purposes of the application, submit information on the process to develop a local immediate community response plan.

**\* Required Activities:**

- **Develop an immediate community response action plan to utilize syndromic surveillance data:** EpiCenter alerts and provides surveillance data to local jurisdictions on increases in emergency visits for drug-related admissions (overdoses, detox, withdrawals). The applicant must develop a comprehensive community response plan within the first six months of funding. The plan must address the following: 1) verification and investigation of data; 2) immediate community response after verification of data; 3) resource identification and allocation; and 4) support of key partners within the community to implement the community response immediately.
- **Provide feedback to ODH community action plans:** When ODH provides guidance to all local health departments, applicants will demonstrate their willingness and ability to offer input and feedback into the guidelines. The applicant will be willing to update their community responses plans to be reflective of ODH guidance.

**\* If the applicant is not a local health department designee with access to the EpiCenter syndromic surveillance data from ODH, the applicant must include a letter of support from the local health department entity stating their intent to work collaboratively to provide timely information from the system.**

### 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 funding from the Centers for Disease Control and Prevention. 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:

- Encourage the adoption of pain management prescribing guidelines for local health care organizations - ([opioidprescribing.ohio.gov](http://opioidprescribing.ohio.gov))
- Encourage the adoption of policy for local law enforcement to carry naloxone.
- **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 (drug lock boxes in homes) or social environment (e.g., norms about opiate use) or may result in changes in procedure (e.g., education of health care providers about screenings for opiate addiction) to improve safety. For example:
  - Assist law enforcement agencies in acquiring drug drop boxes to collect excess medications in the community.
  - Assist pharmacies 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.
  - Work with local health care organizations and health care providers to adopt the use of standardized pain management guidelines.

<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)

- Work with local health care organizations to adopt an overdose education and naloxone distribution program.
- Encourage local health care organizations and health care providers to adopt the use of OARRS.
- Provide physician training and establish a residency in pain medicine for medical school graduates.

## 2. 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 prescription drug overdose prevention education,
  - training health care providers about prescription drug abuse and the availability of prescribing guidelines;
  - training health care provider on overdose recognition, response and referral to treatment;
  - training for law enforcement on the benefits to their community on carrying naloxone;
  - training for local health care providers about the implementation of a Project DAWN site.
- **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 law is passed requiring physicians to check OARRS prior to prescribing an opiate, it is critical that the affected community is aware or the change or policy will not be effective. Alternatively, informing the community about the dangers of addiction to prescription opiates through social media is not likely to be effective in changing behavior unless there is a new policy or another effort such as a drug take back day or overdose prevention kit giveaway to recognize. 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, assist local pharmacies in understanding the need to carry naloxone; assist local health care providers in starting a naloxone education and distribution site.

### 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 APPLICATION GUIDANCE

Only one application per agency will be reviewed. Follow the guidance below.

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.

### Unintentional Prescription Drug Poisoning/Overdose

**Number of Awards:** Up to 5; number of awards will be determined by review scores and need criteria.

**Eligibility Criteria:** The intent of this funding is 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 in the 75<sup>th</sup> percentile and higher will be weighted according to the criteria described in Appendix O. The criteria includes number and rate of overdose deaths, along with indicators for prescribing behaviors. 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 (four years) to accomplish all outcome objectives, but all objectives must be included in the year 1 application.* Follow the instructions in **Appendices F., Program Narrative template and I. Methodology Work Plan** and complete carefully.

1. **Coalition Building and Coalition Evaluation:** See ODH Required Year 1 Activities for all Grantees in Appendix E.
2. **Data & Evaluation:** See ODH required Year 1 Activities for all Grantees in Appendix E.
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,
  - **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 G)** and the **Methodology Work Plan (Appendix J)**.

1. **Coalition Building Objective:** See Appendix E 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, and four times in the first year of funding 7/1/2016 – 8/31/2017. The coalition should include members that encompass the county/multi-county area for which you are applying for funding.

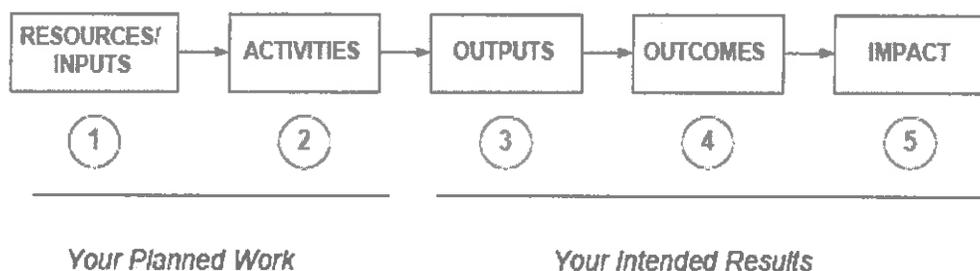
If you have an existing coalition, you must conduct an evaluation of the coalition during year 1. See Appendix E for guidance.

## 2. Data & Evaluation:

All funded projects must conduct evaluation and data surveillance activities in the form of establishment of baseline data for specified outcomes; a revised evaluation plan logic model; development of a community immediate response action plan; and development of a poison death review by August 31, 2017.

**Required: Develop and submit a 3-year evaluation plan logic model that will serve to monitor progress over the 3-year funding period by August 31, 2017.**

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 revision of the logic model submitted with application. For the purposes of the application, describe the process to be used to revise your logic model and how that will form the basis for your project's evaluation. Be sure to include how key stakeholders will be involved in the revision of the logic model.

**Required: Establish baseline data for the following outcomes:**

### Short-term –

- Percentage of those prescribing opioids and benzodiazepines in the last 90 days in Ohio that have requested a patient report within the past month
- Percentage of those prescribing opioids in the last 90 days in Ohio who have requested a patient report within the past month. (Also include delegate's requests)
- Percentage of those prescribing opioids in the last 90 days in Ohio who are registered with OARRS.

