OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

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

John R. Kasich/Governor

Lance Himes/Director of Health

MEMORANDUM

Date: January 2, 2019

To: Subrecipient agencies

From: Sandy Oxley, Chief
Maternal, Child and Family Health
Ohio Department of Health

Subject: Tobacco Use Prevention and Cessation Program

The Ohio Department of Health (ODH), Maternal, Child and Family Health Programs, announces the availability of grant funds. There will be a bidders conference scheduled for January 4, 2019 at 9:00 am to answer questions and address concerns.

You can access the conference through skype at the following link:

https://webpoolblu0b12.infra.lync.com/Meet/?origurl=aHR0cHM6Ly9tZWV0Lmx5bmMuY29tL29oaW9kYXMtaW0vMTAxNTk0MzgvWURMSDQxUDQ_VXNlQ2RuPWZhbHNl&iframe=1&sl=1

Call in for audio at 1-614-230-0229 using the conference code: 29083#

All electronic applications and attachments are due by 4:00 p.m., February 11, 2019. Applications received after the due date will not be considered for funding. Faxed, hand-delivered or mailed applications will not be accepted.

Electronic application components must be submitted via the on-line Grants Management Information System (GMIS). For new staff requiring GMIS access, you must successfully complete GMIS training offered by ODH, no later than January 22, 2019.

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

Submission of the **application** constitutes acknowledgment and acceptance of ODH Grants Administration Policies and Procedures (OGAPP) Manual rules and any other program-specific requirements as outlined in the competitive Solicitation.

If you have questions, please contact Mandy Burkett at 614-644-7553 or e-mail at Mandy.Burkett@odh.ohio.gov

ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

OFFICE OF
Maternal, Child and Family Health

BUREAU OF
Maternal, Child and Family Health

Tobacco Use Prevention and Cessation Program

SOLICITATION
FOR
FISCAL YEAR 2020
(07/01/19 – 06/30/20)

Local Public Applicant Agencies
Non-Profit Applicants

COMPETITIVE GRANT APPLICATION INFORMATION
100% Deliverable Funding

Revised 09/11/2017
For grant starts 4/1/2018 and thereafter

Table of Contents

I. APPLICATION SUMMARY and GUIDANCE

An application for an Ohio Department of Health (ODH) grant consists of a number of required components including an electronic portion submitted via the Internet website "ODH Application Gateway" and various paper forms and attachments. All the required components of a specific application must be completed and submitted by the application due date. **If any of the required components are not submitted by the due date indicated in sections D, G and R, the entire application will not be considered for review.**

This is a competitive Solicitation; a Notice of Intent to Apply for Funding (NOIAF – Appendix A) must be submitted by, 2/11/19 so access to the application via the Internet website "ODH Application Gateway" can be established.

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

The above mentioned forms are located on the Ohio Department of Administrative Services website at: http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.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://www.ohiosharedservices.ohio.gov/SupplierOperations/doc/EFT_Payment_Authorization_OBM4310.pdf**
- **Supplier Information Form** **http://www.ohiosharedservices.ohio.gov/SupplierOperations/doc/Supplier_Information_Form_OBM5657.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 and updates in policies that have been posted on the GMIS Bulletin Board. This manual and GMIS Bulletin Board policy updates must be followed to ensure adherence to the rules, regulations and procedures for preparation of all Subrecipient applications. The OGAPP manual is available on the ODH website: *http://www.odh.ohio.gov*.
(Click on Grant/Contracts, ODH Grants, Grants Administrative Policies and Procedures Manual (OGAPP)) or copy and paste the following link into your web browser:
http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/funding%20opportunities/OGAPP%20Manual%20V100-2%20Rev%2010-1-2014.ashx

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

All budget justifications must include the following language and be signed by the agency head listed in GMIS. Please refer to the budget justification examples listed on the GMIS bulletin board.

Budget Justification Certification language

- Subrecipient understands and agrees that it must follow the federal cost principle that applies to its type of organization (2 CFR, Part 225; 2 CFR, Part 220; or, 2 CFR, Part 230).
- Subrecipient's budgeted costs are reasonable, allowable and allocable under OGAPP and federal rules and regulations.
- The OGAPP and the rules and regulations have been read and are understood.
- Subrecipient understands and agrees that costs may be disallowed if deemed unallowable or in violation of OGAPP and federal rules and regulations.
- The appropriate programmatic and administrative personnel involved in this application are aware of agency policy in regard to subawards and are prepared to establish the necessary inter-institutional agreements consistent with those policies.
- Subrecipient agrees and understands that costs incurred in the fulfillment of the Deliverables must be allowable under OGAPP and federal rules and regulations to qualify for reimbursement.

B. **Application Name:** *Local Tobacco Prevention and Cessation Grants*

C. **Purpose:** *To decrease the initiation and use of tobacco, by youth and adults, and to decrease people's exposure to secondhand smoke, through increasing community readiness to initiate and affect evidence-based strategies for tobacco treatment and control.*

D. ***Qualified Applicants:*** *All applicants must be a local public or non-profit agency. Applicant agencies must attend or document in writing prior attendance at Grants Management Information System (GMIS) training and must have the capacity to accept an electronic funds transfer (EFT). If an applicant agency needs GMIS training prior to the establishment of access to the application, then a GMIS training form must be submitted (Appendix B). State who is eligible to apply. Indicate whether local public and/or non-profit agencies can apply.*

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

1. Applicant does not owe funds to ODH and has repaid any funds due within 45 days of the invoice date.
2. Applicant has not been certified to the Attorney General's (AG's) office.
3. Applicant has submitted application and all required attachments by **4:00 p.m. on Monday, February 11, 2019.**

E. ***Service Area:*** *The focus of this grant is on increasing the readiness of your community to initiate and engage in tobacco control and cessation strategies. If your county has a city of at least 100,000, you must focus on that city for the objectives of this grant. If the largest city in your county is not within your jurisdiction or if you have no city of at least 100,000 in your jurisdiction you will still be required to work toward improvements in community readiness in the largest municipality of your jurisdiction, but the target of some deliverables/objectives may be expanded to focus on larger areas or the entirety of your jurisdiction. The determination of the geographic area to be covered by each applicant will be made within 3 business days of the submission of notice of intent to apply for funding and will be based on collaboration with the assigned public health consultant for your application. An email with the assignment of your public health consultant and their contact information will be sent to*

the email provided on the notice of intent to apply for funding form, so please look for this and be in contact, as early as possible.

F. **Number of Grants and Funds Available:** *TUPCP anticipates awarding up to 30 awards for up to a total of $2,300,000. Funds for prevention initiatives are supported by state and federal sources, while cessation work is supported by state funds only. There is a maximum funding allowance for each grantee of $100,000 (max $40,000 for cessation and max $60,000 for prevention which includes strategies of both protection and prevention) Applicants must apply for both cessation and prevention efforts, unless the applicant county is funded by ODH for the Community Cessation Initiative (CCI). If the applicant county is funded for CCI, cessation efforts will not be available under this opportunity. The counties granted CCI funds, and therefore eligible for only the $60,000 for prevention work are: Erie, Franklin, Huron, Knox, Licking, Lucas, Perry.*

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

G. **Due Date:** All parts of the application, including any required attachments, must be completed and received by ODH electronically via GMIS or via ground delivery by **4:00 p.m. by Monday, (February 11, 2019).** Applications and required attachments received after this deadline will not be considered for review.

