

Child & Family Health Services Program  
Q & A for FY 15 Grant  
3/14/2014

1. NOIAF – What is submitted? To whom? How? Everyone has to do it? (Also referred to as vendor forms.)  
Forms which need to be submitted include the Notice of Intent to Apply for Funding, EFT, W9 form, proof of liability (if applicable) and proof of Non-profit (if applicable). Please submit to [dyane.goganturner@odh.ohio.gov](mailto:dyane.goganturner@odh.ohio.gov) Everyone must submit the above forms.
2. Multiple Counties:
  - a. Does the main applicant submit the NOIAF package?  
The lead agency needs to send the NOIAF package but include who the partners will be on the form.
  - b. How do we complete the program plan? Each county separate program plan?  
Yes, each county should have a separate plan if you are applying for multiple counties.
3. What amount should be put on the Program Plan for the funding requested?  
The amount should be for each measure. For example if you are requesting \$35,000 for the Child & Adolescent Health component, \$10,000 is for reduce the % of children who are overweight (strategy: work with childcare) and \$10,000 is for reduce the % of children who are overweight (strategy: work with schools) then the amount in the Funding requested would be \$20,000 for the measure not \$10,000 for each strategy or \$35,000 for the component.
4. Should the Assurances be mailed and submitted in GMIS?  
Yes
5. Do we copy the eligibility and justification verbatim from Appendix C to Attachment 3?  
No, you need to discuss how you meet the eligibility and justification on Attachment 3. Appendix C just indicates some background information along with the eligibility and justification.
6. Page 42, typo  
In the benchmarks/evaluation measures column below- The following are to be reported on the Mid-Year and Annual report. It should read:  
\_\_\_\_# of women screened  
\_\_\_\_# of women referred receiving treatment
7. Where can we access mental health statistics?  
Local ADAMH board and SAMHSA, refer to the Standards
8. Please provide more detail about how projects should budget for Ohio Healthy Programs (OHP) and what is expected?  
ODH will be providing a 2 day training which will include the curriculum and the materials. The training will be in Columbus. You should budget for 1 person to attend the training and also for duplication of materials. Staff time for implementation of the program is an allowable cost.

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9. Tell me more about Breast for Success.

*Breast for Success* was developed by a team of health professionals in the Cleveland area for community health workers. It is a breastfeeding curriculum that is a supplement to the *Partners for Healthy Baby* curriculum. ODH has adopted this curriculum and customized it to reach our at-risk moms in the OIMRI program. ODH will provide the materials and training for implementation.

10. Are the web sites on page 32 just references?

Yes

11. CHA training amount?

The Community Health Assessment training will be a web-based training which the project director and/or appropriate staff should plan to participate in

12. Can you only bill for Medicaid application assistance if you are funded for direct care?

Yes, you may only charge a one-time fee of \$40 for Medicaid application assistance and that is if you agency is providing direct care. Most agencies are using the Medicaid Administrative Claiming (MAC) program which is a way to receive funds for Medicaid application assistance. For more information on how to MAC you can contact Kimberly Dick @ [Kimberly.dick@odh.ohio.gov](mailto:Kimberly.dick@odh.ohio.gov)

13. Are mailed document due 3/31 or 4/7? (page 24 typo)

Mailed documents are due 4/7.

14. Can additional activities be added?

Yes, but you must include proposed measures and benchmarks.

15. How can I access the county profiles?

You can access the county profiles through the ODH website, CFHS tab, CFHS Community Health Assessment Resources, Health Status Profiles and click on your county.  
Link: [http://www.odh.ohio.gov/odhprograms/cfhs/cf\\_hlth/cha/hsprofiles.aspx](http://www.odh.ohio.gov/odhprograms/cfhs/cf_hlth/cha/hsprofiles.aspx)

16. Why does OIMRI staff have to be part of the Ohio Equity Institute (OEI) travel and/or home team?

OIMRI and OEI are both programs which are working toward improving health disparities and reducing infant mortality. ODH feels it is important to encourage the collaboration between these two programs.

