



OHIO DEPARTMENT OF HEALTH

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Columbus, Ohio 43215

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John R. Kasich/Governor

Richard Hodges/Director of Health

MEMORANDUM

Date: October 3, 2014

To: Preventing Obesity, Diabetes, and Heart Disease and Stroke in Ohio Communities Applicants

From: Mary DiOrio, MD, MPH *M. DiOrio*
Interim Chief
Division of Prevention and Health Promotion

Subject: Notice of Availability of Funds for Preventing Obesity, Diabetes, and Heart Disease and Stroke in Ohio Communities Grant – Applications for Fiscal Year 2015 – 2/1/15–9/29/18

The Ohio Department of Health (ODH), Division of Prevention and Health Promotion, Bureau of Healthy Ohio (BHO), announces the availability of grant funds to support Preventing Obesity, Diabetes, and Heart Disease and Stroke in Ohio Communities projects. The Request for Proposals (RFP) will provide you guidance in completing the online application for the FY15 competitive program period. Proposals are due by **4:00 pm Monday, November 17, 2014**, for the funding period of February 1, 2015 through September 29, 2018. Late applications will not be accepted.

Introduction/Background

ODH, Bureau of Healthy Ohio (BHO), announces the availability of Prevention and Public Health Funds (PPHF) to support the comprehensive population-based Preventing Obesity, Diabetes, and Heart Disease and Stroke in Ohio Communities projects. The purpose of this funding is to support implementation of population-wide and priority population approaches to prevent obesity, diabetes, and heart disease and stroke and reduce health disparities in these areas among adults. There are two components to this competitive RFP – Component 1 and Component 2. Component 1 is to support environmental and system approaches to promote health, support and reinforce healthful behaviors, and build support for lifestyle improvements for the general population and particularly for those with uncontrolled high blood pressure and those at high risk for developing type 2 diabetes. Populations at high risk for type 2 diabetes include those with prediabetes or those who have a sufficient number of risk factors on evidence-based risk tests that put them in a high risk category. Component 2 will support health system interventions and community-clinical linkages that focus on the general population and priority populations. Priority populations are those population subgroups with uncontrolled high blood pressure or at high risk for type 2 diabetes who experience racial/ethnic or socioeconomic disparities, including inadequate access to care, poor quality of care, or low income. Component 1 environmental strategies will be implemented in the same communities and jurisdictions as Component 2 health system and community-clinical linkage strategies, with local improvements supported by ODH's statewide efforts funded by DP14-1422. Components 1 and 2 both focus on the adult population. The strategies in both components should be mutually reinforcing.

Eligible Applicants are:

County subawards: Up to four subawards will be funded to individual counties with a population of 100,000 or more, and (1) a combined black and Hispanic population of 10 percent or more, and/or (2) a poverty level of 18 percent or more (10 percent higher than the state rate). Using these criteria, 14 of Ohio's 88 counties, with a combined population of more than six million, would be eligible to apply in this category.

The following counties are eligible to apply: Allen, Butler, Clark, Cuyahoga, Franklin, Greene, Hamilton, Lorain, Lucas, Mahoning, Montgomery, Richland, Summit and Trumbull.

Multiple-county subawards: One subaward will be funded to a group of 2-3 contiguous counties in Appalachian Ohio with a combined population of 100,000 or more, one county of which must have a poverty level of 18 percent or more.

Based on this poverty criterion, the following 14 Appalachian counties are eligible to apply as the lead for multiple-county subgrants: Adams, Ashtabula, Athens, Gallia, Guernsey, Harrison, Jackson, Meigs, Morgan, Pike, Perry, Ross, Scioto, and Vinton. These counties may only partner with other Appalachian counties.

Notice of Intent to Apply for Funding

All interested parties must submit a Notice of Intent to Apply for Funding (NOIAF) form (attached to this RFP, page 17), no later than **4:00 pm October 15, 2014**, to be eligible to apply for funding.

Once the NOIAF form is received by ODH, the Grants Administration Unit (GAU) will:

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

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

Submit your NOIAF form to Michele Shough via e-mail at michele.shough@odh.ohio.gov by **October 15, 2014**.

Bidders Conference

A Bidders Conference is scheduled for **Friday, October 10, 2014**, from **1-3 pm**, via webinar. If you have questions or need assistance in completing this grant application, every effort should be made to participate in the webinar. There are a maximum of 50 lines for the webinar, so if multiple staff from your agency want to participate, please convene in one location so you only use one line.

<https://odh-ohio.webex.com/odh-ohio/j.php?MTID=m24e6fcd7b741ca15c4eca1b808f2ae24>

Call-in Number: 1-800-510-7500

Participant Code: 379452#

To mute your phone: *1

Please **RSVP** to Michele Shough at michele.shough@odh.ohio.gov by **Wednesday, October 8** if you will be attending the Bidders Conference webinar. Also submit any RFP questions to Michele by this date. Responses to questions received will be discussed at the Bidders Conference and posted on the GMIS Bulletin Board by Friday, October 17.

Important Dates to Remember:

GMIS 2.0 Training Request: As soon as possible

RSVP and Questions Submitted for Bidders Conference: Wednesday, October 8, 2014

Bidders Conference: Friday, October 10, 2014 1-3pm

Notice of Intent to Apply for Funding Due: 4:00 pm, October 15, 2014

Application Due: 4:00pm Monday, November 17, 2014



ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

DIVISION OF

Prevention and Health Promotion

BUREAU OF

Healthy Ohio

Preventing Obesity, Diabetes, and Heart Disease and Stroke in Ohio Communities (Local 1422)

REQUEST FOR PROPOSALS (RFP)

FOR

FISCAL YEAR 2015

(2/01/2015 – 09/29/2015)

Local Public Applicant Agencies
Non-Profit Applicants

COMPETITIVE GRANT APPLICATION INFORMATION

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I. APPLICATION SUMMARY and GUIDANCE

An application for an Ohio Department of Health (ODH) grant consists of a number of required components—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 RFP sections D, G and Q, the entire application will not be considered for review.**

This is a competitive Request for Proposal (RFP); A Notice of Intent to Apply for Funding (NOIAF) must be submitted by October 15, 2014 so access to the application via the Internet website “ODH Application Gateway” can be established. 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), and Authorization Agreement for Direct Deposit of EFT Payments Form (EFT).

The above mentioned forms can be 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

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 subgrantee applications. The OGAPP manual is available on the ODH website:

<http://www.odh.ohio.gov>.

(Click on Our Programs, Funding Opportunities, ODH Funding Opportunities, ODH Grants) or copy and paste the following link into your web browser:

<http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/funding%20opportunities/OGAPP%20Manual%20V100-1%20Rev%205-1-2014.ashx>

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

- B. Application Name:** Preventing Obesity, Diabetes, and Heart Disease and Stroke in Ohio Communities (Local 1422)

- C. Purpose:** The purpose of the funding is to support implementation of population-wide and priority population approaches to prevent obesity, diabetes, and heart disease and stroke and reduce health disparities in these areas among adults. There are two components to this competitive request for proposal (RFP) – Component 1 and Component 2. Component 1 is to support environmental and system approaches to promote health, support and reinforce

healthful behaviors, and build support for lifestyle improvements for the general population and particularly for those with uncontrolled high blood pressure and those at high risk for developing type 2 diabetes. Populations at high risk for type 2 diabetes include those with prediabetes or those who have a sufficient number of risk factors such as family history, obesity, low SES, minority population, poor diet, sedentary lifestyle, etc. Component 2 will support health system interventions and community-clinical linkages that focus on the general population and priority populations. Priority populations are those population subgroups with uncontrolled high blood pressure or at high risk for type 2 diabetes who experience racial/ethnic or socioeconomic disparities, including inadequate access to care, poor quality of care, or low income. Component 1 environmental strategies will be implemented in the same communities and jurisdictions as Component 2 health system and community-clinical linkage strategies, with local improvements supported by ODH statewide efforts funded by DP14-1422. Components 1 and 2 both focus on the adult population. The strategies in both components should be mutually reinforcing. Communities served by this funding must have significant disease burden and sufficient combined populations to allow the strategies supported by this RFP to reach significant numbers of people. Applicants must address both components and all strategies listed in the Work Plan template, Attachment 2, pages 51-67. |

D. Qualified Applicants: |

All applicants must be a local public health department and/or non-profit agency partnering with the local public health department. Non-profit agency applicants must demonstrate that all local health departments in the project area are aware of the proposed project by submitting a letter of acknowledgement with the application. Strong letters of commitment must be attached if a potential high need community IS NOT under the jurisdiction of the applicant agency. All applications in each category are competitive. No applicant is guaranteed funding. **Only one application per county will be funded.**

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 EFT.

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 is not certified to the Attorney General's (AG's) office.
3. Applicant has submitted application and all required attachments by **4:00 pm on Monday, November 17, 2014.** |

E. Service Area:

County subawards: Up to four subawards will be funded to individual counties with a population of 100,000 or more, and (1) a combined black and Hispanic population of 10 percent or more, and/or (2) a poverty level of 18 percent or more (10 percent higher than the state rate). Using these criteria, 14 of Ohio's 88 counties, with a combined population of more than six million, would be eligible to apply in this category.

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See Appendix E for data references.

F. Number of Grants and Funds Available: ODH anticipates having approximately \$2,000,000 for local grant awards and funding up to 5 local awards for this funding period. Funding supporting the subgrant program is from the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, 2014 Prevention and Public Health Fund, State and Local Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke, Funding Opportunity Announcement number DP14-1422.

Applicants may apply for a maximum of \$400,000.

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

Activities within this grant are based on current guidance from CDC. Work Plans may be adjusted accordingly in the future to reflect CDC requirements.

This RFP supports implementation of population-wide and priority population approaches to prevent obesity, diabetes, and heart disease and stroke and reduce health disparities in local areas among adults on the local level. To view information regarding the State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke – financed solely by Prevention and Public Health Funds - CDC-RFA-DP14-1422PPHF14, including the FOA click on the link below:

<http://www.cdc.gov/chronicdisease/about/statelocalpubhealthactions-prevCD/> |

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. Please refer to the GMIS bulletin board for current allotment percentage.

G. Due Date: All parts of the application, including any required attachments, must be completed and received by ODH electronically via GMIS by **4:00 pm on Monday, November 17, 2014**. Applications and required attachments received after this deadline will

not be considered for review.