Contact (Mandy Burkett at 614-644-7553 or Mandy.Burkett@odh.ohio.gov with any questions.

H. **Authorization:** Authorization of funds for this purpose is contained in ORC 3701.04 (A)(5) and/or the *Catalog of Federal Domestic Assistance (CFDA) Number 93.305 – National State Based Tobacco Control Programs.*

I. **Goals:** *The goals of this grant are to create social norm change through community action to decrease initiation and use of tobacco in local communities and to decrease the community's exposure to secondhand smoke. It is the expectation that at the end of each year of the grant there will be evidence of improvement in community readiness (assessment scores) and improvement in the indicators of community engagement and involvement monitored through routine reporting. ODH will review progress toward improvement in making determinations for continuation of funding*

J. **Program Period and Budget Period:** The program period will begin July 1, 2019 and end on June 30, 2022. The budget period for this application is July 1, 2019 through June 30, 2020.

K. Public Health Accreditation Board (PHAB) Standard(s): Identify the PHAB Standard(s) that will be addressed by grant activities. Identify the PHAB Standard(s) that will be addressed by grant activities. 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, Program, 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 10.1: Identify and Use the Best Available Evidence for Making Informed Public Health Practice Decisions. The PHAB standards are available at the following website:

http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf

L. Public Health Impact Statement: All applicant agencies that are not local health districts must communicate with local health districts regarding the impact of the proposed grant activities on the PHAB Standards.

1. *Public Health Impact Statement Summary* - Applicant agencies are required to submit a summary of the proposal to local health districts prior to submitting the grant application to ODH. The program summary, not to exceed one page, must include:

   The Public Health Accreditation Board (PHAB) Standard(s) to be addressed by grant activities:
   - A description of the demographic characteristics (e.g., age, race, gender, ethnicity, disability status, socio-economic status, educational levels) of the target population and the geographical area in which they live (e.g., census tracts, census blocks, block groups;
   - A summary of the services to be provided or activities to be conducted; and,
   - A plan to coordinate and share information with appropriate local health districts.

The applicant must submit the above summary as part of the grant application to ODH. This will document that a written summary of the proposed activities was provided to the local health districts with a request for their support and/or comment about the activities as they relate to the PHAB Standards**.**

2. *Public Health Impact Statement of Support* - Include with the grant application a statement of support from the local health districts, if available. If a statement of support from the local health districts is not obtained, indicate that point when submitting the program summary with the grant application. If an applicant agency has a regional and/or statewide focus, a statement of support should be submitted from at least one local health district, if available**.**

M. Incorporation of Strategies to Eliminate Health Inequities

The ODH is committed to the elimination of health inequities. Racial and ethnic minorities, people with disabilities, the LGBTQ community and Ohio's economically disadvantaged residents experience health inequities 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) Describe how specific social and environmental conditions (social determinants of health) put groups who are already disadvantaged at increased risk for health inequities.

3) Specify how proposed program interventions and/or grant deliverables will address this problem.

4) Link health equity interventions in the grant proposal to national health equity strategies using the GMIS Health Equity Module. These four items should be incorporated into the grant language in specific areas of the application and not left to the applicant to decide where to insert this information. Also care should be taken to avoid repetition to keep the responses focused and specific.

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

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

Certain groups in Ohio face significant barriers to achieving the best health possible. These groups include Ohio's poorest residents, people with disabilities, 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.*

Although no single characteristic fully explains an individual's risk for tobacco use or related health impacts, tobacco surveillance data show that the populations in Ohio at highest risk for smoking include residents that are socioeconomically disadvantaged, those with disabilities or mental health challenges, and those that identify as LGBT. African American Ohioans and women who are pregnant are also populations of special interest for intervention efforts in Ohio due to tobacco-related health consequences. These groups represent current priority populations for tobacco-related prevention and cessation interventions in Ohio. Appendix I contains demographic and market research

data from Nielsen/Claritas at the census tract level in tabular form. This data enables applicants to identify areas where households are most likely to purchase and use tobacco products. In "Program Need" section of the applicant's original application they were required to specify how tobacco disparities and health inequities would be addressed as they relate to the applicant's county and also how data, including Nielsen Market Research Data, was used to inform program interventions in priority areas. Please use information provided at the time of the original application to frame the report and inform plans for this section of the continuation application.

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 that 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.healthy.ohio.gov/healthequity/equity.aspx.

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

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

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

__X_Applicable ____Not Applicable to (Tobacco Use Prevention and Cessation Program Local Tobacco Grants)

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

P. ***Programmatic, Technical Assistance and Authorization for Internet Submission:*** *Initial authorization for Internet submission, for new agencies, will be granted after participation in the GMIS training session. All other agencies will receive their authorization after the* posting of the Solicitation to the ODH website and the receipt of the NOIAF. Please contact Mandy Burkett at Mandy.Burkett@odh.ohio.gov or at 614-644-7553.

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

Q. Acknowledgment: An Application Submitted status will appear in GMIS that

acknowledges ODH system receipt of the application submission.

R. Late Applications: GMIS automatically provides a time and date system for grant application submissions. Required attachments and/or forms sent electronically must be transmitted by the application due date. Required attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before the application due date of **Monday, February 11, 2019 at 4:00 p.m.**

Applicants should request a legibly dated postmark, or obtain a legibly dated receipt from the U.S. Postal Service or a commercial carrier. Private metered postmarks shall **not** be acceptable as proof of timely mailing. Applicants can hand-deliver attachments to ODH, Grants Services Unit (GSU), via the front desk at 246 N. High St., Columbus, Ohio; but they must be delivered by **4:00 p.m**. on the application due date. Fax attachments will not be accepted**. GMIS applications and required application attachments received late will not be considered for review.**

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

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

U. Review Criteria: All proposals will be judged on the quality, clarity and completeness of the application. Applications will be judged according to the extent to which the proposal:

1. Contributes to the advancement and/or improvement of the health of Ohioans;
2. Is responsive to policy concerns and program objectives of the initiative/program/ activity for which grant dollars are being made available;
3. Is well executed and is capable of attaining program objectives;
4. Describe Specific, Measurable, Attainable, Realistic & Time-Phased (S.M.A.R.T.) objectives, activities, milestones and outcomes with respect to time-lines and resources which utilize indicators identified in the tables in Appendix E;
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 which should include evaluation plans for activities that are marked as requiring evaluation, as well as, how applicant will assess overall progress in relation to the indicators being tracked (see Appendix E);
8. Is responsive to the special concerns and program priorities specified in the Solicitation;
9. Has demonstrated acceptable past performance in areas related to programmatic and financial stewardship of grant funds;
10. Has demonstrated compliance to OGAPP;
11. Explicitly identifies specific groups in the service area who experience a disproportionate burden of the diseases; health condition(s); or who are at an increased risk for problems addressed by this funding opportunity and has clearly identified how they will address the specific health equity focus objectives in each deliverable; and,
12. Describe activities which support the requirements outlined in sections I. thru M. of this

Solicitation.