17. Please provide more detail about why outreach was removed.

ODH BCFHS CFHS revisions to the grant program are made to better align with State and Department strategic priorities to reduce infant mortality, obesity and tobacco use. There is increased momentum at the local, state, regional and national level to address the infant mortality

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and disparity issue. At the same time, national and state level changes have occurred which have influenced the future focus of the CFHS program. CFHS continues to focus on the core public health functions of assessment, policy development and assurance of access to health care with an emphasis on infrastructure and population-based services. A comprehensive review of funding and activities was completed. In addition, ODH staff reviewed MCHBG reported activities from around the nation as well as RFPs posted by other state agencies. Many activities reported to ODH supporting direct health care services and other activities may fall under the planning portion of CHAP.

18. What is the deadline for the Q&A?

The deadline is Thursday, March 13, 2014 at 5:00 PM.

19. For OEI, can applicants state that the benchmarks will be approved by CityMatch and ODH?

Yes

20. The only Not on Tobacco (NOT) training provided located was in another state and can we use CFHS grant funds to send personnel to the training?

The American Lung Association (ALA) will be providing NOT training in Columbus via closed sessions for interested parties. Once the grants are awarded and we know how many persons are requesting NOT training, the sessions will be scheduled by ODH. Local dollars will pay the training, which costs \$200 per person and provides a 3-year certification and an instructor manual.

21. What is the definition of uninsured? Under/insured? Does this mean they can have Medicaid? Or partial pay or full pay due to sliding fee schedule.

An uninsured client is one who does not have health insurance coverage of any kind or cannot be insured by Medicaid. An underinsured client is one whose health insurance only partly covers the payment of a direct care or enabling encounter. An underinsured client may also be a client who has an extremely high co-pay and cannot be insured by Medicaid. Clients who are uninsured and/or underinsured can partially pay, fully pay, or not pay for their direct care or enabling services. It does not include clients who are potentially eligible for or enrolled in Medicaid.

22. There are numerous new trainings and programs that I would like clarification on that is not provided in the RFP.

- a. OCCRRA OHP (I heard someone asked about this one on the call – will we need to budget \$ for training and sign up for the registry as a county, or is it taken care of under the auspices of ODH?)

You do NOT do anything through OCCRRA (i.e. signing up for the registry). **ALL** questions should be referred to CFHS in regards to OCCRRA. You will budget for a 2-day training in Columbus for 1 person. You will get one copy of the materials and will

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need to budget for the duplication of materials. Staff time to implement the program is an allowable cost.

- b. Ohio Injury Prevention Partnership (OIPP) Child Injury Action Group – should counties sign up individually, and is there training involved?  
Counties should not signup individually. Yes training is involved. For more information about joining OIPP please visit the following link:  
<http://www.healthy.ohio.gov/vipp/oipp/oipp.aspx>
- c. Can we use CFHS funds for Cribs for Kids since participation is required, or do we need to find auxiliary funding?  
Participation for Cribs for Kids is not required. Per RFP page 37 Appendix C if you chose the strategy Infant Safe Sleep Cribs for Kids is listed as one of the activities to achieve the outcome.
23. Certified Tobacco Treatment Specialist trainings (Perinatal Enabling) – the RFP mentioned this but the only training specified elsewhere in the grant is for Perinatal Direct Care. Will TTS training be provided, or do we need to find our own? I have found trainings that are typically 5 days long – is this common?  
ODH will facilitate the scheduling of the training dates. Full Certification Program is \$1,000.00. The Breathing Association is subsidizing \$500 of this fee. Your cost is \$500 for the full course which is what you need to budget for a 5 day training in Columbus.
24. Baby & Me – Tobacco Free – the Program Plan says one-day training is provided by program, but no mention of the costs we should budget is provided in the RFP.  
ODH will facilitate the scheduling of the training dates. You will need to budget \$1200 for training for one day in Columbus.
25. IPHIS/MATCH forms were referred to as only applying to Direct Care – is this right? Would we no longer be completing these for Enabling services?  
No, if you are still providing Direct Care or Enabling services then you will have to complete MATCH and IPHIS. The change is with the schedule of charges. You will no longer have to submit a schedule of charges for enabling services. Medicaid enabling services are only allowed if an agency is providing direct care. A one-time fee of \$40 may be budgeted for Medicaid application assistance.
26. Are we to send Attachment #1 Program Assurances through GMIS **and** by mail (the original and 1 hard copy)?  
Yes. Please send the mailed copies to the attention of Dyane Gogan Turner.
27. Can you address a question about the Community Health Assessment (CHA). This grant utilizes the Community Health Improvement Cycle CHIC Model but the health departments are working on Public Health Accreditation (PHAB); which utilizes a different CHA model (see below):