### Intermediate –

- Decrease opioid distribution in doses per capita
- Decrease benzodiazepines distribution in doses per capita
- Decrease the number of persons receiving prescriptions at or above 80 MME/day
- Decrease number of individuals exhibiting doctor shopping behavior
- Increase in hospitals implementing ED prescribing guidelines
- Increase in primary care settings implementing acute pain guidelines

For the purposes of the application, include the short and intermediate outcomes in your logic model and as part of your evaluation measures in your work plan. During year 1, ODH will provide technical assistance to counties to determine their baseline for these outcomes. The required activities beginning on page 20 must be included to demonstrate progress toward meeting the outcomes identified above.

**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 2016 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.**

<http://www.pharmacy.ohio.gov/Documents/Pubs/Special/OARRS/Coroner%20Use%20of%20the%20Ohio%20Automated%20Rx%20Reporting%20System.pdf>

**Please note: Relevant information relating to a decedent's prescription history must be included as part of the coroner's report or obtained by the coroner. PDR participants may not have access to the decedent's OARRS report.**

**Develop a local immediate community response action plan** for the purpose of mobilizing immediate local efforts to respond to EpiCenter anomalies when overdose visits to emergency departments and urgent care centers increase in their community. EpiCenter is Ohio's statewide syndromic surveillance system used by state and local public health agencies to detect, track and characterize health events. The system has traditionally been used to monitor pandemic influenza, outbreaks, environmental exposures and potential bioterrorism in real-time. EpiCenter gathers de-identified information on patient symptoms and automatically alerts public health when an unusual

pattern or trend is occurring. The system was recently enhanced to include the ability to identify anomalies when overdose visits increase within a county in an effort to provide local health departments with more timely information to respond to appropriately. The purpose of syndromic surveillance is to act as a catalyst for action among local partners (i.e. first responders aware of increase in overdoses, and provided with additional naloxone; law enforcement informed of increase overdoses and provided with naloxone, etc.) and source for situational monitoring for acute illness events. For the purposes of the application, submit information on the process to develop a local immediate community response plan, as follows:

**\* Required Activities:**

- **Develop an immediate community response action plan to utilize syndromic surveillance data:** EpiCenter alerts and provides surveillance data to local jurisdictions on increases in emergency visits for drug-related admissions (overdoses, detox, withdrawals). The applicant must develop a comprehensive community response plan within the first six months of funding. The plan must address the following: 1) verification and investigation of data; 2) immediate community response after verification of data; 3) resource identification and allocation; and 4) support of key partners within the community to implement the community response immediately.
  - **Provide feedback to ODH community action plans:** When ODH provides guidance to all local health departments, applicants will demonstrate their willingness and ability to offer input and feedback into the guidelines. The applicant will be willing to update their community responses plans to be reflective of ODH guidance.
  - **Implementation:** The applicant will discuss future implementation of the plan including support from key partners and working towards sustainability for resource identification for response.
- \* If the applicant is not a local health department designee with access to the EpiCenter syndromic surveillance data from ODH, the applicant must include a letter of support from the local health department entity stating their intent to work collaboratively to provide timely information from the system.**

**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 1 PSEC-related activity in year one. These may be 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 or personally furnish naloxone to patients who are at risk for an opioid overdose (see Project DAWN guidelines). [www.pharmacy.ohio.gov/naloxone](http://www.pharmacy.ohio.gov/naloxone)

**Examples of Environment and Systems Change Strategies:**

**Required: All 3 of the following PSEC strategies must be included:**

1. **Promote use of Ohio Automated Rx Reporting System (OARRS) among physicians and prescribers.** [www.ohiopmp.gov](http://www.ohiopmp.gov) 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, laws requiring OARRS use 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* [www.opiodprescribing.ohio.gov](http://www.opiodprescribing.ohio.gov)
  - Promote implementation of *Ohio Acute Pain Prescribing Guidelines* <http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Acute-pain-infographic.pdf>
  - Promote trigger guidelines for patients on high doses of opioids: [www.opiodprescribing.ohio.gov](http://www.opiodprescribing.ohio.gov)
  - 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). [www.pharmacy.ohio.gov/naloxone](http://www.pharmacy.ohio.gov/naloxone)
  - 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) 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, pharmacies 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/>
- Resources for Prescribing, Dispensing and Personally Furnishing Naloxone in Ohio:  
[www.pharmacy.ohio.gov](http://www.pharmacy.ohio.gov)

**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
- Promote State Medical Board policy encouraging physicians to co-prescribe or personally furnish naloxone to patients who are at risk for an opioid overdose (see Project DAWN guidelines). [www.pharmacy.ohio.gov/naloxone](http://www.pharmacy.ohio.gov/naloxone)
- Use of pain management contracts.
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Ohio laws related to prescription drug fraud.
- Ohio laws and rules on checking the Ohio Automated Rx Reporting System ([www.pharmacy.ohio.gov/oarrsprescriber](http://www.pharmacy.ohio.gov/oarrsprescriber))

**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* [www.opioidprescribing.ohio.gov](http://www.opioidprescribing.ohio.gov)
- 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

***Required attachment should be named "Insert county\_Narrative\_2016"  
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\_2016*".
- 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 G., labeled: "*Name\_Narrative\_2016*" 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 H**.
- List all personnel who will be directly involved in program activities and working on the grant on **Appendix H**. 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 K) 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 (June 15, 2016). 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 E- F to complete this section.** In addition to the Program Narrative, applicants must also provide an annual plan by completing **Appendix J. 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 F. Injury Prevention Grant RFP Application Guidance** 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 E.** 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 2016-17.
- 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 2016-17.

**2. Data and Evaluation** – Projects will be data-driven and seek to improve the collection of injury data and injury risk factor information.

- List four-year Evaluation Logic Model SMART Program Impact Objective:
- Include a four-year evaluation logic model (guidance in Appendix D) outlining how the

project will make an impact over the next four years. Upload the logical model into GMIS as part of Appendix G "Name\_Narrative\_2016" into GMIS 2.0.