13. Complete required community readiness perspective and fully describe community's readiness in each focus area (cessation, prevention and youth) in terms of the five domains. Must show evidence that proposed activities are tied to level of community readiness.
14. Submit Memorandums of Understanding from each program in your jurisdiction that receives funding from the Bureau of Maternal, Child and Family Health describing how funds will be leveraged to maximize impact.

Please see Application Review Form (Appendix D) 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 Solicitations; **There will be no appeal of the Department's decision.**

V. Freedom of Information Act: The Freedom of Information Act (5 U.S.C.552) and the associated Public Information Regulations require the release of certain information regarding grants requested by any member of the public. The intended use of the information will not be a criterion for release. Grant applications and grant-related reports are generally available for inspection and copying except that information considered being an unwarranted invasion of personal privacy will not be disclosed. For guidance regarding specific funding sources, refer to: 45 CFR Part 5 for funds from the U.S. Department of Health and Human Service; 34 CFR Part 5 for funds from the U.S. Department of Education or, 7 CFR Part 1 for funds from the U.S. Department of Agriculture.

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

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

"This work is funded either in whole or in part by a grant awarded by the Ohio Department of Health, Bureau of Maternal, Child and Family Health , Tobacco Use Prevention and Cessation Program and is partially funded by a sub-award of a grant issued by Centers for Disease Control and Prevention, under the National Tobacco Control Program grant, grant award number CDC-RFA-DP15-150905CONT19], and CFDA number 93.305.

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

Note: Failure to ensure the quality of reporting by submitting incomplete and/or late

program or expenditure reports will jeopardize the receipt of future agency payments.

Reports shall be submitted as follows:

1. **Program Reports:** Subrecipients Program Reports must be completed and submitted via GMIS, as required by the subgrant program by the following dates: 1st Report for July 1 thru September, 2019 will be due October 15, 2019; 2nd report for the time period October 1, 2019 thru December 31, 2019 will be due January 15, 2020; 3rd Report for January 1, 2020 thru March 31, 2020 will be due April 15, 2020; 4th and final report for April 1, 2020 thru June 30, 2020 will be due July 15, 2020. Quarterly reports will consist of submission of ODH provided spreadsheet to provide data on provided indicators associated with the reporting quarter. Grantees will also be required to submit a quarterly success story in a format provided by ODH and on an approved subject as approved by ODH. The final success story must discuss the success of interventions to address disparate populations and the lessons learned from these interventions. Associated deliverable documents must be submitted with each expenditure report on the 10th of the month, either monthly or quarterly as designated by the grantee. Any paper non-Internet compatible report attachments must be submitted to GSU Central Master Files by the specific report due date. **Program Reports that do not include required attachments will not be approved**. All program report attachments must clearly identify the authorized program name and grant number.

   Submission of Subrecipient Program Reports via GMIS indicates acceptance of the OGAPP. *Grantees must be represented at monthly collaborative program calls and must meet individually at least once per month with assigned public health consultant. Applicants may be required to complete occasional webinars for professional development on issues related to grant activities. Grantees should budget for and must be represented at an in-person two-day kick-off meeting during the first month of the grant and at least one other mandatory in-person one-day training.*

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

Period	*Report Due Date*
July 1 – 31, 2019	*August 10, 2019*
August 1 – 31, 2019	*September 10, 2019*
September1 – 30, 2019	*October 10, 2019*
October 1 – 31, 2019	*November 10, 2019*
November 1 – 30, 2019	*December 10, 2019*
December 1 – 31, 2019	*January 10, 2020*
January 1 – 31, 2020	*February 10, 2020*
February 1 – 29, 2020	*March 10, 2020*
March 1 – 31, 2020	*April 10, 2020*
April 1 – 30, 2020	*May 10, 2020*
May 1 – 31, 2020	*June 10, 2020*

June 1 – 30, 2020	*July 10, 2020*

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

Period	*Report Due Date*
July 1 – September 30, 2019	*October 10, 2019*
October 1 – December 31, 2019	*January 10, 2020*
January 1 – March 31, 2020	*April 10, 2020*
April 1 – June 30, 2020	*July 10, 2020*

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

3. **Final Expenditure Reports:** A Subrecipient Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS by 4:00** p.m. on or before *(August 5, 2020)*. The information contained in this report must reflect the program's accounting records and supportive documentation. Any cash balances must be returned with the Subrecipient Final Expense Report. The Subrecipient Final Expense Report serves as an invoice to return unused funds.

Submission of the Monthly/Quarterly and Final Subrecipient Expenditure reports via the GMIS system indicates acceptance of OGAPP. Clicking the "Approve" button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of OGAPP rules and regulations.

Y. Special Condition(s): A Special Conditions link is available for viewing and responding to special conditions within GMIS. The 30-day time period, in which the subrecipient must respond to special conditions will begin when the link is viewable. Subsequent payments will be withheld until satisfactory responses to the special conditions or a plan describing how those special conditions will be satisfied is submitted in GMIS.

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

1. To advance political or religious points of view or for fund raising or lobbying;
2. To disseminate factually incorrect or deceitful information;
3. Consulting fees for salaried program personnel to perform activities related to grant objectives;
4. Bad debts of any kind;
5. Contributions to a contingency fund;
6. Entertainment;
7. Fines and penalties;
8. Membership fees -- unless related to the program and approved by ODH;
9. Interest or other financial payments (including but not limited to bank fees);
10. Contributions made by program personnel;
11. Costs to rent equipment or space owned by the funded agency;
12. Inpatient services;
13. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building;

14. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
15. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants;
16. *Include any additional program specific unallowable costs per CFDA, program regulations and directives or state law specifications.*

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

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

Subrecipients that expend $750,000 or more in federal awards per fiscal year are required to have a single audit which meets OMB's Federal Uniform Administrative Requirements. The subrecipient must submit, a copy of the auditor's management letter, a corrective action plan (if applicable) and a data collection form (for single audits) within 30 days of the receipt of the auditor's report, but no later than nine months after the end of the Subrecipient's fiscal year. The fair share of the cost of the single audit is an allowable cost to federal awards provided that the audit was conducted in accordance with the requirements of OMB's Federal Uniform Administrative Requirements.

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

Once an audit is completed, a copy must be sent to **https://harvester.census.gov/facweb/** or to the ODH, Grants Services Unit, (GSU) within 30 days. Reference: OGAPP and OMB's Omni Circular Federal Uniform Administrative Requirements regarding Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.

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

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

AB. Submission of Application

Formatting Requirements:

- Properly label each item of the application packet (e.g., Budget Narrative, Program

Narrative).

- Each section should use 1.5 spacing with one-inch margins.
- Program and Budget Narratives must be submitted in portrait orientation on 8 ½ by 11 paper.
- Number all pages (print on one side only).
- Program Narrative should not exceed 15 pages (**excludes** appendices, attachments, budget and budget narrative).
- Use a 12 point font.
- Forms must be completed and submitted in the format provided by ODH

The GMIS application submission must consist of the following:

Complete & Submit Via Internet

1. Application Information
2. Project Narrative
3. Project Contacts
4. Budget
   - Other Direct Costs – Costs allocated for each deliverable and objective according to template provided in C2– for consortium counties, please use template C3
5. Civil Rights Review Questionnaire
6. Assurances Certification
7. Federal Funding Accountability and Transparency Act (FFATA) reporting form
8. Change request in writing on agency letterhead **(Existing agency with tax identification number, name and/or address change(s).)**
9. Health Equity Module
10. Public Health Impact Statement Summary (non-health department only)
11. Statement of Support from the Local Health Districts (non-health department only)
12. Attachments as required by Program Work plan using template from Appendix H; letters from at least two major established partners in support of the work of this grant. If you are a health department and have another health department as part of your jurisdiction, you must have a letter of support from this health department.