Contact Michele Shough; 614-644-7864; michele.shough@odh.ohio.gov with any questions. |

H. Authorization: Authorization of funds for this purpose is contained in Amended Substitute *Catalog of Federal Domestic Assistance (CFDA) Number* 93.757. |

I. Goals: | Short-term outcomes include: increased community environments that promote and reinforce healthful behaviors and practices related to obesity, diabetes prevention, and cardiovascular health, including key settings that support physical activity and healthful foods and beverages; increased use and reach of strategies to build support for lifestyle change; improved quality, effective delivery and use of clinical and other preventive services to increase management of hypertension (HTN) and prevention of type 2 diabetes; and increased community clinical linkages to support self-management and control of HTN and prevention of type 2 diabetes. Intermediate-outcomes include: increased consumption of nutritious food and beverages and increased physical activity; increased engagement in lifestyle change programs; improved medication adherence for adults with high blood pressure; increased self-monitoring of high blood pressure tied to clinical support; and increased referrals to and enrollments in lifestyle change programs. Long-term outcomes, CDC monitored, include: reducing death and disability due to diabetes, heart disease and stroke by 3% in the implementation area, and reducing the prevalence of obesity by 3% in the implementation area. |

J. Program Period and Budget Period: The program period will begin February 1, 2015 and end on September 29, 2018. | The budget period for this application is February 1, 2015 through September 29, 2015.

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 1.3: Analyze Public Health Data to Identify Trends in Health Problems, Environmental Public Health Hazards, and Social and Economic Factors That Affect the Public's Health

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 7.1: Assess Health Care Capacity and Access to Health Care Services

Standard 7.2: Identify and Implement Strategies to Improve Access to Health Care Services

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 PHAB Standard(s) to be addressed by grant activities:
 - A description of the demographic characteristics (e.g., age, race, gender, ethnicity, socioeconomic 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.

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. Appropriation Contingency:** Any award made through this program is contingent upon the availability of funds for this purpose. **The subgrantee agency must be prepared to support the costs of operating the program in the event of a delay in grant payments.**
- O. Programmatic, Technical Assistance and Authorization for Internet Submission:** Initial authorization for Internet submission, for new agencies, will be granted after participation in

the GMIS training session. All other agencies will receive their authorization after the posting of the RFP to the ODH website and the receipt of the NOIAF. Please contact [Michele Shough; 614-644-7864; Michele.shough@odh.ohio.gov]

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

- P. Acknowledgment:** An Application Submitted status will appear in GMIS that acknowledges ODH system receipt of the application submission.
- Q. Late Applications:** 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 **4:00 pm Monday, November 17, 2014.**]

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

- R. Successful Applicants:** Successful applicants will receive official notification in the form of a Notice of Award (NOA). The NOA, issued under the signature of the Director of Health, allows for expenditure of grant funds.
- S. Unsuccessful Applicants:** Within 30 days after a decision to disapprove or not fund a grant application, written notification, issued under the signature of the Director of Health, or his designee, shall be sent to the unsuccessful applicants.
- T. Review Criteria:** All proposals will be judged on the quality, clarity and completeness of the application. Applications will be judged according to the extent to which the proposal:
1. Contributes to the advancement and/or improvement of the health of Ohioans;
 2. Is responsive to policy concerns and program objectives of the initiative/program/activity for which grant dollars are being made available;
 3. Is well executed and is capable of attaining program objectives;
 4. Describe Specific, 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 RFP;
 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 RFP.
13. Provide letters of support from at least four (4) partners; two (2) that are key to implementing strategies in Component 1, and two (2) that are key to implementing strategies in Component 2.)
14. Provide a letter of support from the Creating Healthy Communities Program, if applicable.

[See Appendix C for further details of scoring.]

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

U. Freedom of Information Act: The Freedom of Information Act (5 U.S.C.552) and the associated Public Information Regulations require the release of certain information regarding grants requested by any member of the public. The intended use of the information will not be a criterion for release. Grant applications and grant-related reports are generally available for inspection and copying except that information considered being an unwarranted invasion of personal privacy will not be disclosed. For guidance regarding specific funding sources, refer to: 45 CFR Part 5 for funds from the U.S. Department of Health and Human Service; 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. | |

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

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

“This work is funded either in whole or in part by a grant awarded by the Ohio Department of Health, Bureau of Healthy Ohio, Preventing Obesity, Diabetes, and Heart Disease, and Stroke in Ohio Communities and as a sub-award of a grant issued by Ohio Department of Health under the Prevention and Public Health Fund, and CFDA number [93.757].”

W. Reporting Requirements: Successful applicants are required to submit subgrantee 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 RFP 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:** Subgrantees Program Reports must be completed and submitted via GMIS as required by the subgrant program by the following dates: |

April 15, 2015: February 1, 2015–March 30, 2015

July 15, 2015: April 1, 2015–June 30, 2015

October 15, 2015: July 1, 2015–September 29, 2015 |

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

Submission of Subgrantee Program Reports via the ODH's (GMIS) indicates acceptance of the OGAPP.

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

April 15, 2015: February 1, 2015–March 30, 2015

July 15, 2015: April 1, 2015–June 30, 2015

October 15, 2015: July 1, 2015–September 29, 2015 |

Note: Obligations not reported on the 4th quarter expenditure report will not be considered for payment with the final expenditure report.

- 2. Final Expenditure Reports:** A Subgrantee Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS by 4:00 p.m.** on or before November 15, 2015. The information contained in this report must reflect the program's accounting records and supportive documentation. Any cash balances must be returned with the Subgrantee Final Expense Report. The Subgrantee Final Expense Report serves as an invoice to return unused funds.

Submission of the Periodic and Final Subgrantee Expenditure reports via the GMIS indicates acceptance of OGAPP. Clicking the "Approve" button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations.

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

- X. Special Condition(s):** Responses to all special conditions **must be submitted via GMIS within 30 days of receipt of the first quarter payment.** A Special Conditions link is available for viewing and responding to special conditions within GMIS. This link is viewable only after the issuance of the subgrantee's first payment. The 30 day time period,

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

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

Z. Client Incentives and Client Enablers:

Client incentives are *[an unallowable cost.]*
Client Enablers are *[an unallowable cost.]*

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

Subgrantees that expend \$500,000 or more in federal awards per fiscal year are required to have a single audit which meets OMB Circular A-133 requirements, a copy of the auditor's management letter, a corrective action plan (if applicable) and a data collection form (for single audits) within 30 days of the receipt of the auditor's report, but no later than nine months after the end of the subgrantee'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 Circular A-133.

Subgrantees that expend less than the \$500,000 threshold require a financial audit conducted in accordance with Generally Accepted Government Auditing Standards. The subgrantee 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 subgrantee's fiscal year. **The financial audit is not an allowable cost to the program.**

Once an audit is completed, a copy must be sent forward via e-mail to audits@odh.ohio.gov or to the ODH, Grants Services Unit, Central Master Files address within 30 days. Reference: OGAPP, OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.

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

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

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 35 pages (**excludes** appendices, attachments, budget and budget narrative).
- Use a 12 point font.
- Forms must be completed and submitted in the format provided by ODH.

The GMIS application submission must consist of the following:

Complete & Submit Via Internet

1. Application Information
2. Program 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
 11. Statement of Support from the Local Health Districts
 12. Attachments as required by Program (Personnel/Position, Work Plan, CV's/Resumes, Letters of Support) |

One copy of the following document(s) must be e-mailed to 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, 4th 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 RFP is posted to the ODH website.

All applications must be submitted via GMIS. Submission of all parts of the grant application via ODH's GMIS 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 10 of the RFP for unallowable costs.

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

Budgets need to reflect the following percentages:

Component 1: 50% of total award:

- 30% for Strategy 1 – Food and beverage guidelines including sodium standards.
- 70% for Strategies 2 through 7 – Activities related to building lifestyle change/implementing environmental strategies related to physical activity and healthier food access and sales

Component 2: 50% of total award:

- 70% for Strategies 1 through 5 – Activities related to improving hypertension control and eliminating healthcare disparities; health systems interventions to promote meaningful use of electronic health records, increased use of non-physician team members in hypertension management, and increased identification of undiagnosed hypertension and prediabetes.
- 30% for Strategy 6 through 8 – Increased engagement of community health workers to link community resources with clinical systems for adults with high blood pressure, prediabetes, or at high risk for type 2 diabetes.

- 1. Primary Reason and Justification Pages:** Provide a detailed budget justification narrative that describes how the categorical costs are derived. Discuss the necessity, reasonableness, and allocability of the proposed costs. Describe the specific functions of the personnel, consultants and collaborators. Explain and justify equipment, travel, (including any plans for out-of-state travel), supplies and training costs. If you have joint costs refer to OGAPP and the Compliance Section of the application for additional information.
- 2. Personnel, Other Direct Costs, Equipment and Contracts:** Submit a budget with these sections and form(s) completed as necessary to support costs for the period February 1, 2015 to September 29, 2015.

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.

Each funded agency is required to employ a minimum of (2) FTEs: One (1) full-time staff whose sole duties are to administer the Preventing Obesity, Diabetes, and Heart Disease and Stroke in Ohio Communities (Local 1422) Grant. In addition, the equivalent of one (1) FTE staff that has the skills and training to administer strategies in the grant is necessary.

Each funded agency needs to budget for 2 program meetings a year in Columbus.

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. 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 subgrantee must submit the Assurances (Federal and State Assurances for Subgrantees) form within GMIS. This form is submitted as a part of each application via GMIS. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive and any omission of other statutes does not mean such statutes are not assimilated under this certification. Review the form and then press the “Complete” button. By submission of an application, the subgrantee agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

D. Program Narrative: [limit of 35 pages]

Executive Summary:

Applicants are required to submit a one-page summary of the proposed program including purpose and outcomes. This summary should be suitable for public dissemination.

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.

- **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.

Address the Health Equity Component found on page 5-6 of the RFP here:

- **Methodology:**
 - Describes the capacity to carry out the required strategies, including coordination with other federally and privately funded programs within the area in order to minimize duplication, leverage resources, address health equity, and maximize reach and impact (e.g., Creating Healthy Communities, REACH, PICH, etc.).
 - Demonstrates the general readiness to work on strategies, as evidenced by:
 - Established partnerships with groups/organizations relevant to the strategy selected.
 - Prior experience working and providing technical assistance on and demonstrating outcomes for priority populations at the highest level possible for the RFP strategies.
 - Ability to conduct program evaluation and monitor performance, including ability to collect and use population-level data to demonstrate impact on priority populations.
 - Committed leadership within the agency for program planning and development including the identification, hiring, or reassignment and supervision of staff, contractors, and/or consultants sufficient in number and subject matter expertise to plan and implement strategies across the components.
 - Demonstrates readiness to work on component-specific strategies, as evidenced by:
 - Component 1
 - Demonstrated experience in policy/environmental change.
 - Demonstrated experience in building support for lifestyle change for those at high risk for diabetes.
 - Established partnerships with key stakeholders for nutrition and physical activity, policy/environmental change initiatives (e.g., state/large city department of transportation, employers, retailers, food banks, parks and recreation departments, transportation and community planning agencies).