- Describe the process that will be used to revise the 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.
- Describe the process that will be used to identify baseline data for the prescribed short and intermediate outcomes (assistance will be provided from ODH to identify local data; but reviewers need information on the process).
- Describe the process that will be used to develop a poison death review (PDR) committee (specific guidance will be provided by ODH in year 1, but reviewers need information on the process). Describe any experience convening data users. Include a description of how your coalition or key members of your coalition will be engaged in the PDR Process.
- Describe the process that will be used to develop a local immediate community action plan to utilize syndromic surveillance to facilitate local response to increases in drug-related admissions (overdoses, detox, withdrawals). Describe the key partnerships that will be developed to appropriately develop and implement the local immediate community action plan.
- 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 2016. Describe how these data will be used to evaluate activities at the end of the project period.
- 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 how data will be used to identify groups who are disproportionately impacted by unintentional injury.
- Describe any planned activities related to improving the quality and/or use of local fatal and non-fatal injury data.

### **3. Policy, Systems and Environmental Change (PSEC) Strategies: (See Appendices E and F 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 F)**

- 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. The logic model submitted with application will be required to be revised by the end of year 1 and additional technical assistance will be provided by ODH regarding its revision. ODH will assist funded projects with identification of baseline data for the required outcomes on page 10. Describe how the required outcomes (detailed on page 10) will be tracked. Describe how coalition will be involved in revision 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\_2016"  
and attached in GMIS 2.0 Narrative Section**

**KEY PERSONNEL FORM**

**List 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 J).

**Objectives must be written in SMART (Specific, Measurable, Achievable, Relevant, and Time-Framed) format and emphasize population-based interventions. See Appendices D, E, and F 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, Data and Evaluation, PSEC, PSEC-Supportive Strategies). An example of a long term objective is: By August 31, 2019, XYZ Organization and XYZ Community Coalition will reduce prescription drug overdose fatalities by xx% in XYZ County.
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.
  - Program impact objectives must reflect the required short and intermediate outcomes specified on page 10.
  - 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 August 31, 2017, one community-based overdose education and naloxone distribution site will be identified and procedures will be in place to begin distribution of overdose prevention kits.*

*Example: By August 31, 2017, 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 August 31, 2017, two (2) schools will implement procedures to carry and administer naloxone.*

### 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 implemented policy to incorporate OAARRS checks into their procedures; and 80 percent of their patients have been checked.*

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

**Example:** *Prescribing in county at 80MME or higher decreased by 10 % among prescribers 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 August 31, 2017, 80 percent of office staff in four family practice offices will be trained on checking OARRS, current guidelines for appropriate prescribing, and community resources for patients identified with addiction.

#### **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 OARRS and prescribing guidelines.
- f. Follow up with offices regarding use of OARRS and prescribing guidelines and any changes in practice behaviors.

**Sample 2:** By August 31, 2017, One community-based overdose education and naloxone distribution program will be identified and procedures will be in place to begin distribution of overdose prevention kits.

**Activities:**

- a. Identify community-based organization with a terminal distributors license and licensed prescriber on staff.
- b. Educate organization about the importance of naloxone distribution program.
- c. Provide technical assistance to and model materials to implement the site.
- d. Track overdose reversals and kits distributed by the site.

**Sample 3:** By August 31, 2017, the IP Program will facilitate the Availability of naloxone through local law enforcement.

**Activities:**

- a. Complete a usage observation survey to identify communities or settings with low or no naloxone use by law enforcement.
- b. Collaborate with coalition partners to identify a minimum of one settings willing to develop a naloxone use policy.
- c. Schedule meeting with organization leadership (e.g., Human Resources, Chief's Office, Sheriff's Office, and City Council, etc.) to review benefits of naloxone 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 tracking overdose reversals post intervention.

**Complete the methodology work plan (Appendix J) 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. Data and Evaluation (objective must be completed within first 6-months)
3. Policy, Systems and Environmental Change Strategies
4. PSEC Supportive Strategies
  - Training and Education
  - Media Advocacy, Campaigns, Information and Support

You have 3 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 E- F** for additional guidance on required activities.

**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 J) for each area, save all objectives in one file and name "*insert county name\_Workplan\_2016*". Attach in GMIS 2.0.**

**Required attachment should be named "Insert county\_Workplan\_2016" and attached in GMIS 2.0  
Methodology Work Plan**

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

Select Injury Focus Area:  Prescription Drug Abuse and Overdose

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

**A. Long-term Objective:** Write "SMART" impact objective(s) for your plan that address the priority focus area and target population

**Program Impact Objective:**

**Spectrum of Prevention: (Check all that apply)**

- Policy  Organizational Practices  Coalitions  Provider Education  Community Education\*  Individual Knowledge & Skills\*

Please note that those strategies focusing on individual knowledge & 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.

**Impact Evaluation Indicator(s):**

*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			




**Population-based Strategy #2: Data and Evaluation**

**A. Long-term Objective:** Write "SMART" impact objective(s) for your plan that address the priority focus area and target population

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**Program Impact Objective:**

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**Impact Evaluation Indicator(s):**

*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			


**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

<p><b>Long-term Objective:</b> Write “SMART” impact objective(s) for your plan that address the priority focus area and target population for</p>
<p><b>Program Impact Objective:</b></p>
<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>*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., health care system leadership) knowledge or skills in support of an organizational change.</p>
<p><b>Impact Evaluation Indicator(s):</b></p>
<p><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></p>
<p><b>Community or location of intervention (Ultimate or Intermediate):</b></p>





## 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/>

## Sources of Ohio-Specific Injury-Related Data

Appendix L

### OHIO-SPECIFIC INJURY DATA

- **Ohio Violence and Injury Prevention Program – Burden of Injury In Ohio (Selected County Injury Profiles)** <http://www.healthyohiprogram.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 Reports** - 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.childrendefensetynetwork.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>

### PRESCRIPTION DISPENSING DATA

- **Ohio Automated Rx Reporting System – County Data:** <https://www.ohiopmp.gov/Portal/County.aspx>

### 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			

Appendix M

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>			
<b>Youth Serving Organizations (specify)</b>			
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			8,782,329	77%
	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 (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 within the 75<sup>th</sup> percentile for specific drug overdose indicators. Additional points are noted below and the maximum number of points permitted from each county is in the table in Appendix O. Data used to compile the table in Appendix O is also available.