One copy of the following document(s) must be uploaded to **https://harvester.census.gov/facweb/** 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
35 E. Chestnut Street
Columbus, Ohio 43215

II. APPLICATION REQUIREMENTS AND FORMAT

GMIS access will be provided to an agency after it has completed the required ODH sponsored training. Agencies who have previously completed GMIS training will receive access after the Solicitation is posted to the ODH website.

All applications must be submitted via GMIS. Submission of all parts of the grant application via the ODH's GMIS system indicates acceptance of OGAPP. Submission of the application signifies authorization by an agency official and constitutes electronic acknowledgment and acceptance of OGAPP rules and regulations in lieu of an executed Signature Page document.

A. Application Information: Information on the applicant agency and its administrative staff must be accurately completed. This information will serve as the basis for necessary communication between the agency and the ODH.

B. Budget: Prior to completion of the budget section, please review page 11 of the Solicitation for unallowable costs.

The model for reimbursement for this funding opportunity is a deliverables-based model. Reimbursement will be made based on progress toward, and achievement of, units of deliverables that include outcome measures as well as outputs. The budget narrative should be based on the costs to complete each deliverable. While payments may be made throughout the budget period for activities or objectives leading to a deliverable, no less than 30% of the cost for a deliverable will be reserved for payment upon completion of the deliverable. Refer to the Scope of Work in Appendix E for a listing of each deliverable. The budget associated with each deliverable should be delineated in the "Other Direct Costs" category in GMIS; no line items should be created in the "Personnel", "Equipment" or "Contracts" categories in GMIS.

For your convenience, a budget justification narrative example is available in Appendix C2 or if you are a consortium bid, C3. In line with Scenario 3 of budget examples provided in GMIS all total costs associated with objectives (not activities) listed under each deliverable in your work plan should be listed in this document, as well. Budget figures for the total deliverable (sum of the objectives for each deliverable) in Budget Narrative are required to match the deliverables totals entered into GMIS budget.

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

1. **Primary Reason and Justification Pages:** Provide a budget justification narrative outlining how the deliverable will be met. (A budget justification example can be found on GMIS). This is C2 or C3, referred to above.

2. **Other Direct Costs:** Submit a budget for this section and the necessary form(s) to support costs for the period July 1, 2019 to June 30, 2020. All deliverable costs should be listed under this category. No costs should be entered into other budget categories in GMIS.

The applicant shall retain all original fully executed contracts on file.

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

D. **Project Narrative:**

1. **Executive Summary:** *Provide a short summary of your application (not to exceed one page) that identifies:*

- *Jurisdiction*
- *Amount of Funding Requested*
- *Level of Community Readiness for Each Focus Area (Cessation, Prevention, Youth)*
- *Overview of staff working on program and their experience*
- *Disparity Focus Ideas*
- *What other funding sources you may have for tobacco work in your community (local, state or federal)*

2. Description of Applicant Agency/Documentation of Eligibility/Personnel:
Briefly discuss the applicant agency's eligibility to apply. Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program. Specifically identify what personnel will be doing the day to day work of the project, describe their education, experience, and what portion of their time will be dedicated to this grant's work.

Please also describe any other funding your agency receives from ODH or others for work on tobacco issues and for what tobacco activities or interventions the funds are received (e.g., Creating Health Communities Funds used for promotion of Tobacco 21 in "x" city).

Describe the capacity of your organization, its personnel or contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English proficiency, those who are not literate, have low literacy skills, and individuals with disabilities.

3. Problem/Need: 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 geographic population targets for each deliverable/objective.

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. Also, include a description of what other tobacco work you conduct and under what funding source.

4. **Methodology:** In narrative form, identify the program goals, **SMART** process, impact, or outcome objectives and activities. Speak to each deliverable and associated objectives. Indicate how these activities relate to your community's readiness scores.

   Indicate how they will be evaluated to determine the level of success of the program. Evaluation measures and SMART goals/objectives should incorporate at least some of the indicators being collected and reported on, quarterly.

   Describe health disparities and/or health inequities as they relate to tobacco in your community. Describe how program activities will be designed to address these issues, especially for the objective in each focus area that has a health disparity requirement. Indicated by * on table in Appendix E.

   Describe existing partnerships and describe what partners you will pursue in the coming year increase community engagement. Potential partners should be aligned with needs as determined by community readiness assessment. Provide at least two letters from significant potential partners who are ready to collaborate with your agency on the activities of this grant.

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

F. Federal Funding Accountability and Transparency Act (FFATA): All applicants applying for ODH grant funds are required to complete the FFATA reporting form in GMIS. Applicants must ensure that the information contained in SAM.gov, DUN & Bradstreet and the FFATA reporting form match. ODH will hold all payments if an applicant's information does not successfully upload into the federal system.

All applicants for ODH grants are required to obtain a Data Universal Number System (DUNS), register in SAM.gov and submit the information in the grant application. For information about the DUNS, go to http://fedgov.dnb.com/webform. For information about System for Award Management (SAM) go to www.sam.gov.

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 (February 11, 2019**

Reimbursement Type
Select one of the options below:

☐ Monthly
OR
☐ Quarterly

Appendix A

NOTICE OF INTENT TO APPLY FOR FUNDING

Ohio Department of Health
Office of Maternal, Child and Family Health
Bureau of Maternal, Child and Family Health

ODH Program Title:
Tobacco Use Prevention and Cessation Program

Submission Required

See Due Date Below

ALL INFORMATION REQUESTED MUST BE COMPLETED.

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)**

Please note that the agency head listed above must match the agency head listed in GMIS. Unless a new agency, NOIAF's will not be accepted if name doesn't match what is listed in GMIS. If the agency head needs updated in GMIS, please include a letter on agency letterhead outlining the change. The new agency head's signature will be accepted with receipt of the update letter.

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

If yes, no further action is needed.