- Established partnerships with key stakeholders for building support for lifestyle change (e.g., employers, insurers, state Medicaid agencies, health systems, representatives of CDC recognized lifestyle change programs, etc.).
 - Component 2
 - Access to health systems data, including, for example, payer data, aggregate EHR data from healthcare providers/clinics, and health plan performance data.
 - Demonstrated experience in recruiting/working with community health systems to implement quality improvement processes.
 - Demonstrated experience in engaging health care extenders to promote linkages between health systems and community resources.
 - Established partnerships with key stakeholders for health system interventions to improve the quality of health care delivery to populations with the highest hypertension and prediabetes disparities.
 - Demonstrated experience in developing systems to facilitate bi-directional referral between health systems and community resources.
 - Established partnerships with key stakeholders for promoting community-clinical linkages (e.g., CHW Associations, Community Pharmacists, community organizations offering the CDC recognized lifestyle change programs).
 - Existing partnerships that are integral in accomplishing the grant's goals and objectives.
- Project Management
 - Describes core program management to execute Components 1 and 2 including the roles and responsibilities of project staff.
 - Describes who will have day-to-day responsibility for key tasks such as: leadership of the project; monitoring of the project's on-going progress; preparation of reports; program evaluation; and communication with partners and ODH.
 - Describes any contractual organization(s), consultants, and/or partner organizations that will have a significant role(s) in implementing program strategies and achieving project outcomes.
 - Describes an efficient and effective mechanism for making sub-awards to communities, jurisdictions, and other local organizations and for ensuring accountability of sub-awardees for demonstrating impact on the project period outcomes.
- Provide a brief summary of current efforts (outcomes and successes) made in the past three (3) years that demonstrate capacity to implement the strategies in this RFP.
- **Work Plan** – Using the template provided in Attachment 2, develop a Work Plan. The Work Plan does not count towards the 35 page limit.

E. Civil Rights Review Questionnaire–EEO Survey: The Civil Rights Review Questionnaire Survey is a part of the Application Section of GMIS. Subgrantees must complete the questionnaire as part of the application process. This questionnaire is submitted automatically

with each application via the Internet.

F. Federal Funding Accountability and Transparency Act (FFATA) Requirements:

FFATA was signed on September 26, 2006. FFATA requires ODH to report all subgrants receiving \$25,000 or more of federal funds. All applicants applying for ODH grant funds are required to complete the FFATA reporting form in GMIS.

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

Information on Federal Spending Transparency can be located at www.USAspending.gov or the Office of Management and Budget's website for Federal Spending Transparency at 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 November 17, 2014**.

1. Personnel/Position
2. CVs or Resumes for all personnel on grant
3. Work Plan
4. Letters of Support
 - i. Letter of Support from Creating Healthy Communities Program (if applicable)
 - ii. 4 Additional Letters of Support from local partners necessary to complete work plan strategies
 1. two (2) that are key to implementing strategies in Component 1
 2. two (2) that are key to implementing strategies in Component 2

III. APPENDICES

- A. Notice of Intent to Apply For Funding
- B. GMIS Training Form
- C. Application Review Form
- D. Logic Model
- E. Guidelines for Completing the Work Plan

- F. County Data Indicators
- G. Glossary of Terms

NOTICE OF INTENT TO APPLY FOR FUNDING

Ohio Department of Health
 Division of Prevention and Health Promotion
 Bureau of Healthy Ohio

ODH Program Title:

Preventing Obesity, Diabetes, and Heart Disease and Stroke in Ohio Communities (Local 1422)

ALL INFORMATION REQUESTED MUST BE COMPLETED.

(Please Print Clearly or Type)

County of Applicant Agency _____ Federal Tax Identification Number _____

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

Type of Applicant Agency (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? 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

Submit all required forms even if no changes to ODH. ODH will forward the forms to Ohio Shared Services.

FORMS MUST BE RECEIVED BY October 15, 2014]

Mail: Michele Shough
 Ohio Department of Health Bureau of Healthy Ohio
 246 N High St –
 Columbus, OH 43215
 E-mail: michele.shough@odh.ohio.gov

NOTE: NOIAF’s will be considered late if any of the required forms listed above are not received 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

Appendix B

GMIS TRAINING REQUEST (Competitive Cycle ONLY)

This document is to be used for GMIS during a competitive cycle only. **EACH** person requesting training must complete a form. Requests will only be honored when form is signed by your **Agency Head** or **Agency Financial Head**. Confirmation of your GMIS training session will be e-mailed once a date has been assigned by ODH.

Grant Program: _____ **RFP Due Date:** _____

Agency Name: _____

Salutation: (Dr., Mrs., etc.) _____

User's Name: (no nicknames, please) _____

User's Job Title: (e.g., Program Director) _____

Phone Number: _____

Fax Number: _____

E-mail address: _____

Agency/Financial Head Signature: _____
(*Signature of Agency/ Financial Head)

(*Printed Name of Agency /Financial Head)

TRAINING REQUEST FORMS MUST BE SUBMITTED WITH THE NOTICE OF INTENT TO APPLY FOR FUNDING FORM

Users will receive his/her username and password via e-mail once they have completed training.

Appendix C

Reviewer Number: _____

Date: _____

Application Review Form

Applicant Agency: _____ Total Requested Budget \$ _____

County(ies) to be Served: _____ Contracts: \$ _____

Scoring Instructions

Does Not Meet	Weak	Weak to Meets	Meets	Meets to Strong	Strong
0	1	2	3	4	5

DOES NOT MEET (0): Response does not comply substantially with requirements or is not provided

WEAK (1): Response was poor related to meeting the objectives

WEAK TO MEETS (2): Response indicates the objectives will not be completely met or at a level that will be below average

MEETS (3): Response generally meets the objectives (or expectations)

MEETS TO STRONG (4): Response indicates the objectives will be exceeded

STRONG (5): Response significantly exceeds objectives or expectations

***Note: Certain subcategories cannot exceed a maximum of 3 points.**

Section	Maximum Pts	Score
Executive Summary	5	
Description of Applicant Agency	21	
Problem/Need	35	
Methodology	105	
Work Plan	225	
Budget	41	
Total Points	432	

General Comments on this Application: _____

Approval of Application as Submitted _____

Approval of Application with Special Conditions: (Please List) _____

Disapproval of Application: (Statement of Rationale) _____

Category	Max	Score	Comments: Strengths, Weaknesses
<i>Executive Summary</i>			
One-page summary of the proposed program including purpose and outcomes	5		
Executive Summary Total	5		
<i>Description of Applicant Agency/ Documentation of Eligibility/Personnel</i>			
Adequately summarized the agency's structure as related to this program and how the agency will manage the program	5		
Described capacity to communicate in a manner easily understood by diverse audiences	5		
Noted personnel and/or equipment deficiencies	3		
Described plans for hiring and training	3		
Delineated all personnel who will be involved in the program activities	5		
Description of Applicant Agency Total	21		
<i>Problem/Need</i>			
Identified and clearly described local health status concerns addressed with this program	5		
State and local data discussed	5		
Clearly described segments of the target population who have the greatest burden of chronic disease	5		
Included a description of other agencies/organizations also addressing this problem/need	5		

<i>Health Equity Component</i>			
Explained the extent to which health disparities are manifested in the problem to be addressed. Included specific groups who experience disproportionate burden of disease.	5		
Explained and identified how specific social and environmental conditions (social determinants of health) put groups who are already disadvantaged at increased risk for health inequities	5		
Clearly described how program activities will address health disparities	5		
Problem/Need Total	35		
<i>Methodology</i>			
Describes the capacity to carry out the required strategies, including coordination with other federally and privately funded programs within the state in order to minimize duplication, leverage resources, address health equity, and maximize reach and impact (e.g., Creating Healthy Communities, REACH, PICH, etc.)	5		
Demonstrates the general readiness to work on strategies, as evidenced by:			
Established partnerships with groups/organizations relevant to the strategies	5		

Prior experience working and providing technical assistance on and demonstrating outcomes for priority populations at the highest level possible for the RFP strategies	5		
Ability to conduct program evaluation and monitor performance, including ability to collect and use population-level data to demonstrate impact on priority populations	5		
Committed leadership within the agency for program planning and development including the identification, hiring, or reassignment and supervision of staff, contractors, and/or consultants sufficient in number and subject matter expertise to plan and implement strategies across the components	5		
Demonstrates readiness to work on component-specific strategies, as evidenced by:			
Demonstrated experience in policy/environmental change	5		
Demonstrated experience in building support for lifestyle change for those at high risk for diabetes	5		
Established partnerships with key stakeholders for nutrition and physical activity, policy/environmental change initiatives (e.g., state/large city department of transportation, employers, retailers, food banks, parks and recreation departments, transportation and community planning agencies)	5		
Established partnerships with key	5		

stakeholders for building support for lifestyle change (e.g., employers, insurers, state Medicaid agencies, health systems, representatives of CDC recognized lifestyle change programs, etc.)			
Access to health systems data, including, for example, payer data, aggregate EHR data from healthcare providers/clinics, and health plan performance data	5		
Demonstrated experience in recruiting/working with community health systems to implement quality improvement processes	5		
Demonstrated experience in engaging health care extenders to promote linkages between health systems and community resources	5		
Established partnerships with key stakeholders for health system interventions to improve the quality of health care delivery to populations with the highest hypertension and prediabetes disparities	5		
Demonstrated experience in developing systems to facilitate bi-directional referral between health systems and community resources	5		
Established partnerships with key stakeholders for promoting community-clinical linkages (e.g., CHW Associations, Community Pharmacists, community organizations offering the CDC recognized lifestyle change programs)	5		

Existing partnerships that are integral in accomplishing the grant's goals and objectives	5		
Describes core program management to execute Components 1 and 2 including the roles and responsibilities of program staff	5		
Describes who will have day-to-day responsibility for key tasks such as: leadership of the program; monitoring of the program's on-going progress; preparation of reports; program evaluation; and communication with partners and ODH	5		
Describes any contractual organization(s), consultants, and/or partner organizations that will have a significant role(s) in implementing program strategies and achieving program outcomes	5		
Describes an efficient and effective mechanism for making sub-awards to communities, jurisdictions, and other local organizations and for ensuring accountability of sub-awardees for demonstrating impact on the program period outcomes	5		
Provides a brief summary of current efforts (outcomes and successes) made in the past three (3) years that demonstrate capacity to implement the strategies in this RFP	5		
Methodology Total	105		
Work Plan (Attachment 2)			
Component 1: Strategy 1			

Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 1: Strategy 2			
Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 1: Strategy 3			
Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 1: Strategy 4			
Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 1: Strategy 5			

Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 1: Strategy 6			
Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 1: Strategy 7			
Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 2: Strategy 1			
Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 2: Strategy 2			

Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 2: Strategy 3			
Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 2: Strategy 4			
Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 2: Strategy 5			
Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 2: Strategy 6			

Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 2: Strategy 7			
Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Component 2: Strategy 8			
Adequate number of process steps within each Activity to accomplish Program Strategy	5		
Descriptions under Activities are tailored to the selected strategy	5		
Timeline contains specific dates and is feasible	5		
Work Plan Total	225		
Budget			
Budget does not exceed maximum award	3		
Primary reason and justification is satisfactory and relates expenditures to Work Plan	5		
Clearly describes how categorical costs are	5		

derived			
Adequately discusses the reasonableness of proposed costs	5		
Clearly describes the specific functions of the personnel	5		
Adequately explains and justifies equipment, travel, supplies, and training costs	5		
Personnel, Other Direct costs, Equipment, and Contracts are identified and appropriate to program scope of work	5		
Program Coordinator is 100% time on Local 1422	3		
Budget is reasonable and adequate to meet the goals and objectives of the program	5		
Budget Total	41		
<i>Additional Requirements (For Internal Use Only)</i>			
GMIS application requirements such as Civil Rights Review, Assurances Certification, FFATA	Not scored		
Completed GMIS Health Equity Module	Not scored		

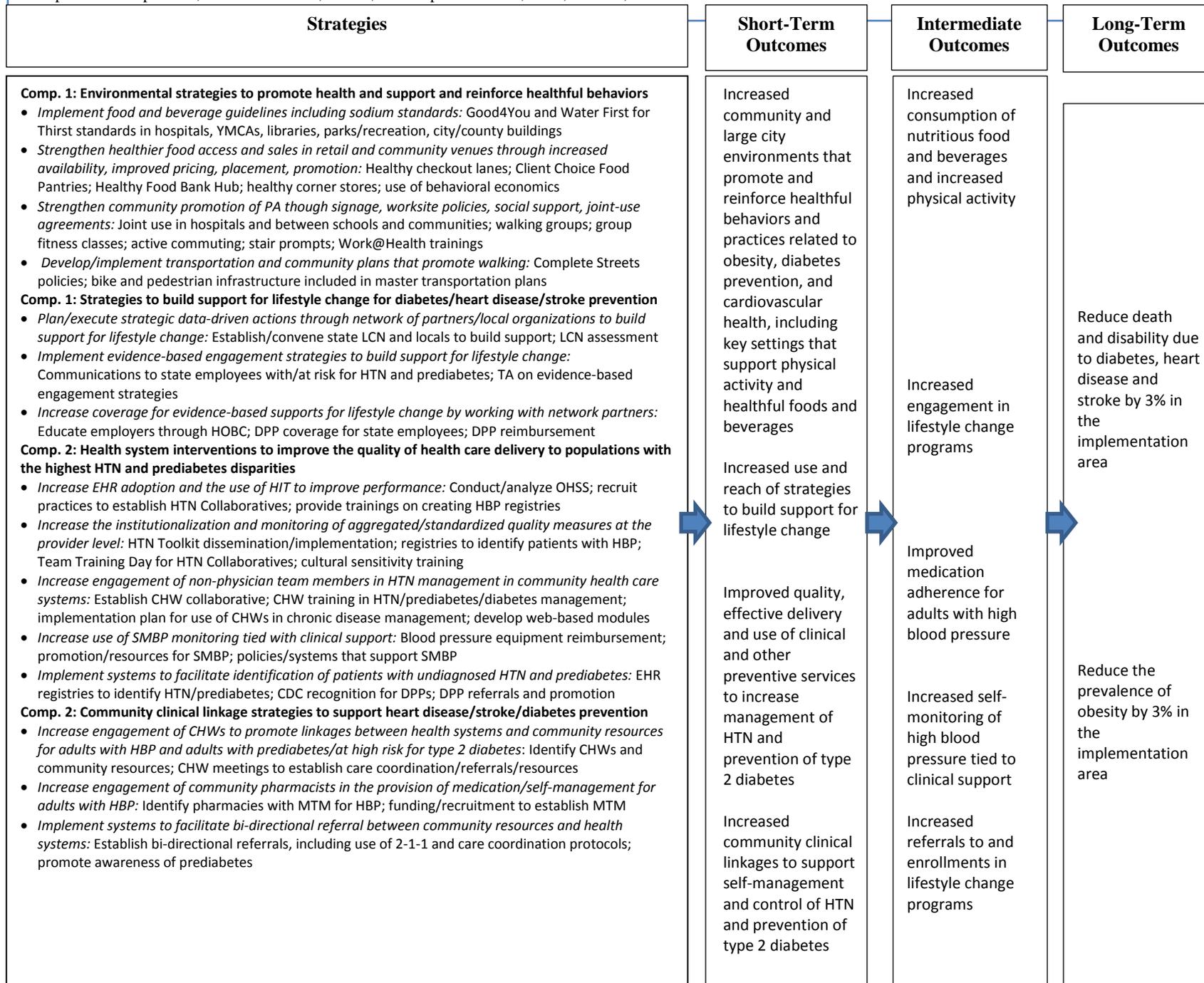
Attachments

- Personnel/Position (Attachment 1)
- Work Plan (Attachment 2)
- CV/Resumes and Job Descriptions (Attachment 3)
- Letters of Support (Attachment 4)

Yes

No

Inputs: Funding—1422, leveraged funds from 1305, PHHSBG, Million Hearts™, state GRF; **Partners**—OCDC, Medicaid, OHA, SRTS, HOBC, ODA, Ohio YMCAs, OCHWA, OAFP, OPA, OSU College of Pharmacy, Ohio QIN, DPPs; **Contracts**—1422 Evaluator, OAFP, Abt SRBI, OCHWA, Ohio Colleges of Pharmacy, Food Trust, Smart Growth America; **Guidance/Support**—DDT, DHDSP, DNPAO, ODH Leadership; **Data/Software**—SQPR, BRFS, Food Environment Index, USDA Food Atlas, Complete Streets policies, LCN assessment, OHSS, benefit provider data, OPA, Nielsen, GIS



Guidelines for Completing the Work Plan (Attachment 2)

In order to maximize impact with the CDC funding that supports this program, ODH and local projects are implementing similar Work Plans and Program Strategies, and using the same Performance Measures, Data Sources and Targets to measure progress over the four-year project period. The Program Strategies are pre-filled on this Work Plan according to CDC guidance.

Program Strategies

The Program Strategies in each Component reflect a four-year timeline. Performance Measures will be reported on a quarterly basis.

Activities

Under each Program Strategy a list of several Activities to accomplish the longer-term Strategies is included. Under each Activity applicants are required to identify specific agencies, activities, and steps needed during Year 1 to succeed. Significant progress is needed in Year 1. However, because of the shortened grant year all activities do not need to be met in Year 1.

Target

Target values provided in the Work Plan for each Program Strategy reflect the outcomes expected over the four-year project period.

Progress

Each quarter, provide in narrative or bullet form, the progress to date for each Activity. **NOTE: This section should be left blank for the initial application.**

County Data Indicators

County	Pop. Rank (2013, 1=largest)	Population (2013)	Black (2012)	Hispanic (2012)	Access to Care Rank (2014, 1=good)	Quality of Care Rank (2014, 1=good)	Below Poverty Level (2008- 2012)	Diabetes Prevalence (2010)	Hyper- tension Prevalence (2011)	Heart Disease Mortality Rate (2012)	Stroke Mortality Rate (2012)
Vinton	88	13,276	0.4%	0.7%	82	83	21.4%	10.8%		253.13	44.18
Monroe	87	14,585	0.5%	0.5%	78	73	16.3%	11.3%		259.06	35.92
Noble	86	14,628	2.7%	0.5%	86	69	14.1%	12.3%		173.95	25.34
Morgan	85	14,904	3.0%	0.7%	87	79	18.0%	12.9%		194.94	76.14
Harrison	84	15,622	2.2%	0.7%	72	86	19.4%	12.8%		205.17	28.95
Paulding	83	19,254	1.0%	4.5%	65	71	14.0%	10.1%		192.34	71.87
Wyandot	82	22,447	0.3%	2.5%	61	5	9.4%	10.9%		156.74	30.98
Meigs	81	23,496	0.9%	0.5%	85	72	21.6%	13.0%		182.83	54.57
Henry	80	28,092	0.6%	6.9%	48	6	12.5%	11.0%		205.58	42.31
Adams	79	28,105	0.4%	0.8%	83	88	23.1%	10.2%		193.89	52.43
Carroll	78	28,275	0.6%	1.0%	81	12	15.0%	11.3%		218.20	35.19
Pike	77	28,367	1.0%	0.8%	73	84	22.0%	12.8%		214.17	56.07
Van Wert	76	28,459	1.1%	2.6%	36	3	10.4%	11.7%		205.44	37.75
Hocking	75	28,665	0.8%	0.8%	67	30	16.7%	11.7%		190.55	39.72
Fayette	74	28,800	2.3%	1.9%	66	51	19.3%	11.0%		312.12	51.38
Gallia	73	30,621	2.6%	1.0%	12	39	19.0%	12.0%		205.42	42.76
Hardin	72	31,641	0.9%	1.4%	80	75	18.0%	10.3%		272.85	64.72
Jackson	71	32,783	0.7%	0.9%	68	78	24.8%	11.5%		251.73	33.11
Putnam	70	34,088	0.5%	5.7%	28	13	7.5%	9.7%		164.37	41.70
Morrow	69	35,033	0.5%	1.3%	76	76	13.8%	11.3%		169.89	38.26
Perry	68	35,997	0.4%	0.7%	77	25	18.2%	11.0%		250.47	41.10
Coshocton	67	36,760	1.1%	0.9%	84	68	17.0%	11.5%		230.36	23.23
Williams	66	37,500	1.1%	4.0%	43	70	13.7%	11.7%		175.69	33.20
Defiance	65	38,532	2.1%	9.3%	30	52	14.6%	10.7%		167.31	47.56
Champaign	64	39,455	2.3%	1.3%	56	35	14.8%	10.6%		154.19	47.08
Guernsey	63	39,636	1.5%	1.0%	51	65	18.5%	12.1%		180.57	40.84