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The process used may be an accepted state or national model; a model from the public, private, or business sector; or other participatory process model. Examples of models include: Mobilizing for Action through Planning and Partnership (MAPP), Healthy Cities/Communities, or Community Indicators Project. Examples of other tools and processes that may be adapted for the community assessment include: community asset mapping, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Healthy People 2020, and Protocol for Assessing Community Excellence in Environmental Health (PACE-EH).

It would be more productive and cost effective if one community assessment model could be used by all. Agencies already have a very tight budget, so there are no resources or time for people to be involved in to two or three different groups conducting a community assessment. Does the CHIC Model have to be the model used in this grant as long as all 9 steps of the CHIC model are addresses?

CFHS applicant agencies are not required to use the CHIC model to conduct their community health assessment. The process used may be an accepted state or national model; a model from the public, private, or business sector; or other participatory process model. Examples of models include: Mobilizing for Action through Planning and Partnership (MAPP), Healthy Cities/Communities, or Community Indicators Project. Examples of other tools and processes that may be adapted for the community assessment include: community asset mapping, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Healthy People 2020, and Protocol for Assessing Community Excellence in Environmental Health (PACE-EH). The model used should include all nine steps described in the CHIC model.

28. Under child & adolescent health (safe sleep education), does it matter if we propose # of organizations or # of professionals trained/educated, or do you have to do both?  
No, it doesn't matter if it is organizations or professionals. The benchmark only asks for a number in regards to professionals and organizations.
29. There are 2 documents required to be sent as a hard copy (page 15/16 of the RFP). Are those to be uploaded as well?  
The 2 documents are the Attachment #1 CFHS Program Assurance and Attachment #7 OEI (if applicable). Yes the documents should be uploaded.
30. Our application is pending for the ODH Tobacco grant. ODH requires Tobacco grantees to establish two "STAND" groups of 10 students between March 29, 2014 and March 28, 2015. If we are selected for the ODH Tobacco grant AND the CFHS grant in Lucas County, will we be required to use/recruit for both strategies with the same age population?  
The Stop Tobacco and Nicotine Dependence (STAND) program and the Not on Tobacco (NOT) program are two separate and distinct programs. The STAND program is a youth led advocacy

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and prevention program for junior high through High School age youth. The NOT program is a smoking cessation counseling program for teens 14-19. In answer in your question, you will recruit according to the RFP measure requirements for each program.

31. When budgeting for the required Baby & Me Tobacco Free program, do we need to purchase CO monitoring equipment?

Yes, purchase of CO monitoring equipment is required.

32. Since identify and train select staff as "Certified Tobacco Treatment Specialist" is a *suggested* activity on page 10 of the program standards, is this an optional activity? Can we contract with a local hospital which already has TTS to provide cessation services rather than train CFHS staff?

Yes, contracting with the local hospital to provide cessation services is acceptable.

33. For nutrition education in the reduction of childhood obesity, is food an allowable cost? This would be used as a part of the nutrition education lessons, not breakfast or lunch to the participants.

Yes

34. Has the list of approved school based nutrition programs changed from FY14? Where can that list be found?

No, it has not changed from the RFP for SFY 14. The list is as follows: Let's Move, Nutrition Expedition and /or Fuel Up to Play 60, Choose My Plate, CATCH (K-8), CATCH Kid's Club After-School Program (K-8), SPARK and Veggie U.

35. In small rural areas like ours, many of the childcare facilities the children bring packed lunches and snacks. Child obesity is a big concern in our area; so how would the Ohio Healthy Programs work if they pack?