Drug Overdose Indicators	Number of Available Points
Number of Deaths due to Unintentional Drug Poisoning 2010 – 2014	2
Unintentional Drug Overdose Death Rate 2010 – 2014	2
Drug Overdose Hospital Admission Rate 2009 – 2014	1
Number of Persons Prescribed >= 80 MED (Morphine Equivalent Dose) 2014	1
Number of Opiate Doses Dispensed 2014	1
Per Capita Opiate Doses 2014	1
Enrolled in Behavioral Health 2013	1

This formula allows for extremely limited resources to be focused on areas with disparate needs.

$$\text{Average Reviewer Score} + \text{Weighted need-based Score (if applicable)} = \text{Total Applicant Score}$$

Counties in the 75<sup>th</sup> Percentile for Drug Overdose Indicators

Number of deaths <sup>1</sup> 2010-2014 (2) points	Unintentional Drug Overdose Age Adjusted Death Rate <sup>2</sup> 2010-2014 (2) points	Drug Overdose Hospital Admission Rate <sup>3</sup> 2009-2013 (1) point	Number of persons prescribed $\geq$ 80 MED <sup>4</sup> 2014 (1) point	Rate of $\geq$ 80 MED <sup>5</sup> 2014 (1) point	Number of Opiate Doses Dispensed <sup>6</sup> 2014 (1) point	Per Capita Opiate Doses <sup>7</sup> 2014 (1) point	Enrolled in Behavioral Health <sup>8</sup> 2013 (1) point
Franklin	Brown	Pickaway	Franklin	Vinton	Franklin	Jackson	Marion
Hamilton	Montgomery	Hamilton	Hamilton	Jackson	Hamilton	Vinton	Vinton
Montgomery	Butler	Jefferson	Montgomery	Gallia	Montgomery	Adams	Pike
Butler	Adams	Franklin	Summit	Hocking	Summit	Perry	Gallia
Summit	Jackson	Montgomery	Lucas	Pike	Lucas	Pike	Mercer
Lucas	Jefferson	Marion	Butler	Perry	Stark	Hocking	Jackson
Lorain	Marion	Ashtabula	Stark	Ross	Butler	Ross	Brown
Mahoning	Clinton	Lucas	Lorain	Madison	Trumbull	Gallia	Meigs
Lake	Ross	Gallia	Trumbull	Lawrence	Lorain	Jefferson	Madison
Trumbull	Clark	Butler	Mahoning	Jefferson	Mahoning	Trumbull	Monroe
Stark	Hamilton	Ross	Warren	Meigs	Lake	Muskingum	Butler
Clark	Pike	Highland	Lake	Athens	Warren	Guernsey	Pickaway
Warren	Trumbull	Summit	Delaware	Clinton	Clark	Huron	Trumbull
Greene	Ashtabula	Clinton	Licking	Guernsey	Portage	Washington	Hardin
Licking	Fayette	Clark	Fairfield	Pickaway	Licking	Highland	Fairfield
Ashtabula	Mahoning	Madison	Portage	Brown	Fairfield	Clinton	Wood
Richland	Erie	Adams	Medina	Franklin	Medina	Pickaway	Darke
Ross	Lake	Huron	Clark	Knox	Greene	Harrison	Crawford
Jefferson	Pickaway	Brown	Greene	Fairfield	Muskingum	Brown	Athens
Columbiana	Hocking	Lake	Richland	Adams	Ross	Meigs	Ross
Portage	Vinton	Jackson	Ross	Muskingum	Columbiana	Madison	Putnam

Points by County	
Maximum of 10 points	
Ross	9
Butler	8
Trumbull	8
Clark	7
Hamilton	7
Lake	7
Montgomery	7
Brown	6
Franklin	6
Jackson	6
Jefferson	6
Mahoning	6
Pickaway	6
Adams	5
Clinton	5
Fairfield	5
Lucas	5
Pike	5
Summit	5
Vinton	5
Ashtabula	4
Gallia	4
Greene	4
Licking	4
Lorain	4
Madison	4
Marion	4
Portage	4
Stark	4
Warren	4
Medina	3
Meigs	3
Muskingum	3
Richland	3
Athens	2
Columbiana	2
Delaware	2
Erie	2
Fayette	2
Guernsey	2
Highland	2
Hocking	3
Huron	2
Perry	2
Preble	1
Wood	2
Crawford	1
Darke	1
Hardin	1
Harrison	1
Knox	1
Lawrence	1
Mercer	1
Monroe	1
Putnam	1
Washington	1

<sup>1</sup>Number of Ohio residents who died due to unintentional drug poisoning (primary underlying cause of death X40-X44). Sources: Ohio Dept. of Health, Office of Vital Statistics, Analysis by Injury Prevention Program.

<sup>2</sup> Death rates per 100,000 population of Ohio residents from unintentional drug poisoning. US Census census estimates. Rate suppressed if < 10 total deaths for 20010-2014; may be unreliable.

<sup>3</sup>Drug overdose hospital admission rate per 10,000 population. Source: Ohio Hospital Association.

<sup>4</sup>Number of unique persons with greater or equal to 80 MED (Morphine Equivalent Dose). Source: Ohio Automated Rx Reporting System (OARRS).

<sup>5</sup>Number of oral solid doses dispensed (bup & combinations included). Source: OARRS.