Mercer	62	40,784	0.4%	1.6%	46	18	8.2%	11.1%		242.94	47.82
Ottawa	61	41,153	1.0%	4.6%	23	33	10.0%	11.6%		230.09	56.33
Preble	60	41,732	0.5%	0.7%	74	59	10.7%	11.2%		220.15	37.19
Clinton	59	41,945	2.3%	1.6%	21	80	15.4%	10.6%		225.95	66.14
Fulton	58	42,488	0.6%	8.0%	33	32	10.3%	12.0%		145.80	32.72
Crawford	57	42,808	0.9%	1.3%	64	50	14.7%	13.5%		171.82	38.78
Madison	56	43,277	6.5%	1.5%	45	34	11.1%	11.3%		212.61	43.76
Highland	55	43,299	1.5%	0.8%	79	77	17.6%	11.6%		182.59	43.54
Holmes	54	43,593	0.4%	0.9%	88	41	15.6%	9.5%		181.87	35.55
Brown	53	44,264	1.0%	0.7%	75	61	12.8%	12.8%		183.65	44.76
Logan	52	45,481	1.7%	1.3%	37	8	15.6%	12.7%		173.86	51.63
Auglaize	51	45,920	0.4%	1.3%	25	15	7.9%	11.9%		193.07	42.83
Shelby	50	49,192	2.0%	1.4%	40	28	11.7%	10.1%		196.36	46.04
Darke	49	52,376	0.6%	1.3%	69	26	12.0%	11.5%		188.57	35.68
Ashland	48	53,043	0.8%	1.1%	53	9	16.3%	11.1%		201.00	46.92
Union	47	53,306	2.5%	1.3%	9	16	7.3%	9.8%		139.41	54.07
Seneca	46	55,914	2.5%	4.7%	54	55	14.9%	10.0%		239.57	40.23
Pickaway	45	56,304	3.7%	1.2%	38	54	13.5%	10.2%		204.68	36.41
Huron	44	58,889	1.2%	5.9%	59	31	14.7%	11.2%		163.69	44.77
Sandusky	43	60,098	3.1%	9.2%	27	47	13.9%	11.8%		159.72	31.76
Knox	42	60,810	0.9%	1.3%	60	27	14.6%	10.7%		224.21	43.70
Washington	41	61,310	1.2%	0.9%	44	57	15.6%	11.5%		182.64	49.17
Lawrence	40	61,917	2.2%	0.8%	57	81	16.0%	12.4%		211.73	57.67
Athens	39	64,681	2.8%	1.8%	62	60	32.2%	9.7%		221.57	41.82
Marion	38	65,905	6.3%	2.3%	58	67	19.6%	11.3%		183.59	33.81
Jefferson	37	67,964	5.6%	1.2%	49	87	16.8%	16.2%		281.73	38.92
Belmont	36	69,571	4.1%	0.7%	52	82	14.6%	12.2%		273.22	36.52
Hancock	35	75,773	1.7%	4.8%	41	1	13.6%	9.9%		143.83	49.91
Erie	34	76,048	8.7%	3.6%	11	24	12.9%	10.8%		160.71	29.81
Ross	33	77,910	6.0%	1.1%	16	45	19.1%	11.2%		226.89	48.27
Scioto	32	78,153	2.7%	1.2%	55	85	23.0%	12.0%		275.68	46.93
Muskingum	31	85,231	3.9%	0.8%	31	56	17.3%	11.3%		173.98	59.49
Tuscarawas	30	92,672	0.8%	2.1%	63	64	13.6%	9.1%		180.75	34.69

Geauga	29	93,972	1.3%	1.2%	13	4	8.3%	9.8%		136.43	18.86
Ashtabula	28	99,811	3.8%	3.5%	70	66	18.0%	11.7%		202.52	36.59
Miami	27	103,439	2.1%	1.4%	34	36	12.3%	10.5%		179.14	38.87
Allen	26	105,298	12.2%	2.5%	18	63	18.8%	12.0%		198.28	43.80
Columbiana	25	105,893	2.4%	1.4%	71	58	16.1%	12.3%		207.68	45.70
Wayne	24	115,071	1.6%	1.6%	50	20	11.8%	9.9%		171.90	47.81
Richland	23	121,773	9.4%	1.5%	32	62	14.8%	10.5%		203.52	33.73
Wood	22	129,264	2.6%	4.9%	7	21	13.8%	10.6%		189.87	42.16
Clark	21	136,167	9.0%	2.9%	39	49	17.7%	12.5%		198.89	53.80
Fairfield	20	148,867	6.5%	1.9%	10	38	11.4%	10.7%	36.9%	155.30	52.81
Greene	19	163,204	7.6%	2.4%	3	43	13.4%	10.3%		178.84	30.94
Portage	18	163,862	4.4%	1.5%	42	48	15.1%	8.9%		196.88	33.60
Licking	17	168,375	3.6%	1.5%	35	2	12.4%	11.9%	37.1%	181.14	42.59
Medina	16	174,915	1.3%	1.8%	6	19	7.3%	11.1%		153.51	32.37
Delaware	15	184,979	3.5%	2.3%	1	11	4.7%	8.7%		126.53	34.86
Clermont	14	200,218	1.3%	1.6%	22	42	10.3%	9.8%		166.50	57.74
Trumbull	13	206,442	8.5%	1.5%	47	53	16.8%	11.2%	38.7%	213.50	37.56
Warren	12	219,169	3.4%	2.4%	2	7	6.4%	8.6%		167.31	40.57
Lake	11	229,857	3.6%	3.6%	29	17	9.3%	11.2%		180.51	35.48
Mahoning	10	233,869	16.0%	5.0%	17	37	17.5%	11.8%	33.0%	213.79	41.80
Lorain	9	302,827	8.8%	8.7%	24	40	14.2%	11.6%	28.7%	168.50	32.25
Butler	8	371,272	7.9%	4.2%	26	44	13.6%	10.4%	32.9%	152.33	36.53
Stark	7	375,432	7.7%	1.7%	20	10	14.5%	11.3%	36.1%	176.96	41.06
Lucas	6	436,393	19.5%	6.4%	19	74	20.5%	10.3%	32.5%	231.47	44.40
Montgomery	5	535,846	21.1%	2.5%	15	29	16.8%	12.5%	34.3%	173.56	41.14
Summit	4	541,824	14.6%	1.8%	8	46	14.8%	10.4%	30.6%	174.69	37.82
Hamilton	3	804,520	25.9%	2.7%	5	14	17.1%	10.6%	31.8%	169.19	49.89
Franklin	2	1,212,263	21.8%	5.0%	14	22	17.7%	10.0%	29.6%	174.69	44.17
Cuyahoga	1	1,263,154	30.2%	5.1%	4	23	17.7%	10.6%	32.1%	198.47	35.38

- County population estimates, 2013: Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: July 1, 2013
- Percent black and Hispanic population, 2012: Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2012
- Percent of population below 100% of the poverty level, 2008-2012: Selected Characteristics Of The Total And Native Populations In The United States, 2008-2012 American Community Survey 5-Year Estimates

Glossary of Terms

Access	Tactics that increase the availability of factors that promote desired behavior or reduce the availability of factors that allow undesirable behaviors.
Active Transportation Commute Support	A means of getting around that is powered by human energy, primarily walking and bicycling. Often called “non-motorized transportation.” Examples of commute support include: changing room or lockers with showers, bicycle parking, bicycle racks/shelters in safe, convenient, and accessible locations).
Award	Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.
Best Practices	Strategies or programs that have been shown to be effective through outcomes and/or research. Strategies found in the Guide to Community Preventive Services (Community Guide), Guide to Clinical Preventive Services , IOM’s Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation , CDC’s Common Community Measures for Obesity Prevention (COCOMO) , RJWF’s Action Strategies Toolkit , Best Practices for Comprehensive Tobacco Control Programs—2014 provide strategies that can serve as best practices for programs.
Budget Period or Budget Year:	The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.
Built Environment	Human-made (versus natural) resources and infrastructure designed to support human activity, such as buildings, roads, parks, restaurants, grocery stores and other amenities.
CDC-recognized lifestyle change program	Programs recognized by the National Diabetes Prevention Recognition Program that are designed to prevent or delay the onset of type 2 diabetes in individuals with prediabetes. http://www.cdc.gov/diabetes/prevention/index.htm
Certified Electronic Health Record Technology (CHERT)	An Electronic Health Record (EHR) that stores data in a structured format. Structured data allows patient information to be easily retrieved and transferred, and it allows the provider to use the EHR in ways that can aid patient care.
Chronic Conditions	Any illness, disease, disorder, or disability that is of long duration or frequently recurs and is either not curable or has residual features that result in limitations in daily living requiring

	adaptation in function or special assistance. These may include, but are not limited to, hypertension, obesity, and diabetes.
Coalition	A formal alliance of organizations or an organized group of people in a community that come together to work for a common goal. The coalition can have individual, group, institutional, community, and/or public policy goals.
Collective Impact	The idea that alignment of many organizations toward a common goal makes impact greater than any individual agency.
Community	A group of people who have common characteristics or shared identity. Communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar common bonds. Ideally, there would be available assets and resources, as well as collective discussion, decision-making and action.
Community-Clinical Linkages	Strategies or programs to ensure that communities support and clinics refer patients to programs that improve management of chronic conditions. Activities address those with or at high risk for chronic diseases and facilitate access, referral and payment for quality community resources, to best manage their condition or disease. For example, interventions such as clinician referral, community delivery and third-party payment for effective programs that increase the likelihood that people with high blood pressure, diabetes or prediabetes will better manage their conditions.
Community Health Worker (CHW)	CHWs are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community/population being served. http://www.cdc.gov/dhdsp/docs/chw_brief.pdf
Community Setting	Encompasses norms, social networks, patterns of leadership, culture, religion, housing and environment. Examples include: <ul style="list-style-type: none"> • City/county/government • Neighborhood groups/resource centers • Housing complexes or units • Local farmers' markets • Local food shelves • Community organizations, such as the Boys & Girls Clubs, YMCA/YWCA, and 4-H • Caregivers • Transportation

	<ul style="list-style-type: none"> • Chamber of Commerce • Media • Cooperative extension services • Faith-based organizations • Parks and recreation
Continuous Quality Improvement	The use of a deliberate and defined process, such as Plan-Do-Study-Act (PDSA), in a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality services or processes which achieve equity and improve the health of a defined population.
Contracts	An award instrument that establishes a binding, legal procurement relationship between CDC and a recipient, and obligates the recipient to furnish a product.
Dietary Guidelines for Americans	Evidence-based nutrition information and advice for people age two and older. The Guidelines serve as the basis of Federal food and nutrition education programs. The Dietary Guidelines for Americans, 2010 are the current Federal policy.
Engagement Strategies	Strategies intended to increase enrollment in and attendance at structured lifestyle change programs, e.g., DPP, for priority populations. The strategies are designed to make it easy for people to achieve their goals by drawing attention to health messages, motivating people through the behavior of others, or making things timely and relevant at key moments and decision points. Examples include leveraging social networks, such as senior support groups, to increase the lifestyle change program enrollment and attendance; or ensuring a “warm Hand-off” to a Community Health Worker who can help a patient enroll in the lifestyle change program before he/she leaves their medical appointment.
Environmental Change	Changes in both the social, cultural, and political environment, as well as the physical environment, at the community level; a change in organizational practice or policy. Examples: sidewalks, walking paths, and recreation areas are included into community development design; or worksite vending machines contain only healthy snacks and beverages.
Evaluation	The systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future program development.
Evidence-Based Strategies	Effective approaches based on principles of scientific evidence, including systematic uses of data and information systems, and appropriate use of behavioral science theory.