Some centers may not provide any meals or snacks—the children bring packed lunches. However, all child care centers are required to have a protein, fruit, and vegetable to supplement a child's packed lunch. The OHP features several components, and the component primarily affected by this is the menu planning. (The other lessons related to OHP will not be affected.) CFHS will provide technical assistance and provide information to the centers related to lunch packing standards and parent education on healthy lunch packing.

36. Can other evidence-based programs be used for child care facilities? (Our agency has been using a program that has previously been approved, but not on the list)

No, the only program available for child care facilities is the Ohio Healthy Programs (OHP).

37. How should we communicate that we want to use a program for schools that is not on the list of approved programs?

State that your program is seeking approval by ODH and give a brief, concise description of the program you are using.

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38. Since reading over the RFP several times now, I have some questions regarding the measures. In the reduce percentage of children who are overweight, it states in the strategies to implement the OCCRRA Ohio Health Projects Program in child care facilities. I have gone on the site, but I find no specific curriculum that should be followed, so I am a little fuzzy on the participation the childcare facility would have with the OCCRRA.

ODH will be providing a training that will provide you with the curriculum and the materials. The curriculum features 3 modules: Healthy Habits, Healthy Menus, and Healthy Policies. ODH will be doing things a little differently than what is listed on the OCCRRA website. Please continue to direct ALL questions to CFHS.

39. On page 31 of the RFP not allowable, we have parents call in stating their child needs a pre-k or sports physical. In the past we have seen this child and completed a well-child comprehensive physical. Can we continue this?

Yes, as long as you are following the guidelines of the RFP (Page 31 Appendix C under not allowable states these physicals are not allowed outside of the well child visit).

40. Measure: Ensure that the social emotional health and/or addiction needs of children and adolescents are met.

a. Is the definition of children 0 to 12?

Our definition of child and adolescents is 0-21. We do not specifically define the age categories for children and/or adolescents.

b. In the strategy, is the definition of “mental health” al en-compassing to include developmental and behavioral issues?

Yes, however there needs to be a screening and referral process.

c. The screening tools – you mention the Pediatric Symptom Checklists 17 and 35. Is the Ages and Stages screening tool an acceptable tool to screen for “mental health.”

No, as the questions are very broad when it comes to “mental health.” You can use that to supplement one of the other recommended screening tools found in the Standards.

41. Measure: Reduce the rate of smoking among pregnant women and women of childbearing age.

a. Will this enabling program require IPHIS reporting?

Yes, this enabling program will require IPHIS reporting.

b. Who pays for the \$25 vouchers women will receive if they are smoke free postpartum? Is this part of the CFHS budget or is there some other funding source?

Yes, the \$25 vouchers will need to be part of the CFHS budget.

42. Measure: Ensure that social/emotional health and addiction needs of pregnant and post-partum women are met.

a. In the required activities, care coordination activities are mentioned. Who will be providing this service? Do we find some agency to provide care coordination or is this our role as the granted agency? This is confusing because this is listed as an infrastructure activity but care coordination sounds like an enabling activity. Please clarify roles.

Your role as the subgrantee agency would be to put the “infrastructure” in place so that there is a point of screening, a point of referral, and a point of tracking to ensure the services/appointments are being carried out. The subgrantee agency would be providing the infrastructure so these activities could happen. We would not be paying for the on-going counseling services. Care coordination refers to ensuring the women are screened, referred to appropriate treatment, and actually linked with a provider and appointment.

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You would definitely need to work with someone that would be providing the actual treatment services.

43. Looking at the social/emotional for women again, I don't read that as the coordinating agency doing anything specifically with or for the woman other than handling the referral from the provider and getting her into mental health care. Would this include speaking with her on the phone and then tracking out the referral? I don't read this as a face-to-face relationship with the care coordinator agency. But I could be totally wrong.

You would need to look at your community and how it is currently set up to handle this type of activity. The main focus is: women are screened, referred, and tracked. There should be a path that is established to decide what/where the women would go'

- a. Would ODH give examples that would be very helpful?

An example would be that there is a "map" of what happens/where women go when they have certain scores on the screening tool. The women would be screened, the screening would be sent to a central location if warranted by the score, and then depending on the resources in the community the women would be linked to an appropriate provider. There would need to be a feedback loop so the information could be tracked whether it be the agency sends a form back once client has attended their first appt. and then the outcome of the treatment. Again this could be done by the subgrantee agency or contract agencies.