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

The NOIAF must be accompanied by the agency's Proof of Non-Profit status (if applicable); Proof of Liability Coverage (if applicable); Request for Taxpayer Identification Number and Certification (W-9), Authorization Agreement for Direct Deposit of EFT Payments Form (EFT), (New Agency Only) Vendor Information Form. These forms are located on the Ohio Department of Administrative Services website at: http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx.**You can also access these forms at the following websites:**

- **Request for Taxpayer Identification Number and Certification (W-9),** http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx
- **Authorization Agreement for Direct Deposit of EFT Payments Form (EFT)** **http://www.ohiosharedservices.ohio.gov/SupplierOperations/doc/EFT_Payment_Authorization_OBM4310.pdf**
- **Supplier Information Form** **http://www.ohiosharedservices.ohio.gov/SupplierOperations/doc/Supplier_Information_Form_OBM5657.pdf**

Forms are only required for NEW AGENCIES or if UPDATES are needed for current agencies. ODH will forward the forms to Ohio Shared Services. FORMS MUST BE RECEIVED BY January 16, 2019

Mail, E-mail: Mandy Burkett, Mandy.Burkett@odh.ohio.gov , 614-644-7553
Ohio Department of Health , Tobacco Use Prevention and Cessation Program
246 North High Street – 6th Floor
Columbus, OH 43215
E-mail: Mandy.Burkett **@odh.ohio.gov**

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

Appendix B

GMIS Training, User Access, Access Change or Deactivation Request

One request per person. Requests will only be honored when signed by your **Agency Head** or **Agency Financial Head** and complete. In addition, if a user leaves your agency, you are to notify ODH so that their account is rendered inactive and submit a form for the replacement. The user will receive his/her username and password via e-mail once the request is processed. *Please note: GMIS Training is only required for New Agencies to ODH. If you are new to your agency someone there should train you. Refresher guides can be found on the ODH web site: http://www.odh.ohio.gov/en/about/grants/grants.aspx ODH Grants Page – "GMIS Training Resource" Section.* Confirmation of your GMIS training session will be e-mailed once a date has been assigned by ODH. Also use this form when user changes are needed.

`Date: _____

Check the type of access and complete the information requested: **[ ] Employee - needs GMIS Training**

[ ] New Employee - needs GMIS Access. Effective Date of Activation: _____

[ ] Existing Employee - New GMIS User or GMIS User Access Change. Effective/Change Date:

_____

[ ] Deactivation – User no longer needs access to ODH Application Gateway/GMIS 2.0 or GMIS 2.0 only:

Effective Date of Deactivation (ODH Application Gateway/GMIS 2.0): _____

Or **Effective Date of Deactivation (GMIS 2.0 access only):** _____

Agency Name & Address: _____

_____

Employee Name (no nicknames):

Employee Job Title:

Employee Office Phone Number:

Employee Office Fax Number:

Employee Office Email Address:

User Access Section: Please check all that applies and enter requested information:

Email Notifications: [ ] Yes [ ] No

GMIS Project Number(s) user needs access to: _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Authorization Signature for User Access/Change/Deactivation:

_____ _____

Signature of Agency Head or Agency Financial Head | Printed Name of Agency Head or Agency Financial Head

To be completed by Grants System Officer ONLY - Date Received: **Date Processed:**

Deliver Requests to Karen Tinsley, Grants System Officer, 614-644-7546
Mail: ODH/OFA, 35 E. Chestnut St.,4th Floor, Columbus, Ohio 43215 ***Or***
Scan & Email: karen.tinsley@odh.ohio.gov

Name of Subgrant Program:
Budget Period:
# of Deliverables:
Use Budget Justification Scenario#:
___ Base and Deliverables
X Deliverables Only

Deliverable – Objective 1: Decrease the number of people exposed to secondhand smoke in public spaces or multi-unit housing by the percentage associated with your community's level of readiness.
Objective A: Conduct Community Survey
Objective B: Complete Policy Scan
Objective C: Conduct Ongoing Community Readiness Activities
Objective D: Identify Policy Targets
Objective E: Attend Hearing on Adoption before Decision Makers
Objective F: Implement SHS Policy

Deliverable – Objective 2: Decrease accessibility and availability of tobacco to youth by increasing compliance rates with sales to minors laws by 5% [LMH] (RM9) and by the adoption of at least POS targeted policy [H]
Objective A: Conduct Compliance Checks OR
Objective B: Conduct Store Audits
Objective C: Conduct Ongoing Community Readiness Activities
Objective D: Identify Policy Targets
Objective E: Attend Hearing on Adoption before Decision Makers
Objective F: Implement POS Policy

Deliverable – Objective 3: Conduct paid media activities to educate communities on point of sale, retail environment, smoke-free spaces, and youth initiation, and to direct community members to the Ohio Tobacco Quit Line and cessation services.
Objective A: Develop Communication Plan
Objective B: Conduct Three Paid Media Campaigns for Cessation
Objective C: Conduct Three Paid Media Campaigns for Prevention/SHS
Objective D: Conduct Three Paid Media Campaigns for Youth

Deliverable – Objective 4: Increase community readiness of community organizations and services provider to address tobacco dependence and increase individual readiness of tobacco users to quit.
Objective A: Document availability of community cessation services
Objective B: Conduct Ongoing Community Readiness Activities
Objective C: Increase Utilization of Cessation Services
Objective D: Facilitate Individual Readiness to Quit

Deliverable – Objective 5: Create evidence of Sustainability for Tobacco Control Efforts
Objective A: Integrate Tobacco Objective into Community Strategic Plans
Objective B: Improve Prevention Sustainability
Objective C: Improve Youth Sustainability
Objective D: Improve Cessation Sustainability

Deliverable – Objective 6: Complete Final Community Readiness Brief Assessment

Appendix C2: Deliverable - Objective Allocations
Scenario #3

Deliverable Objective 1 (P) $
Objective A $
Objective B $
Objective C $
Objective D $
Objective E $
Objective F $

Deliverable Objective 2 (Y) $
Objective A $
Objective B $
Objective C $
Objective D $
Objective E $
Objective F $

Deliverable Objective 3 (M) $
Objective A $
Objective B $
Objective C $
Objective D $

Deliverable Objective 4 (C) $
Objective A $
Objective B $
Objective C $
Objective D $

Deliverable Objective 5 (S) $
Objective A $
Objective B $
Objective C $
Objective D $

Deliverable Objective 6 (CR) $
Objective A $

Appendix C3 – Budget Narrative – Consortium Application

Deliverable Objective 1 (P) $
County One $
County Two $
County Three $

Deliverable Objective 2 (Y) $
County One $
County Two $
County Three $

Deliverable Objective 3 (M) $
County One $
County Two $
County Three $

Deliverable Objective 4 (C) $
County One $
County Two $
County Three $

Deliverable Objective 5 (S) $
County One $
County Two $
County Three $

Deliverable Objective 6 (CR) $
County One $
County Two $
County Three $

Appendix D - Application Review Form

Reviewer:_____

Date:_____

Local Tobacco Control Grant Evaluation Form

Applicant Agency:_____Total Requested Budget: _____

Target Community or Communities: _____

Average Community Readiness Score: **Prevention** L M H **Youth** L M H **Cessation** L M H Other funding sources _____

_____ CCI _____Non-CCI Y N MOUs Provided?

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

ϒ Recommend
ϒ Not recommended

Comments:

Special Conditions:

(use back as necessary)

Section	Maximum Points		Score	
Applicant Information	5			
Program Narrative	40			
Health Disparities	15			
Work Plan	30			
Human Trafficking	5			
Priority Points	5 (each)			
Budget	5			
Total	100	115		

*max score for prevention only applicants (no points for Cessation Work Plan)