Fiscal Year	The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.
Foundational Skills	The knowledge, skills, and abilities necessary for successful health improvement work. The broad categories of foundational skills include health equity, community engagement, communications, assessment, planning, evaluation, and general understanding of policy, system and environment change.
Grant	A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.
Health Disparities	A difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have progressively experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability.
Health Equity	Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities. (Source: Healthy People 2020, http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34).
Health Systems	The health systems referenced in the RFP are health care delivery organizations and may include primary care practices, Patient Centered Medical Homes, health maintenance organizations (HMOs), Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and other clinical groups operating within the community.

Health System Interventions	Programs or activities designed to improve the clinical environment to more effectively deliver quality preventive services and help community residents more effectively use and benefit from those services. For example, health system and quality improvement changes such as electronic health records, systems to prompt clinicians and deliver feedback on performance, and requirements for reporting on outcomes such as control of high blood pressure and the proportion of the population up-to-date on chronic disease preventive services, as well as outreach to consumers to help reduce barriers to accessing these services.
Healthy People 2020	National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.
High-Risk Populations	Groups of individuals that experience disparities in the social determinants of health, quality of life, and/or health outcomes. Disparities are related to race, ethnicity, economic status, age, sex, sexual orientation, disability and geographic location.
Implementation	The process of developing, adopting, executing, enforcing, maintaining, and evaluating strategies.
Inclusion	Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.
Indicators	A measurable index that shows progress in meeting desired outcomes. <ul style="list-style-type: none"> • Population: percent of individuals who report/exhibit some change • Threshold: minimum progress to confirm that outcomes are being achieved • Timeline: period in which this will be reported
Indirect Costs	Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.
Letter Of Intent (LOI)	A preliminary, non-binding indication of an organization's intent to submit an application.

Lobbying	Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.
Maintenance of Effort	A requirement contained in authorizing legislation, or applicable regulations that a recipient must agree to contribute and maintain a specified level of financial effort from its own resources or other nongovernment sources to be eligible to receive federal grant funds. This requirement is typically given in terms of meeting a previous base-year dollar amount.
Medication Therapy Management (MTM)	A service or group of services that optimize therapeutic outcomes for individual patients. Pharmacists provide MTM to help patients get the best benefits from their medications by actively managing drug therapy and by identifying, preventing, and resolving medication-related problems. MTM services are independent of, but can occur in conjunction with, the provision of a medication or medical device. http://www.cdc.gov/dhdsp/programs/nhdsp_program/docs/pharmacist_guide.pdf
Modifiable Risk Factors	Risk factors are characteristics of individuals that increase the probability that they will experience a disease or specific cause of death (genetic, behavioral, sociocultural living conditions, environmental exposures). Modifiable risk factors are ones that can be changed such as sociocultural living conditions. For example, implementing a new healthy market in a community that has low access to healthy foods.
Monitoring	The ongoing tracking of achieving the plan’s goals and the initiation of corrective action if needed.
Notice of Award (NOA)	The only binding, authorizing document between the recipient and CDC that confirms issue of award funding. The NOA will be signed by an authorized GMO and provided to the recipient fiscal officer identified in the application.

Objective Review	A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.
Ordinance	A formally-adopted law, rule or regulation that is enacted by the governing body of a city or county and affects tobacco use and exposure, physical activity, and/or nutrition.
Outcome	The observable benefits or changes for populations or public health capabilities that will result from a particular program strategy.
Outcomes	The intended/desired or unintended changes in individuals, policies, or environments. A major component of an objective that describes what will change as a result of the program.
Partnerships	A collaborative alliance or union of businesses, organizations, policy makers, individuals etc., concerned with similar goals and strategies that cooperates in joint action and unites together for a common purpose or cause. Partnerships allow members to combine resources and become more impactful than when they each act alone.
Performance Measurement	The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A “program” may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.
Physical Activity Guidelines For Americans	Science-based guidance to help Americans aged six and older improve their health through appropriate physical activity. The 2008 Physical Activity Guidelines for Americans is the current document.

Policy	For purposes of this RFP, policy refers to programs and guidelines adopted and implemented by institutions, organizations and others to inform and establish practices and decisions and to achieve organizational goals. Policy efforts do not include activities designed to influence the enactment of legislation, appropriations, regulations, administrative actions, or Executive Orders (“legislation and other orders”) proposed or pending before the Congress or any state government, state legislature or local legislature or legislative body, and awardees may not use federal funds for such activities. This restriction extends to both grass-roots lobbying efforts and direct lobbying. However, for state, local, and other governmental grantees, certain activities falling within the normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking and administrative processes within the executive branch of that government are not considered impermissible lobbying activities and may be supported by federal funds.
Policy Change	A shift in the formal operations of organizations and/or governmental institutions that allows new or different activities to occur. These shifts may arise from information-sharing, community participation, professional input, compromise, and consensus-building and are usually the result of effective advocacy.
Policy Strategies	A law, ordinance, resolution, mandate, regulation, or rule (both formal and informal). Examples are laws and regulations that restrict smoking in public buildings and organizational rules that provide time off during work hours for physical activity. Sub-types of policies include: <ul style="list-style-type: none"> • Public Policy: A set of agreements about how government shall address societal needs and spend public funds that are articulated by leaders in all three branches of government and embedded in many different policy instruments (e.g., ordinances and resolutions). • Organizational Policies: A set of rules and understandings that govern behavior and practice within a business, nonprofit or government agency. • Regulatory Policies: Rules and regulations created, approved, and enforced by governmental agencies, generally at a federal or state level.
Policy, System and Environmental (PSE) Changes	Increases widespread and sustainable community change with regard to public health, reaching beyond individual behavior change by creating multi-level interactions to significantly impact a community’s norms and values. Focuses on improving socioeconomic factors as well as physical and social environments, and has a greater impact on a community’s health and economic

	vitality.
Population-Based Health	A health promotion approach that aims to address social and structural factors that affect behaviors. Population-based approaches focus on communities, neighborhoods, cities, states and even entire nations instead of concentrating solely on individual responsibility and behavior. This approach seeks to alter our environment through policy, regulation, changes in practices or forging new social norms to create a culture of wellness and an environment that support healthy choices.
Population-Based Interventions	Planned and systematic activities that create change in social systems and environmental conditions at the community level that will influence and support individual behavior change.
Priority Community	A specific group of people, often living in a defined geographical area, who share a common culture, values, and norms and are arranged in a social structure according to relationships the community has developed over time.
Priority Populations	High risk, high burden populations are referred to as “priority populations” and are those population subgroups with pre-diabetes or uncontrolled high blood pressure who experience racial/ethnic or socioeconomic health disparities including inadequate access to care, poor quality of care, or low income.
Program Strategies	Public health interventions or public health capabilities.
Programs	Activities, individual or group instruction, curricula, and counseling. In the context of this RFP, programs are services targeted to individuals that teach behavioral skills to increase physical activity, and/or improve nutrition. Such programming can support the work of this RFP, but funds are not to be used for individual-based programming.
Project Period Outcome	An outcome that will occur by the end of the RFP’s funding period.
Public Health Accreditation Board (PHAB)	National, nonprofit organization that improves tribal, state, local, territorial, and U.S. public health departments and strengthens their quality and performance through accreditation.
Public Transit Improvements	Enhancements to existing transportation system or development of new systems that can support a healthy lifestyle. Examples may include: providing trips to grocery stores in rural areas for people with limited mobility, allowing bicycles to be placed on the front of buses, adding bus stops in areas where fresh food is sold, bike share programs, etc.
Self-Measured Blood Pressure Monitoring (SMBP)	The regular use of a personal blood pressure measurement device (home blood pressure monitor) that is used by the patient outside a clinical setting. http://millionhearts.hhs.gov/Docs/MH_SMBP.pdf

Setting	The place and conditions where strategies take place. Specifically, health care sites, worksites, and communities.
Shared Use Agreement (SUA)	Also known as joint-use agreement. SUA is a formal agreement between two separate entities, often a school district and a city or county, setting forth the terms and conditions for the shared use of public property. Typically, each party under a SUA helps fund the development, operation, and maintenance of the facilities that will be shared. In so doing, no single party is fully liable for the costs and responsibilities.
Smart Objectives	<p>Specific—Identifies a specific event or action that will take place or change that will occur. Who is expected to change or benefit? Measurable—Quantifies the number of events or the amount of change to be achieved. What or how much is expected? Measurable objectives use action verbs such as, “establish,” “enact,” “train,” “adopt,” “commit,” “institute,” or “organize.” Achievable—Realistic given available resources and plans for implementation, yet challenging enough to accelerate program efforts. Uses baseline measures to assist in estimating potential success. Relevant—Logical and relates to the program’s goals. It is sufficiently meaningful and important. Considers the financial and human resources and the cost benefit of the intervention. Time—Specifies a time by which the objective will be achieved. When will the event or change occur?</p>
Social Determinants of Health	<p>Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a range of health, functioning, and quality-of-life outcomes and risks.</p> <ul style="list-style-type: none"> • Availability of resources to meet daily needs, such as educational and job opportunities, living wages, or healthful foods • Social norms and attitudes, such as discrimination • Exposure to crime, violence, and social disorder, such as the presence of trash • Social support and social interactions • Exposure to mass media and emerging technologies, such as the Internet or cell phones • Socioeconomic conditions, such as concentrated poverty • Quality schools • Transportation options • Public safety • Residential segregation
Stakeholders	Any person or organization with a vested interest in a common initiative. Usually decision makers, program partners, or clients. Individuals or groups affected by the issue.