<sup>6</sup>Weighted persons (per 1000) with greater or equal to 80 (MED). Source: OARRS.

<sup>7</sup>Per Capita Opiate Doses. Source: OARRS.

<sup>8</sup>Percent of unique persons enrolled in the behavioral health system with an opiate diagnosis in state fiscal year (SFY) 2013 (Medicaid and Non-Medicaid). Source: Ohio Mental Health and Addiction Services.

Drug Overdose Indicators by County

County	Number of deaths <sup>1</sup> 2010-2014		Unintentional Drug Overdose Death Rate <sup>2</sup> 2010-2014		Drug Overdose Hospital Admission Rate <sup>3</sup> 2009-2013		Number of persons prescribed $\geq$ 80 MED <sup>4</sup> 2014		Rate of $\geq$ 80 MED <sup>5</sup> 2014		Number of Opiate Doses Dispensed <sup>6</sup> 2014		Per Capita Opiate Doses <sup>7</sup> 2014		Enrolled in Behavioral Health <sup>8</sup> 2013	
	Number	County Rank	Rate	County Rank	Rate	County Rank	Number	County Rank	Rate	County Rank	Number	County Rank	Per Capita	County Rank	Percent	County Rank
Adams	38	43	26.80	4	31.05	17	963	63	33.73	20	3,009,113	55	105.40	3	43.90%	31
Allen	55	29	10.40	62	22.25	37	1,837	37	17.28	76	6,204,888	30	58.35	59	33.94%	52
Ashland	10	76	3.80	78	10.15	79	1,057	60	19.89	68	2,421,863	65	45.58	78	32.37%	58
Ashtabula	104	16	20.70	14	38.47	7	2,838	24	27.96	36	7,363,582	24	72.55	33	35.39%	47
Athens	44	37	13.60	45	21.04	42	2,376	29	36.69	12	4,967,428	36	76.71	24	51.32%	19
Auglaize	16	70	7.00	75	11.68	73	797	69	17.35	75	2,710,950	62	59.00	58	22.73%	76
Belmont	42	41	12.00	53	10.68	77	1,772	38	25.17	47	5,041,102	35	71.61	35	34.96%	49
Brown	76	24	34.20	1	30.50	19	1,569	43	34.99	16	3,650,373	46	81.40	19	61.90%	7
Butler	502	4	27.10	3	35.63	10	11,992	6	32.58	22	26,793,329	7	72.78	32	59.83%	11
Carroll	12	73	8.40	67	7.74	82	406	79	14.08	80	1,377,268	78	47.76	77	16.28%	81
Champaign	34	49	17.20	24	21.32	41	1,094	58	27.28	40	2,860,529	60	71.34	36	43.15%	32
Clark	155	12	22.60	10	33.35	15	3,585	18	25.92	45	10,928,191	13	79.00	23	35.17%	48
Clinton	51	32	24.40	8	34.01	14	1,520	44	36.16	13	3,577,613	47	85.10	16	31.20%	63
Columbiana	89	20	16.70	30	17.43	55	2,552	27	23.66	52	7,679,680	21	71.21	37	37.40%	44
Coshocton	15	72	8.20	69	13.13	66	871	65	23.60	53	2,429,135	64	65.83	47	14.71%	83
Crawford	28	58	13.00	48	24.18	34	1,417	48	32.36	23	3,294,613	52	75.25	30	55.88%	18
Darke	39	42	14.80	40	16.25	57	858	66	16.20	78	2,386,973	66	45.07	80	56.25%	17
Defiance	23	65	11.90	54	17.74	54	739	70	18.93	73	2,171,228	68	55.62	65	19.48%	78
Delaware	65	28	7.10	74	18.08	53	5,058	13	29.03	32	7,409,837	23	42.53	82	48.63%	22
Erie	75	25	19.60	17	25.78	29	2,227	31	28.89	33	5,892,241	31	76.44	26	32.21%	59
Fairfield	78	23	10.50	60	21.39	40	4,949	15	33.86	19	9,833,431	16	67.28	43	56.54%	15
Fayette	29	56	20.10	15	26.50	25	834	67	28.73	34	2,032,196	70	70.00	39	41.71%	33
Franklin	984	1	16.40	32	40.50	4	40,286	1	34.63	17	71,062,624	1	61.08	53	38.26%	42
Fulton	28	59	13.20	47	21.45	39	1,074	59	25.15	48	2,866,952	59	67.14	45	34.04%	51
Gallia	25	61	16.30	34	35.93	9	1,397	49	45.16	3	3,050,576	53	98.62	8	63.89%	4
Geauga	48	34	10.20	63	14.96	60	1,768	39	18.93	72	3,751,457	44	40.17	83	17.39%	80
Greene	134	14	16.40	33	24.90	32	3,204	19	19.83	69	8,435,247	18	52.21	71	38.27%	41
Guernsey	34	50	17.10	26	25.59	30	1,427	46	35.60	14	3,672,290	45	91.61	12	32.69%	56
Hamilton	879	2	21.90	11	51.17	2	22,878	2	28.51	35	46,444,795	2	57.88	61	39.80%	37
Hancock	37	44	9.80	64	12.89	67	1,351	51	18.07	74	3,380,138	51	45.20	79	28.57%	68
Hardin	24	63	15.10	37	27.10	24	718	71	22.40	59	2,085,336	69	65.05	48	57.14%	14
Harrison	10	77	12.70	49	13.19	65	348	80	21.94	62	1,296,993	79	81.76	18	24.32%	73
Henry	6	81	12.49	81	12.49	69	546	74	19.35	70	1,561,493	74	55.34	66	15.79%	82
Highland	36	47	16.60	31	34.61	12	1,354	50	31.06	25	3,786,591	41	86.87	15	39.46%	39
Hocking	27	60	18.50	20	23.52	36	1,230	55	41.87	4	2,954,104	56	100.55	6	44.90%	26
Holmes	3	84	4.81	84	4.81	84	451	76	10.65	85	992,759	83	23.43	85	0.00%	85
Huron	51	33	17.20	25	30.61	18	1,905	36	31.95	24	5,408,045	32	90.70	13	41.48%	34