General Application Information	Score	Weight	Total	Comments:
Appropriate contact information provided		.34		
Formatting and page length requirement are met		.34		
If applicable, past performance has met expectations		.34		
Program Narrative/Problem Need/Methodology	Score	Weight	Total	Comments
Agency has appropriate experience, structure and capacity to manage the grant		.57		
Program Manager/Supervisor appropriate experience to manage project		.57		
Direct line staff are appropriately qualified and have sufficient time assigned		.57		
Agency capacity to convey information effectively to diverse audiences		.57		
Local health status for tobacco described – using local data		.57		
Applicant has adapted workplan and activities to be specific to their community		.57		
Activities as adapted are measurable, achievable and realistic		.57		
Evaluation is addressed in relation to objectives that require specific evaluation (communications, media activities, meetings/presentations with decision makers and overall evaluation of grant activities)		.57		

Established partners identified		.57		
Appropriate potential partners identified and letters of support provided		.57		
Key informant interviews completed and scored		.57		
Brief assessments completed and scored		.57		
Findings from Key Informant interviews used to support plans		.57		
Community Readiness accurately reported, and impact of rating is described		.57		
Health Disparity/Inequity Activities	Score	Weight	Total	Comments
Local disparate populations identified – subpopulation(s) and/or geographic area(s) of focus are identified		1		
Discussion of how program activities will be designed to address health disparities identified (i.e., choosing policy target(s), youth counter-marketing, providers of cessation accessible to community member disparately affected by tobacco)		1		
Specific interventions and indicators to reach disparate populations are identified		1		
Work Plan	Score	Weight	Total	Comments
Work plan contains all required goals and objectives		.56		
Objectives and activities are aligned with community readiness score (brief assessment) for Prevention		.56		

Objectives and activities are aligned with community readiness score (brief assessment) for Youth		.56		
Objectives and activities are aligned with community readiness score (brief assessment) for Media		.56		
Objectives and activities are aligned with community readiness score (brief assessment) for Cessation		.56		Do not mark for CCI counties – add 2 to final score for this section
Objectives and activities are aligned with community readiness score (brief assessment) for Sustainability		.56		
Person responsible is listed for all activities		.56		
Projected start and end dates are provided and are appropriate		.56		
Person responsible is listed for all activities		.56		
Projected start and end dates are provided and are appropriate		.56		
Reasonable and appropriate budget amounts are provided for each sub activity with deliverable total supplied which matches budget narrative		.56		
Human Trafficking	Score	Weight	Total	Comments
Victims of human trafficking are included in agency's population		.5		
Agency promotes expansion of services to ID and serve those affected by human trafficking		.5		
Budget	Score	Weight	Total	Comments
Does not exceed the maximum allowable award		.2		

Personnel, Equipment, Contracts and Direct Costs are contained within Deliverables in the Other Direct Costs category – GMIS matches budget narrative provided		.2		
Budget narrative identifies the unit cost for each deliverable and the cost assigned to each objective		.2		
Figures in budget are accurately reflected on work plan document		.2		
Activities are reasonably costed		.2		

Scope of Work

The goals of this grant are to create social norm change through community action to decrease initiation and use of tobacco in local communities and to decrease the community's exposure to secondhand smoke. It is the expectation that at the end of three years there will be evidence of sustainable change.

Cessation is a priority in order to promote health and decrease tobacco related illness. Decreasing initiation of use of tobacco products is to promote health and prevent potentially devastating and life-threatening illnesses associated with tobacco use. Promotion of smoke-free and tobacco-free policies are chosen to decrease exposure of the community to secondhand smoke, but also because we know that such policies work to prevent initiation of tobacco use, promote quitting, and decrease the amount of tobacco used.

Grant deliverables and objectives will be guided by activities that focus on increasing community readiness to focus on tobacco control. Funding will be awarded, and work will be approached using the Community Readiness Model as developed by the Tri-Ethnic Center for Prevention Research at Colorado State University. Community readiness is the degree to which a community is willing and prepared to take action on an issue. Often, community members are expected to respond immediately to new projects and community change without adequate time to adjust to new ideas or without the knowledge to fully understand them. Beliefs or values related to culture or regional differences can also hamper actions to change. This model and its methods are about how to understand and measure exactly how ready a community is to address a particular issue, and how to use that knowledge to stimulate community change.

In addition, because communities are more complicated in their processes of change than individuals, these researchers also built the Community Readiness Model on social action work done in the field of community development. The social action process identifies stages on the community level that lay the groundwork for collective action. These five (5) stages include:

- Stimulation of Interest – the recognition of need
- Initiation – involves development of the problem definition and workable solutions via programs proposed by community members
- Legitimization – acceptance of local leaders of the need for action
- Decision to Act – development of specific plans involving members from the wider community
- Action – Implementation

These stages of readiness relate to five different dimensions of community readiness which include:

- Community Knowledge of Efforts – how much the community knows about the current programs and activities related to an issue
- Leadership – what the attitude is of community leaders toward addressing the issue

- Community Climate – the community's attitude toward addressing the issue
- Community Knowledge of the Issue – how much the community knows about the issue
- Resources – the resources that are being used to address the issue

It is our belief that given the resources ODH has placed into local grants, to date, various communities will be at varying levels of community readiness. Therefore, applicants are required to conduct a community readiness survey, community readiness interviews and a plan for action and workplan based on the results of the surveys and interviews. In the tables below, please find the associated deliverables and objectives. Note that you will need to submit quarterly reports with identified measures of progress toward deliverables and objectives.

The focus of this grant is on increasing the readiness of your community to initiate and engage in tobacco control and cessation strategies. If your county has a city of at least 100,000, you must focus on that city for the objectives of this grant. If the largest city in your county is not within your jurisdiction or if you have no city of at least 100,000 in your jurisdiction you will still be required to work toward improvements in community readiness in the largest municipality of your jurisdiction, but the target of some deliverables/objectives may be expanded to focus on larger areas or the entirety of your jurisdiction. The determination of the geographic area to be covered by each applicant will be made within 3 business days of the submission of notice of intent to apply for funding and will be based on collaboration with the assigned public health consultant for your application. An email with the assignment of your public health consultant and their contact information will be sent to the email provided on the notice of intent to apply for funding form, so please look for this and be in contact, as early as possible.

Overarching Tobacco Control Goals

- Social norm change within the community which results in:
    - Reduced cigarette use rates by youth and adults
    - Reduced tobacco use rates by youth and adults