Statute	An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations. <i>Black's Law Dictionary 2 Kent, Comma 450.</i>
Supplemental Activities	Support primary population-based activities. Supplemental activities include direct education/services, media campaigns, information dissemination and support. They must enhance and complement primary activities, but are not meant as stand-alone initiatives. These activities should be kept to a minimum.
Sustainability	Ensuring that an effort or change lasts. Sustainability is often misunderstood as securing further or ongoing funding for a program that otherwise would end. Note that sustainability can be achieved without ongoing funding by changing policies, norms, attitudes, etc. For example, a health day that discourages smoking at a park will likely not effect permanent change, whereas a tobacco-free park policy will create a sustainable change without future investments/resources.
System	A group of independent but interrelated and interacting elements etc., individuals, institutions or infrastructures that form a unified whole or network system. A system may include structure, behavior, procedures, or processes. Examples include: <ul style="list-style-type: none"> • A classification or arrangement • A network or communication, transportation or distribution • A method or process of doing things • An assembly of interdependent units • A point of view or doctrine used to interpret knowledge
Systems Change	A permanent change to the policies, practices, and decisions of related organizations or institutions in the public and/or private sector. Changes that impact all elements of an organization, institution, or system; they may include a policy or environmental change strategy. Examples include: <ul style="list-style-type: none"> • A local health department reviews all community development plans to make recommendations that improve the health impact of the plan (e.g., walkability, location of food resources, etc.) • A large health center establishes a protocol to refer patients with newly-diagnosed type 2 diabetes to a Diabetes Self-Management Program.

Team-Based Care	The provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care.
Technical Assistance	Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.
Work Plan	The summary of annual strategies and activities, personnel and/or partners who will complete them, and the timeline for completion.
Worksite Setting	<p>A worksite is defined by a location, permanent or temporary, where an employee performs work or work related activities. Worksite facilities include lunchrooms, restrooms, break rooms, vehicles used for work, and parking facilities. If specified, it can also include the grounds around the worksite. Examples include:</p> <ul style="list-style-type: none"> • Offices • Manufacturing plants • Retail • Food service • Transportation • Wholesale • Agriculture • Construction • Health care (employees) • School districts (employees)

Personnel/Position

Person/Position (Provide CV or resume for existing staff; Position description for staff to be hired)	% of Time	% of Time Paid by the Grant	Function (Briefly describe responsibilities of the Person/Position specific to Component 1 or Component 2)

Year 1 Work Plan Preventing Obesity, Diabetes, and Heart Disease and Stroke in Ohio Communities (Local 1422)			
Expected Outcome(s) for the Project Period <ul style="list-style-type: none"> • Reduce death and disability due to diabetes, heart disease and stroke in implementation area • Reduce the prevalence of obesity in implementation area 			
COMPONENT 1: Environmental strategies to promote health and support and reinforce healthful behaviors			
Program Strategies	Performance Measures	Data Source	Target
1. Implement food and beverage guidelines including sodium standards in public institutions, worksites and other key locations such as hospitals	<ul style="list-style-type: none"> • # of community locations that implement nutrition/beverage standards • # of adults with access to community locations that implement nutrition/beverage standards • Consumption of fruits, vegetables, healthy beverages 	<ul style="list-style-type: none"> • Subawardee Quarterly Program Reports (SQPR), CDC modified Retail Food Environment Index (mRFEI), USDA Food Atlas • SQPR • Purchase data for participating venues from SQPR 	<ul style="list-style-type: none"> • 20% ↑ in locations implementing standards • 20% ↑ in adults with access to community locations • 2% ↑ in fruit, vegetable, & healthy beverage consumption
Activities			Quarterly Progress
Recruit local higher education institutions to implement healthy food and beverage guidelines. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Collaborate with local hospitals to implement food and beverage standards. <i>(FILL IN SPECIFICS</i>			Q1

<i>HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q2
			Q3
			Q4
Collaborate with YMCAs to implement food and beverage guidelines, specifically Water First for Thirst messaging and guidelines. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q1
			Q2
			Q3
			Q4
Recruit local libraries, parks and recreation, city and county buildings to implement healthy food and beverage guidelines, specifically Water First for Thirst messaging and guidelines. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q1
			Q2
			Q3
			Q4
Program Strategies	Performance Measures	Data Source	Target
2. Strengthen healthier food access and sales in retail venues and community venues through increased availability, improved pricing, placement, and promotion	<ul style="list-style-type: none"> • # retail venues that promote healthier food access • # community venues that promote healthier food access • # adults with access to retail venues that promote healthier food access 	<ul style="list-style-type: none"> • SQPR, mRFEI, USDA Food Atlas • SQPR, mRFEI, USDA Food Atlas • SQPR • SQPR • Purchase data for 	<ul style="list-style-type: none"> • ↑ of 1 retailer in each subaward community that promote healthier food access • 20% ↑ in community venues that promote healthier food access • 20% ↑ in adults with retail access that promote healthier food access

	<ul style="list-style-type: none"> • # adults with access to community venues that promote healthier food access • Consumption of fruits and vegetables 	participating venues from SQPR	<ul style="list-style-type: none"> • 20% ↑ in adults with community access that promote healthier food access • 2% ↑ in fruit and vegetable consumption
Activities			Quarterly Progress
Implement healthy corner stores using the behavioral economics model. Provide technical assistance and marketing materials with the Ohio healthy corner store “brand.” <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Implement healthy checkout lanes (retail venue) using behavioral economics strategies. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Implement healthy Client Choice Food Pantries (community venue) through placement and promotion of healthy foods. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4

Program Strategies	Performance Measures	Data Source	Target
3. Strengthen community promotion of physical activity (PA) through signage, worksite policies, social support, and joint-use agreements in communities and jurisdictions	<ul style="list-style-type: none"> • # and type of community venues that promote PA through signage, worksite policies and shared-use/joint use agreements • # of adults who have access to community venues that promote PA • # of adults who meet PA guidelines 	<ul style="list-style-type: none"> • SQPR • SQPR • BRFS 	<ul style="list-style-type: none"> • ↑ in 1 community venue promoting PA in each sub-awarded community • 20% ↑ in adults with access to community venues that promote PA • 2% ↑ in adults meeting PA guidelines
Activities			Quarterly Progress
Implement joint use agreements, specifically between school districts and their respective communities/cities/counties. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Implement walking groups for social support linking walking to culture (e.g., art walks, walk with a doc, etc.). <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Implement free group fitness classes at parks, farmers’ markets and other public spaces. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1

			Q2
			Q3
			Q4
<p>Develop, educate and implement worksite active living policies specific to active commuting such as bike and walk-to-work infrastructure support. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i></p>			Q1
			Q2
			Q3
			Q4
<p>Post stair prompt signage at worksites, and other point of decision signage promoting walking in parks. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i></p>			Q1
			Q2
			Q3
			Q4
<p>Collaborate with Regional HOBC members to support and participate in Work@Health trainings to local businesses, including the CDC’s Worksite Health Scorecard to assess pre- and post-worksite wellness programs. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i></p>			Q1
			Q2
			Q3
			Q4
Program Strategies	Performance Measures	Data Source	Target

4. Develop and/or implement transportation and community plans that promote walking	<ul style="list-style-type: none"> • # of communities that develop and/or implement a transportation plan that promotes walking • # of adults who have access to communities that develop and/or implement plans to promote walking • # of adults who meet PA guidelines 	<ul style="list-style-type: none"> • SQPR, Complete Streets Policy Inventory • SQPR • BRFSS 	<ul style="list-style-type: none"> • ↑ from 12 to 15 the # of communities with Complete Streets policies • 20% ↑ in adults with access • 2% ↑ in adults meeting PA guidelines
Activities			Quarterly Progress
Work with Municipal Planning Organizations (MPO), Safe Routes to School National Partnership-Ohio Network (SRTS) and city/county planning departments to adopt and implement Complete Streets policies in high need areas. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q1
			Q2
			Q3
			Q4
Work with local MPOs and city/county planning to adopt and implement inclusion of bike and pedestrian infrastructure into master transportation plans. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q1
			Q2
			Q3
			Q4
COMPONENT 1: Strategies to build support for lifestyle change, particularly for those at high risk, to support diabetes and heart disease and stroke prevention efforts			
Program Strategies	Performance Measures	Data Source	Target

5. Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for lifestyle change	<ul style="list-style-type: none"> • # of unique sectors represented in the network • Annual participation/response rate of network partners in network self-assessments • # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program 	<ul style="list-style-type: none"> • SQPR • Lifestyle Change Network (LCN) assessment results • CDC Diabetes Prevention Recognition Program (DPRP) reports 	<ul style="list-style-type: none"> • ↑ to 5 unique sectors represented • ↑ to 75% the rate of partners participating in self-assessment • 5% ↑ in Diabetes Prevention Program (DPP) enrollment
Activities			Quarterly Progress
Identify community stakeholders and partners that can facilitate connection of lifestyle change programs to healthcare systems and engage community members. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Promote awareness of and enrollment in DPP through insurance companies, local Area Agencies on Aging, parks and recreation, senior centers and faith-based organizations. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Program Strategies	Performance Measures	Data Source	Target
6. Implement evidence-based engagement strategies to build support for lifestyle change	<ul style="list-style-type: none"> • # of people reached through evidence-based engagement strategies 	<ul style="list-style-type: none"> • SQPR • CDC DPRP reports 	<ul style="list-style-type: none"> • ↑ to 5,000 # of people reached • 5% ↑ in DPP enrollment