- b. In the Benchmark, a screening system is in place and each woman is screened using an ODH approved screening tool. Who does this screening? Are we helping providers build screening capacity or is our care coordination program actually providing the direct screen?

Every community is different. As stated in the previous answer. You would need to look at your community and how it is currently set up to handle this type of activity. The main focus is the women are screened, referred, and tracked. There should be a path per se that is established to decide what/where the women would go.

44. Our community has an adequate number of OB/GYN providers. The women in our community miss many prenatal appointments. Is there a measure for rural communities for case management/care coordination for prenatal visits?

No there is not a measure at this time. That service can be provided under the umbrella of direct care, if perinatal direct care is provided. Care coordination can only be provided for the measure, soci-emotional for mental health and addiction.

45. We are one of the OEI counties and are planning to implement a Fetal Infant Mortality Review (FIMR) in our county in the coming year. We will be using the \$28,000 designated for FIMR but would like to use more of our CFHS funds to support the process – is that allowable?

Yes, it is allowable if it is identified as a necessary part of primary data collection for community health assessment. To be funded through CFHS, the FIMR would need to adhere to meet the ODH guidance which includes being a multi-disciplinary, multi-agency, community based program that identifies local infant mortality issues through the review of fetal and infant deaths using the standard components of the FIMR model (e.g., maternal interviews and community action teams)and develops recommendations and initiatives to reduce infant deaths.

46. What needs to be submitted for RFP Section I.M.? Is a separate document required?

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Based on the programmatic focus of the RFP, the applicant will have to explain the extent of the health disparity and/or health inequity in the target area, the specific social determinants of health that contribute to the problem, and how the activities that they propose will respond to the disparity given the social and environmental changes in the target area **but not in a separate document.**

47. The last competitive grant cycle was to go through until 2016. What is the reasoning why this competitive grant is a year early?

ODH can post a competitive grant at any time. The timeframes usually remain the same but occasionally they change, including some cycles may be extended a year or two.

The Ohio Department of Health (ODH), Division of Family and Community Health Services (DFCHS), Bureau of Child and Family Health Services (BCFHS), announces the availability of competitive grant funds to support the Child and Family Health Services (CFHS) Program in Ohio. This competitive announcement and revisions to the grant program are made to better align with State and Department strategic priorities to reduce infant mortality and obesity. There is increased momentum at the local, state, regional and national level to address the infant mortality and disparity issue. A comprehensive review of funding and activities was completed. In addition, ODH staff reviewed Maternal and Child Health Block Grant reported activities from around the nation as well as RFPs posted by other state agencies. The new CFHS program component is the Ohio Institute for Equity in Birth Outcomes is also known as the Ohio Equity Institute or OEI. From 2000-2010, the US infant mortality rate improved 11% while the Ohio infant mortality rate got 3% worse. Therefore, the gap or disparity between Ohio and the rest of the nation is widening. The OEI is an initiative designed by CityMatCH, the national organization of urban maternal & child health) to strengthen the scientific focus and evidence base for realizing equity in birth outcomes. The Institute is a data-driven, high-visibility movement by nine urban Ohio communities. This effort marks the first time that CityMatCH will work in so many cities in a single state at the same time. The hope is for Ohio to become a template for other states or communities also wishing to make measurable reductions in birth outcome inequities.

48. The RFP was put out using PDF format instead of WORD document.

This document has been posted as a pdf document for more than six years. As stated during the bidders' conference, the attachments will be sent to the applicants who submitted a NOIAF so the documents can be completed in the correct format. That has been the practice for many years and will continue this year.

49. Would you please give more information about implementing your Ohio Healthy Programs? We are a local health department and applying for funding and this is one of our options. Is this a program implemented directly for the children, or is this a program that is more of a train the trainer for the staff?

In terms of providing training for Ohio Healthy Programs, OCCRRA's role is to train the trainers. Once trained, trainers deliver the training to ECE providers. Trainers do not deliver the program to children or families.