Drug Overdose Indicators by County, Continued

County	Number of deaths <sup>1</sup> 2010-2014		Unintentional Drug Overdose Death Rate <sup>2</sup> 2010-2014		Drug Overdose Hospital Admission Rate <sup>3</sup> 2009-2013		Number of persons prescribed $\geq$ 80 MED <sup>4</sup> 2014		Rate of $\geq$ 80 MED <sup>5</sup> 2014		Number of Opiate Doses Dispensed <sup>6</sup> 2014		Per Capita Opiate Doses <sup>7</sup> 2014		Enrolled in Behavioral Health <sup>8</sup> 2013	
Jackson	44	38	26.70	5	29.67	21	1,504	45	45.27	2	4,077,578	39	122.73	1	63.07%	6
Jefferson	90	19	26.30	6	42.84	3	2,611	26	37.46	10	6,756,327	25	96.92	9	44.79%	27
Knox	43	39	14.10	42	18.85	50	2,066	32	33.91	18	3,951,060	40	64.86	49	44.74%	28
Lake	225	9	19.60	18	29.75	20	5,415	12	23.54	54	14,003,175	11	60.87	55	31.44%	62
Lawrence	53	30	17.10	27	1.09	85	2,390	28	38.27	9	4,248,456	38	68.03	41	17.86%	79
Licking	105	15	12.50	51	20.91	43	4,989	14	29.97	27	10,063,299	15	60.44	56	38.46%	40
Logan	24	64	10.50	61	19.00	49	1,272	52	27.74	37	3,505,080	48	76.43	27	44.00%	30
Lorain	256	7	16.90	29	28.74	22	6,397	8	21.23	64	18,375,769	9	60.98	54	29.67%	66
Lucas	386	6	17.60	23	37.57	8	12,963	5	29.34	31	31,315,324	5	70.88	38	47.87%	23
Madison	34	51	15.70	35	31.83	16	1,676	41	38.59	8	3,465,793	49	79.79	21	60.49%	9
Mahoning	232	8	19.70	16	26.29	27	5,952	10	24.92	49	18,084,322	10	75.51	29	30.09%	65
Marion	85	22	25.70	7	38.71	6	1,986	33	29.86	29	5,276,035	34	79.34	22	71.59%	1
Medina	68	27	7.80	70	17.24	56	3,981	17	23.10	55	8,957,879	17	51.98	73	29.23%	67
Meigs	18	67	15.30	36	19.35	48	887	64	37.32	11	1,931,714	72	81.27	20	60.66%	8
Mercer	17	69	8.30	68	11.37	74	449	77	11.00	84	1,578,583	73	38.68	84	63.64%	5
Miami	73	26	14.20	41	20.72	44	2,251	30	21.96	61	6,449,160	27	62.91	51	34.27%	50
Monroe	5	83	8.30	83	8.73	80	299	84	20.42	67	829,345	84	56.64	64	60.00%	10
Montgomery	832	3	31.10	2	39.79	5	14,366	3	26.84	41	40,712,465	3	76.08	28	45.50%	25
Morgan	10	78	13.40	46	12.13	71	346	81	22.98	56	1,152,300	80	76.54	25	33.33%	53
Morrow	30	55	17.10	28	18.84	51	1,022	61	29.35	30	2,222,306	67	63.81	50	35.90%	46
Muskingum	29	57	6.70	76	27.35	23	2,864	22	33.27	21	7,890,920	19	91.68	11	25.25%	72
Noble	2	85	7.70	85	12.57	68	327	83	22.33	60	776,584	85	53.03	69	44.44%	29
Ottawa	16	71	7.70	71	16.24	58	1,003	62	24.21	51	2,784,916	61	67.22	44	25.93%	70
Paulding	7	79	10.60	79	10.90	75	259	85	13.20	82	1,111,671	82	56.68	63	33.33%	54
Perry	19	66	10.60	59	25.91	28	1,421	47	39.41	6	3,760,302	43	104.28	4	45.68%	24
Pickaway	53	31	18.80	19	52.31	1	1,975	34	35.46	15	4,664,839	37	83.75	17	59.00%	12
Pike	31	54	21.80	12	19.73	46	1,138	57	39.64	5	2,927,141	57	101.96	5	67.36%	3
Portage	88	21	10.90	58	24.40	33	4,194	16	25.98	43	10,083,363	14	62.47	52	30.25%	64
Preble	37	45	17.70	22	18.73	52	1,162	56	27.49	38	3,044,886	54	72.03	34	25.33%	71
Putnam	7	80	15.10	80	6.46	83	480	75	13.91	81	1,520,587	75	44.08	81	50.00%	21
Richland	93	17	15.10	38	19.59	47	3,183	20	25.57	46	7,496,655	22	60.23	57	39.88%	36
Ross	91	18	23.50	9	35.56	11	3,040	21	38.94	7	7,803,760	20	99.97	7	51.32%	20
Sandusky	37	46	12.20	52	10.19	78	1,245	53	20.43	66	3,455,413	50	56.70	62	26.75%	69
Seneca	32	53	11.40	57	13.33	64	1,243	54	21.91	63	3,771,893	42	66.47	46	31.88%	61
Shelby	34	52	13.80	43	13.70	62	833	68	16.85	77	2,575,733	63	52.12	72	41.18%	35
Stark	215	11	11.50	56	15.65	59	8,599	7	22.89	57	27,402,601	6	72.96	31	19.57%	77
Summit	407	5	15.00	39	34.56	13	14,348	4	26.48	42	36,784,156	4	67.89	42	32.05%	60