	<ul style="list-style-type: none"> # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program 		
Activities		Quarterly Progress	
Assist ODH in developing and identifying evidence-based engagement strategies that use social marketing principles and tools. Implement the identified strategies to promote awareness of prediabetes and increase enrollment of high-risk individuals in DPP. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)		Q1	
		Q2	
		Q3	
		Q4	
Work with benefit providers/employers, including regional HOBC members, to develop targeted communications to high-risk employees using engagement strategies, such as social media, to direct employees to DPP. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)		Q1	
		Q2	
		Q3	
		Q4	
Program Strategies	Performance Measures	Data Source	Target
7. Increase coverage for evidence-based supports for lifestyle change by working with network partners	<ul style="list-style-type: none"> # of employees with prediabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle change programs as a covered benefit # of persons with prediabetes or at high risk for type 2 diabetes 	<ul style="list-style-type: none"> Benefit provider data CDC DPRP reports 	<ul style="list-style-type: none"> Maintain # of employees with access 5% ↑ in DPP enrollment

	who enroll in a CDC-recognized lifestyle change program		
Activities		Quarterly Progress	
Promote and participate in regional HOBC presentations on the return on investment of DPP as a covered benefit and develop strategies to increase employer benefit plan coverage for DPP. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>		Q1	
		Q2	
		Q3	
		Q4	
COMPONENT 2: Health System Interventions to Improve the Quality of Health Care Delivery to Populations with the Highest Hypertension and Prediabetes Disparities			
Program Strategies	Performance Measures	Data Source	Target
1. Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance (e.g., work with health system partners to implement advanced Meaningful Use data strategies to identify patient populations who experience CVD-related health disparities)	<ul style="list-style-type: none"> • % patients within healthcare systems with EHR appropriate for treating patients with high blood pressure (HBP) • Proportion of adults with HBP in adherence to medication regimens 	<ul style="list-style-type: none"> • Ohio Health Systems Survey (OHSS) • BRFSS 	<ul style="list-style-type: none"> • 1% ↑ in # of patients within systems that have EHR appropriate for treating HBP • 2% ↑ in adults in adherence
Activities		Quarterly Progress	
Identify the Patient Centered Medical Homes (PCMH), large family medicine practices, and/or FQHCs with Certified Electronic Health Records Technology (CHERT) that serve high-need patients in the intervention area and recruit their participation in the Hypertension		Q1	
		Q2	

Collaborative. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q3
			Q4
Determine if the practices recruited for the Hypertension Collaborative have the ability to use their EHRs to generate registries of patients with undiagnosed/uncontrolled hypertension by race and gender. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q1
			Q2
			Q3
			Q4
Program Strategies	Performance Measures	Data Source	Target
2. Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider level (e.g., use dashboard measures to monitor healthcare disparities and implement activities to eliminate healthcare disparities)	<ul style="list-style-type: none"> • % of persons within healthcare systems with systems to report standardized clinical quality measures for the management and treatment of patients with HBP • Proportion of adults with HBP in adherence to medication regimens 	<ul style="list-style-type: none"> • OHSS • BRFSS 	<ul style="list-style-type: none"> • 1% ↑ in persons within systems that have EHR appropriate for reporting HBP quality measures • 2% ↑ in adults in adherence
Activities			Quarterly Progress
Provide cultural sensitivity training, technical assistance and resources (including the <i>Check it. Change it. Control it. Blood Pressure Toolkits for African-American Men and Women</i>) to healthcare providers recruited for the Hypertension Collaborative and other healthcare providers and public health staff in the intervention area(s). (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q1
			Q2
			Q3

			Q4
Identify the training needs of practices recruited for the Hypertension Collaborative to incorporate patient tracking and Clinical Decision Support (CDS) using standardized clinical quality measures (CQMs) and alerts for patient reminders and referrals to improve care coordination and patient outcomes for hypertension. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q1
			Q2
			Q3
			Q4
Program Strategies	Performance Measures	Data Source	Target
3. Increase engagement of non-physician team members (i.e., nurses, pharmacists, dietitians, physical therapists, and patient navigators/community health workers) in HTN management in community healthcare systems	<ul style="list-style-type: none"> • % of patients within healthcare systems with policies or systems to encourage a multi-disciplinary team approach to blood pressure control • Proportion of adults with HBP in adherence to medication regimens 	<ul style="list-style-type: none"> • OHSS • BRFS 	<ul style="list-style-type: none"> • 1% ↑ in patients within systems that encourage a multi-disciplinary team approach to HBP control • 2% ↑ in adults in adherence
Activities			Quarterly Progress
Survey practices recruited for Hypertension Collaborative and identify type of non-physician team members working in practices and the protocols in place for referring patients with HBP to team members. If gaps in teams exist, determine if protocols for referral to external resources are in place. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q1
			Q2
			Q3
			Q4
Program Strategies	Performance Measures	Data Source	Target
4. Increase use of self-measured	<ul style="list-style-type: none"> • % of patients within healthcare 	<ul style="list-style-type: none"> • OHSS 	<ul style="list-style-type: none"> • 1% ↑ in patients within systems

blood pressure (SMBP) monitoring tied with clinical support	<ul style="list-style-type: none"> systems with policies or systems to encourage SMBP Proportion of patients with HBP that have a self-management plan 	<ul style="list-style-type: none"> BRFSS 	<ul style="list-style-type: none"> that have SMBP policies/systems 2% ↑ in adults with HBP that have a self-management plan
Activities			Quarterly Progress
Develop messages and identify dissemination channels to promote SMBP monitoring tied with clinical support to providers and patients in high-need communities. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Compile and disseminate resources (e.g., American Heart Association’s HEART 360, Check it. Change it. smartphone app for recording blood pressure readings, etc.) to healthcare providers that support and encourage SMBP. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Program Strategies	Performance Measures	Data Source	Target
5. Implement systems to facilitate identification of patients with undiagnosed HTN and people with prediabetes	<ul style="list-style-type: none"> % of patients within health-care systems with policies or systems to facilitate identification of patients with undiagnosed HTN and people with prediabetes Proportion of adults with HBP 	<ul style="list-style-type: none"> OHSS BRFSS CDC DPRP reports 	<ul style="list-style-type: none"> 1% ↑ in patients within systems that have policies/systems to identify undiagnosed HTN and prediabetes 2% ↑ in adults in adherence 5% ↑ in persons enrolled in DPP

	<p>in adherence to medication regimens</p> <ul style="list-style-type: none"> • # of persons with prediabetes or at high risk of type 2 diabetes who enroll in a CDC-recognized lifestyle change program 		
Activities			Quarterly Progress
<p>Work with partners to develop provider resources and DPP referral protocols for patients with prediabetes. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i></p>			Q1
			Q2
			Q3
			Q4
<p>Develop messages and identify dissemination channels to inform providers and promote DPPs to patients. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i></p>			Q1
			Q2
			Q3
			Q4
<p>Identify and recruit existing DPPs and American Association of Diabetes Educators (AADE)/American Diabetes Association (ADA) programs in subaward communities that are interested in becoming CDC-recognized DPPs. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i></p>			Q1
			Q2
			Q3

			Q4
COMPONENT 2: Community-Clinical Linkage Strategies to Support Heart Disease and Stroke and Diabetes Prevention Efforts			
Program Strategies	Performance Measures	Data Source	Target
6. Increase engagement of CHWs to promote linkages between health systems and community resources for adults with HBP and adults with prediabetes or at high risk for type 2 diabetes	<ul style="list-style-type: none"> • # of health systems that engage CHWs to link patients to community resources that promote self-management of HBP and prevention of type 2 diabetes • Proportion of adults with HBP in adherence to medication regimens • Proportion of patients with HBP that have a self-management plan • # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program 	<ul style="list-style-type: none"> • OHSS • BRFSS • BRFSS • CDC DPRP reports 	<ul style="list-style-type: none"> • 1% ↑ in # of health systems that link patients to community resources • 2% ↑ in adults in adherence • 2% ↑ in adults with HBP self-management plan • 5% ↑ in persons enrolled in DPP
Activities			Quarterly Progress
Increase the number of community resources available for people with HTN, prediabetes and those at risk of type 2 diabetes (e.g., CDC-recognized DPPs, Diabetes Self-Management courses, AADE and ADA-recognized Diabetes Self-Management Education (DSME) programs). (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q1
			Q2
			Q3
			Q4

Identify community-based agencies/health systems that currently employ CHWs to determine populations reached and health conditions addressed. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Establish quarterly meetings with CHWs currently working in communities to strengthen relationships, establish care coordination and referral processes for HTN, prediabetes and diabetes to existing community resources. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Provide training and technical assistance to CHWs to build capacity for addressing HTN and prediabetes in high-need populations. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>			Q1
			Q2
			Q3
			Q4
Program Strategies	Performance Measures	Data Source	Target
7. Increase engagement of community pharmacists in the provision of medication/self-	<ul style="list-style-type: none"> # community pharmacists that promote medication/self-management 	<ul style="list-style-type: none"> Ohio Pharmacists Association (OPA) BRFSS 	<ul style="list-style-type: none"> 5% ↑ of pharmacists that promote medication/self-management 2% ↑ in adults in adherence

management for adults with HBP	<ul style="list-style-type: none"> • Proportion of adults with HBP in adherence to medication regimens • Proportion of patients with HBP that have a self-management plan 	<ul style="list-style-type: none"> • BRFSS 	<ul style="list-style-type: none"> • 2% ↑ in adults with HBP self-management plan
Activities			Quarterly Progress
Identify community pharmacists that currently provide Medication Therapy Management (MTM) for adults with HBP. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q1
			Q2
			Q3
			Q4
Identify health care providers, PCMH practices, FQHCs, etc. that have a pharmacist on staff or protocols established with a community pharmacy to provide MTM for patients with HBP. (FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)			Q1
			Q2
			Q3
			Q4
Program Strategies	Performance Measures	Data Source	Target
8. Implement systems to facilitate bi-directional referral between community resources and health systems, including lifestyle change programs (e.g., EHRs, 800 numbers, 211 referral	<ul style="list-style-type: none"> • # health systems with an implemented community referral system for evidence-based lifestyle change programs • # persons with prediabetes or at high risk for type 2 diabetes 	<ul style="list-style-type: none"> • OHSS • CDC DPRP reports • CDC DPRP reports 	<ul style="list-style-type: none"> • ↑ by 1 the # of systems with referral systems in each subaward community • 5% ↑ in persons with HBP enrolled • 5% ↑ in persons with prediabetes/at risk type 2 diabetes

systems, etc.)	who enroll in a CDC-recognized lifestyle change program	enrolled
Activities		Quarterly Progress
Determine if bi-directional referral systems exist for lifestyle change programs in high-need communities. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>		Q1
		Q2
		Q3
		Q4
Establish care coordination protocols and processes that community agencies and providers can use to refer patients to lifestyle change programs. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>		Q1
		Q2
		Q3
		Q4
Provide 211 systems serving priority populations/communities information on lifestyle change programs in their area and establish a bi-directional referral system. <i>(FILL IN SPECIFICS HERE – identify partners, timeframe to complete activity, list of process steps.)</i>		Q1
		Q2
		Q3
		Q4