	TUPCP 19-20 Local Grant Deliverables & Activities	Low	Medium	High	Reporting Measure(s) (RM)	Data Source for Reporting Measure(s)	Frequency of Report-ing
1 (P)	**Decrease the number of people exposed to secondhand smoke in public spaces or multi-unit housing by [% below].**						
A	**Conduct Community survey** - conduct survey on smoke-free/tobacco-free schools, colleges, outdoor spaces, workplaces, T21, POS policies, etc. *(ODH will supply base questions, additional questions may be added by grantee - questions will differ depending on level of community readiness)*	X	X	X	1. Results from survey (indicators determined by ODH) 2. Number of times survey results incorporated into presentations/ meetings/etc. (min of 5)	1. Community survey results 2. Reporting indicators form	1. Q1, Q2 2. Q3, Q4
B	**Complete Policy Scan** - Conduct (L) or conduct or update (MH) community policy scan to identify current tobacco policies and begin to identify gaps or a community need for a new tobacco policy. Types of policies to be collected include all K-12 public schools, all colleges/universities, 10 workplaces, 10 multi-unit housing, and 10 other public places under jurisdiction of grantee.	X (Conduct)	X (Conduct if not existing or Update)	X (Conduct if not existing or Update)	3. Number and type (i.e. school, college, housing, workplace, etc.) of policies 4. Number of people (i.e. residents in MUH property, students and staff in school, employees in workplace, etc.) protected by each policy	3. Policy scan results, grantee past work, etc. 4. Occupancy data for housing, Enrollment data for schools/universities , employment data, population	3. Q1 4. Q1
C	**Conduct Ongoing Community Readiness Activities** – Meet with community members and decision-making groups in the community. See guidance for types of activities. Number of activities required will vary by type (intensity) and by level of community readiness.	6 per month (mostly low-intensity activities)	4 per month (mixture of low, medium and high intensity activities)	3 per month (mostly high-intensity activities)	5. Number and type of activities 6. Evaluation measures for communication activities 7. Community readiness scores	5. Monthly call reporting form 6. Monthly reporting forms 7. Com. Readiness Assessment	5. Monthly 6. Q1, Q2, Q3, Q4 7. App, Q4
*D	**Identify Policy Targets –** demonstrate work with stakeholder groups (including members of	2 targets	4 targets	6 targets	8. Number and type of policy targets	8. Deliverable form	8. Q2

	a disparate population and a champion from a disparate group) to determine policy targets (LMH). At least one target must address a disparate population.				9. Disparate population	9. Evaluation methods	9. Q2
E	**Hearing on Adoption before Decision Making Group** related to policy to reduce exposure to secondhand smoke by prescribed percentage. Show evidence of meeting with/presentation to decision-making group, community-member support for policy and community engagement in adoption of the policy.	Population over 200,000			10. Number of community supporters present 11. Number of champions/decision-makers present	10. Evaluation methods for communication activities (pre/post, anecdotal eval. etc.) 11. Grantee reports	10.Q3, Q4 11.Q3, Q4
		5%	7%	9%			
		Population under 200,000					
		8%	13%	18%			
F	**Implement SHS policy(s)** aimed at reducing, by prescribed percentage, exposure to secondhand smoke.	Population over 200,000			12. Number and type of policies passed or strengthened from baseline 13. Number of people protected by each policy from baseline	12. Policies passed through grantees' work (Baseline = RM 3) 13. Number of people protected by policies passed (Baseline = RM R)	12. Q4 13. Q4
		2%	4%	6%			
		Population under 200,000					
		5%	10%	15%			

2 (Y)	**Decrease accessibility and availability of tobacco to youth by increasing compliance rates with sales to minors laws by 5% [LMH] and by the adoption of at least one POS targeted policy [M/H]**						
	Note: completion of compliance checks or store audits will occur every other year on a rotating basis. ODH will select year one assignments when grantee completes Notice of Intent to Apply.				14. Increased compliance rate among retailers in Ohio 15. Baseline compliance rate among retailers in Ohio 16. POS Indicators • T21 (y/n/in progress) • % stores with flavored products • % stores with tobacco products within 12" of youth products • Lowest price for tobacco product	14. Calculation from ODH reporting system 15. Calculation and data entry into the ODH reporting system 16. ODH reporting system	14. Baseline (Q1), Q2 15. Baseline (Q1), Q2 16. Baseline (Q1), Q2
A	**Conduct Compliance Checks** - attend compliance check training, train youth confidential informants, and conduct representative sample (determined by ODH) baseline assessment (L) or conduct representative sample of compliance checks to decrease compliance rate (CR) from 18-19 baseline assessment (MH) by 5%.	N/A	X (Increase CR by 5%)	X (Increase CR by 5%)			
B	**Conduct Store Audits** - attend store audit/retail environment training, train youth on how to conduct audits (sample prescribed by ODH), conduct representative sample of store audits, input data.	X	X	X			
C	**Conduct Ongoing Community Readiness Activities –** meet with youth and community to educate on the dangers of tobacco, meet or conduct tobacco retailer education on compliance with sales to minors laws, meet with city councils or decision-making groups on the importance of comprehensive sale to minors laws or other various POS policies. Number of activities required will vary by type (intensity) and by level of community readiness.	6 per month (mostly low-intensity activities)	4 per month (mixture of low, medium and high intensity activities)	3 per month (mostly high-intensity activities)	17. Number and type of activities 18. Evaluation measures for communication activities 19. Community readiness scores	17. Monthly call reporting form 18. Evaluation forms 19. Com. Readiness Assessment	17.Monthly 18. Q1, Q2, Q3, Q4 19. App, Q4
*D	**Identify Policy Targets –** demonstrate work with stakeholder groups (including at-risk youth (See Appendix J) and a champion from a disparate group) to determine policy targets (LMH).	1	2	2	20. Number and type of policy targets 21. Disparate population	20. Deliverable form 21. Deliverable form	20. Q3 21. Q3

E	**Hearing on Adoption before Decision Making Group** related to policy aimed at decreasing accessibility and availability of tobacco to youth. Show evidence of meeting with decision-making group, community-member support for policy and community engagement in adoption of the policy.	N/A	X	X	22. Number of community supporters present 23. Number of champions/decision-makers present	22. Deliverable form 23. Deliverable form	22.Q3, Q4 23.Q3, Q4
F	**Implement POS policy** - implement new POS policy.	N/A	0-1	1	24. Change in number and type of policies that limit availability and accessibility of tobacco to youth	24. Policy records (signed or enacted policy, vote, date, etc.)	24.Q2, Q4

3 (M)	**Conduct paid media activities to educate communities on point of sale, retail environment, smoke-free spaces, and youth initiation, and to direct community members to the Ohio Tobacco Quit Line and cessation services.**						
A	**Communication Plan -** Using provided guidance develop a communication plan to increase community engagement in quitting tobacco, community engagement in decreasing exposure to SHS, & community engagement in decreasing youth initiation. Guidance provided by ODH.	X	X	X	25. Communication plan checklist completed	25. Communication plan that adheres to ODH specifications	25.Q1
*B	**Cessation Paid Media - 3** community readiness appropriate cessation-focused paid media campaigns - pre-approved by ODH • **2** campaigns to target disparities (one must target pregnant women for QL pregnancy protocol) • **1** campaign to target providers	X	X	X	26. Impressions/ Reach of campaign	26. Analytics collected for media source or from relevant marketing placement agency for other medium	26.Q1, Q2, Q3, Q4
*C	**Prevention/SHS Paid Media - 3** community readiness appropriate prevention/SHS paid media campaigns - pre-approved by ODH • **2** campaigns to target disparities • **1** campaign to target population at grantees discretion	X	X	X	27. Engagement Rate/# of engagements with campaign	27. Engagement Reports from grantee	27.Q1, Q2, Q3, Q4
*D	**Youth/POS Paid Media - 3** community readiness appropriate youth-prevention or POS paid media campaigns - pre-approved by ODH • **2** counter-marketing campaigns targeted at high-risk youth tobacco-users (see Appendix J for risk factors) with evidence of youth involvement in campaign development • **1** campaign targeted at POS target policy change	X	X	X	28. Qualitative results of paid media 29. Verification of campaign implementation	28. Evaluation reports from grantee conducted evaluations 29. Receipts, screenshots, etc.	28.Q1, Q2, Q3, Q4 29.Q1, Q2, Q3, Q4