Drug Overdose Indicators by County, Continued

Appendix O

County	Number of deaths <sup>1</sup> 2010-2014		Unintentional Drug Overdose Death Rate <sup>2</sup> 2010-2014		Drug Overdose Hospital Admission Rate <sup>3</sup> 2009-2013		Number of persons prescribed $\geq$ 80 MED <sup>4</sup> 2014		Rate of $\geq$ 80 MED <sup>5</sup> 2014		Number of Opiate Doses Dispensed <sup>6</sup> 2014		Per Capita Opiate Doses <sup>7</sup> 2014		Enrolled in Behavioral Health <sup>8</sup> 2013	
	Number	County Rank	Rate	County Rank	Rate	County Rank	Number	County Rank	Rate	County Rank	Number	County Rank	Per Capita	County Rank	Percent	County Rank
Trumbull	225	10	21.70	13	25.28	31	6,289	9	29.90	28	19,540,773	8	92.91	10	57.88%	13
Tuscarawas	45	36	9.70	65	12.28	70	1,923	35	20.77	65	6,421,604	29	69.36	40	13.13%	84
Union	25	62	9.40	66	21.50	38	1,589	42	30.38	26	2,883,422	58	55.13	67	39.59%	38
Van Wert	18	68	12.60	50	10.73	76	335	82	11.65	83	1,383,077	77	48.12	76	33.33%	55
Vinton	12	74	18.00	21	26.48	26	613	72	45.63	1	1,515,922	76	112.83	2	68.49%	2
Warren	150	13	13.80	44	23.94	35	5,517	11	25.94	44	11,270,596	12	52.99	70	38.00%	43
Washington	36	48	11.70	55	14.28	61	1,691	40	27.37	39	5,367,804	33	86.89	14	22.82%	75
Wayne	43	40	7.50	72	20.44	45	2,779	25	24.27	50	6,658,304	26	58.14	60	36.36%	45
Williams	12	75	6.40	77	11.74	72	600	73	15.94	79	2,006,824	71	53.31	68	23.38%	74
Wood	46	35	7.20	73	13.60	63	2,857	23	22.77	58	6,427,886	28	51.22	74	56.52%	16
Wyandot	6	82		82	8.68	81	430	78	19.01	71	1,138,381	81	50.34	75	32.43%	57

<sup>1</sup>Number of Ohio residents who died due to unintentional drug poisoning (primary underlying cause of death X40-X44). Sources: Ohio Dept. of Health, Office of Vital Statistics, Analysis by Injury Prevention Program.

<sup>2</sup>Death rates per 100,000 population of Ohio residents from unintentional drug poisoning. US Census population estimates. Rate suppressed if < 10 total deaths for 2010-2014; may be unreliable.

<sup>3</sup>Drug overdose hospital admission rate per 10,000 population. Source: Ohio Hospital Association.

<sup>4</sup>Number of unique persons with greater or equal to 80 MED (Morphine Equivalent Dose). Source: Ohio Automated Rx Reporting System (OARRS).

<sup>5</sup>Number of oral solid doses dispensed (bup & combinations included). Source: OARRS.

<sup>6</sup>Weighted persons (per 1000) with greater or equal to 80 (MED). Source: OARRS.

<sup>7</sup>Per Capita Opiate Doses. Source: OARRS.

<sup>8</sup>Percent of unique persons enrolled in the behavioral health system with an opiate diagnosis in state fiscal year (SFY) 2013 (Medicaid and Non-Medicaid). Source: Ohio Mental Health and Addiction Services.

**2016 Reviewer Score Sheet**  
**Ohio Department of Health, Division of Prevention and Health Promotion, Bureau of Healthy Ohio**  
**Injury Prevention Program Grants**

<b>Applicant Agency</b> _____	<b>County(s) to Be Served</b> _____		
<b>Applicant Number</b> _____	<b>Requested Budget \$</b> _____		
<b>Reviewer Name</b> _____	<b>Date</b> _____		
<b>Grant Focus Area(s):</b> <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>	_____	
	Minimum score 120 (67%)		
<b>Funding Recommendation:</b>	Y N		
<b>Technical Assistance or Training Needs (Suggestions for this grantee to strengthen the application)</b>			

Recommended Special Conditions (Reviewer note: please complete last.)	Comments		
<p><b>Reviewer Note:</b> 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.</p>			
<p><b>Review by Sections</b></p>			
Category – 1. Executive Summary (10 points)	Comments	Maximum Score	Reviewer’s Score
<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  1 point	
<p><b>Total Executive Summary</b></p>		<p><b>5 points</b></p>	

Category – Description of Applicant Agency and Documentation of Eligibility (25 points)	Comments	Maximum Score	Reviewer's Score
<ul style="list-style-type: none"> <li><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</li> <li><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.</li> <li><input type="checkbox"/> Lists all personnel working on the grant on the Key Personnel Form (Appendix H). 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</li> <li><input type="checkbox"/> Includes position description and resumes</li> <li><input type="checkbox"/> Provides documentation and demonstrates compliance that an individual is 100% dedicated to injury prevention (See Appendix H)</li> <li><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</li> <li><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 K).</li> <li><input type="checkbox"/> Includes background information about contract agency or individuals and all work to be conducted, if applicable</li> </ul>		<p>3 points</p> <p>3 points</p> <p>4 points</p> <p>3 points</p> <p><b>Required</b></p> <p>4 points</p> <p>5 points</p> <p>No Score</p>	<p></p> <p></p> <p></p> <p></p> <p><b>Y N N/A</b></p> <p></p> <p></p> <p><b>Y N N/A</b></p>
	<p>Applicants that do not provide this assurance are not eligible for this funding.</p>		

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>Y N N/A</p> <p>Y N N/A</p>
<b>Total Applicant Agency</b>			
<p><b>Category – Problem Statement/Need (25 points)</b></p> <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"/> Specifically links disparities to health equity strategies.</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>2 points</p> <p>1 point</p> <p>3 points</p> <p>5 points</p> <p>4 points</p> <p>No Score</p>	<p>Reviewer's Score</p> <p>Y N N/A</p>
<b>Total Problem Statement/Need</b>			
		<b>25 points</b>	<b>Y N N/A</b>



<p><input type="checkbox"/> Describe plans to recruit coalition members from diverse communities including racial and ethnic minority populations.</p> <p><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.</p> <p><input type="checkbox"/> Describes planned coalition activities and initiatives during 2016.</p> <p><b>Data and Evaluation</b></p> <p><input type="checkbox"/> List three-year Evaluation Logic Model SMART Program Impact Objective.</p> <p><input type="checkbox"/> Includes three -year evaluation logic model.</p> <p><input type="checkbox"/> Describe the process that will be used to revise the 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.</p> <p><input type="checkbox"/> Describe the process that will be used to develop a poison death review (PDR) committee (specific guidance will be provided by ODH in year 1, but reviewers need information on the process). Describe any experience convening data users. Include a description of how your coalition or key members of your coalition will be engaged in the PDR Process.</p> <p><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 2016. Describe how these data will be used to evaluate activities at the end of the project period.</p> <p><input type="checkbox"/> Describes process to develop immediate community response plan within the first six months. Describes roles of key partners; and components of the plan that will be included</p> <p><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.</p>	<p>10 points</p>	
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<ul style="list-style-type: none"> <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> </ul>			
<p><b>Policy, Systems and Environmental Change (PSEC) Strategies</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Describes plans to adopt new IP policy(ies), ordinances, regulations. Describes which coalition members will be engaged in this effort, what settings will be impacted and how the efforts will be evaluated.</li> <li><input type="checkbox"/> Describes what systems will be developed, enhanced, improved, changes, etc. to reduce injury risk factors.</li> <li><input type="checkbox"/> Describes methods to engage key stakeholders and decision-makers. Discusses anticipated opponents and a plan to engage them in process.</li> <li><input type="checkbox"/> Describes any previous success in PSEC strategies.</li> <li><input type="checkbox"/> Describes plans to evaluate the effectiveness of PSEC strategies.</li> <li><input type="checkbox"/> Provides evidence for strategies selected.</li> <li><input type="checkbox"/> Describes at least 3 PSEC strategies.</li> </ul>		<p>15 points</p>	
<p><b>PSEC-Supportive Strategies</b></p> <p><b>Training and Education</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Describes proposed training and education strategies. Describes which coalition members will be engaged, how disparities will be addressed, what settings will be impacted and how the efforts will be evaluated.</li> <li><input type="checkbox"/> Describes the intermediary (i.e., influential and credible persons, leaders, decision-makers, professionals, etc.) that will be targeted to achieve goals.</li> <li><input type="checkbox"/> Describes use of any health behavior strategies/theories to change knowledge, attitudes and behavior.</li> </ul> <p><b>Media Advocacy, Campaigns, Information and Support</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Describes available media outlets in community and how to use them to accomplish proposed activities.</li> <li><input type="checkbox"/> Describes planned media strategies/campaigns including the proposed</li> </ul>		<p>9 points</p>	

<p>audience. Describes which coalition members will be engaged in effort, how disparities will be addressed, what settings will be affected and how the efforts will be evaluated.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Describes how messages be tailored for proposed audience.</li> <li><input type="checkbox"/> Describes how media will be used to elevate injury as a significant public health threat among target population.</li> </ul> <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>
<p><b>Total Methodology Narrative</b></p>		<p>55 points</p>

**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 (Specific, Measurable, Achievable, Relevant, and Time-framed)</b> 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 7/1 – 8/31).</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><b>Category – 5. Methodology Work Plan – Data and Evaluation</b></p>	<p><b>Comments</b></p>	<p><b>Maximum Score</b></p>	<p><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 description of how coalition will be engaged in logic model revision process in year 1.</li> <li><input type="checkbox"/> Impact objectives are population-based and written in SMART 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 7/1 – 8/31).</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><b>Total Data and Evaluation Work Plan</b></p>		<p><b>10 points</b></p>	

<p><b>Category – 5. Methodology Work Plan – Policy, Systems and Environmental Changes (PSEC) Strategies and PSEC Supportive Strategies – 30 points</b></p>	<p><b>Comments</b></p>	<p><b>Maximum Score</b></p>	<p><b>Reviewer’s Score</b></p>
<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 7/1 – 8/31).</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>			
<p><b>Total Policy Enactment and Enforcement Work Plan</b></p>		<p><b>30 points</b></p>	

Focus Area Requirements	Comments	Maximum Score	Reviewers Score
<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 letter of support from EpiCenter County designee</li> <li><input type="checkbox"/> Includes the following 3 PSEC strategies: increase use of OARRS, increase access to naloxone, promote adoption of standardized pain management guidelines.</li> <li><input type="checkbox"/> Includes two PSEC-supportive strategies related to training of health care providers.</li> </ul>		10 points	
<p><b>Focus Area Requirements</b></p>		10 points	
<p><b>Budget Justification</b></p>	<p>Comments</p>	<p>Maximum Score</p>	<p>Reviewer's Score</p>
<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>10</p> <p>Y N</p>	

<p><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)</p> <p><input type="checkbox"/> REQUESTED EXPENDITURES ARE ALLOWABLE (Personnel, Other Direct Costs, Equipment, Contracts) – Pending GSU Final Approval</p> <p><input type="checkbox"/> ARE COSTS NECESSARY, REASONABLE AND ALLOCABLE Pending GSU Final Approval</p>		<p><b>Y N</b></p> <p><b>Y N</b></p> <p><b>Y N</b></p>	
<p><b>From program perspective, is Budget Justification reasonable and appropriate?</b></p>		<p><b>10 Points</b></p>	

<p><b>Additional Comments/Reviewer Notes</b></p>
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## 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>.

The Ohio Department of Health Prescription Drug Overdose Prevention Logic Model

Overarching Goal: Reduce the rate of drug overdose death in Ohio.