4 (C)	**Increase community readiness of community organizations and services provider to address tobacco dependence and increase individual readiness of tobacco users to quit.**						
A	**Document availability of community cessation services and increase provider service capacity** to treat no less than X% (based on CR) of all smokers in the community. (ODH will provide estimated number of smokers in each county)	5%	10%	15%	30. # patient appointments available	30. Stakeholder survey; Grantee report	30. Q1, Q4
B	**Conduct Ongoing Community Readiness Activities** – meet with community members, organization, healthcare workers and decision makers to increase community readiness. Outcomes must include at least the following: • At least XX (to be filled in by funded entity using requirements provided by ODH in RFP, based on need and county size) **<u>new</u>** community partnerships will be established to support and promote tobacco cessation services in the community as evidenced by the submission of letters of commitment and engagement in at least two (M) and three (H) program activities. • At least XX (to be filled in by funded entity using requirements provided by ODH in RFP) people will attend tobacco cessation-related training (using ODH list of topics), offered by funded agency.	5 letters, 0 activities # people trained on four topics	4 letters, 2 activities # people trained on three topics	3 letters, 3 activities # people trained on two topics	31. # of partners 32. # of partners engaged in activities 33. # trainings provided 34. # people trained 35. # of refer sources	31. Letters of Commitment 32. Activity Logs 33. Training agendas 34. Sign-in sheets 35. Stakeholder survey	31. Q1, Q2, Q3, Q4 32. Q1, Q2, Q3, Q4 33. Q1, Q2, Q3, Q4 34. Q1, Q2, Q3, Q4 35. Q1, Q4

*C	**Increase Utilization of Cessation Services** • Increase awareness of services and increase enrollments through the Ohio Tobacco Quit Line by X% above July, 2019 baseline, with special focus on pregnancy protocol • Increase utilization of tobacco cessation services in the funded county by XX% from baseline.	2% 2%	7% 7%	10% 10%	36. # referrals 37. # enrollments and pregnancy protocol enrollments 38. # of patient appointments completed	36. Quit Line Data 37. Quit Line Data 38. Stakeholder Survey	36. Q2, Q4 37. Q2, Q4 38. Q1, Q4
D	**Facilitate individual readiness to quit -** Develop, plan (L) and initiate (M,H) effort to increase individual tobacco users readiness to quit by recruiting (L) and training cohort (M,H) of former tobacco users to participate (H) in mentoring/sponsorship program.	Develop Plan, form cohort	Train cohort	Implement	39. # contracts made with former tobacco users 40. # in cohort 41. #trainings/#trained 42. #program participants 43. # meetings 44. # quit attempts 45. # of participants quit at three months	39. Program reports 40. Program reports 41. Training Sign-ins 42. Program reports 43. Stipends offered 44. Program reports 45. Program reports	Q2, Q4

5 (S)	**Create evidence of Sustainability for Tobacco Control Efforts**						
A	**Integrate Tobacco Objectives into Community Strategic Plans –** Identify community strategic plans, identify whether tobacco is a priority objective, work to have tobacco included in required number of plans	2	1	0	30. # and type of tobacco objectives included in community strategic plans	30. Published plan or letter of commitment stating will be in next published plan	36. Q2, Q4
B	**Improve Prevention Sustainability** – obtain commitment from community to provide resources to sustain policy efforts. Potential targets must be pre-approved by ODH.	0	>$1,000 in monetary or in-kind	>$5,000 in monetary or in-kind	31. # and type of sustainability options 32. #Sustainability options committed 33. # sustainability options obtained	31. Deliverable Documents 32. Deliverable Documents 33. Evidence of resources	37. Q2, Q4
C	**Improve Youth Sustainability –** obtain commitment from community to provide resources to sustain youth efforts. Potential targets must be pre-approved by ODH.	0	>$1,000 in monetary or in-kind	>$5,000 in monetary or in-kind	34. # and type of sustainability options 35. #Sustainability options committed 36. # sustainability options obtained	34. Deliverable Documents 35. Deliverable Documents 36. Evidence of resources	38.
D	**Improve Cessation Sustainability** - obtain commitment from community to provide resources to sustain cessation efforts. Potential targets must be pre-approved by ODH.	0	>$1,000 in monetary or in-kind	>$5,000 in monetary or in-kind	37. # and type of sustainability options 38. #Sustainability options committed 39. # sustainability options obtained	37. Deliverable Documents 38. Deliverable Documents 39. Deliverable Documents	39.Q1, Q4
6 CR	**Readiness Assessment (Increase Avg. CR score by 0.5-2 points)**	X	X	X	40. Change in readiness score	40. Post-grant assessment	40.Q4

Appendix F: Guidance on Conducting Brief Community Readiness Assessments During the Application Period

Deliverable: Use the Brief Community Readiness Assessment to Develop Your Application

The Community Readiness Model measures the degree to which a community is willing and prepared to take action on an issue. ODH identified three issues on which to assess the community's readiness for change:

1. Accessibility and Availability of Tobacco to Youth
2. Adult Tobacco Use related to Low Availability and Utilization of Cessation Services
3. Exposure to Secondhand Smoke

In order to write your application, you must assess the community's readiness for change in each of these three issues in identified municipality. Municipality is defined as a geographic area with a governing body capable of passing ordinances or regulations for that area. The brief assessment measures the community's readiness levels on several dimensions that can help diagnose where initial efforts should be directed. Sector leaders will serve as proxies for the community-at-large's attitudes, behaviors, and knowledge towards these three issues. The brief assessment during the application period will be conducted using SurveyMonkey after sector leaders are identified by the applicant. The brief assessment will be conducted for each of the three issues during one survey. You will want to select at least one leader from each sector identified below that will be able to objectively represent the community's readiness for each of the three issues. You may add additional leaders or sectors.

Table 1:

Sector	Role
Education	Superintendent, Principal, College/University Administrators, Preschool Educator, Head Start Representative; Parents or PTA leaders
Law Enforcement	Prosecutor, Police Officer
Business	Grocery Store Manager, Convenience Store Manager, Chamber of Commerce Member
Government	Mayor, Parks & Recreation Director, City Council Member, Librarian
Health/Medical Professional	Clinical Care Provider/Physician, Hospital Administrator, Board of Health Member, Mental Health Service Provider, Board of Developmental Disability Member
Housing	Multiunit Housing Administrator
Involved Citizen	Coalition Leader, Rotary Club President, Non-governmental Agency Employee, Youth Leaders, Non-profit Directors
Faith-Based	Preacher, Rabbi, Priest
Civic Associations	YMCA Director, Service Organization Members, Youth Group Leaders
Media	Radio Hosts, Newspaper Editors, News Producers
Community Organizations	Big Brothers/Big Sisters; Lung Association; LGBT organizations; Heart Association; Cancer Society

ODH will provide you with a link specific to your application. You will want to approach your sector leaders early in the application process so that you have time to collect, analyze, and interpret the responses to your brief assessment. You will want to select sector leaders for each issue that will have some knowledge of the community's attitudes, knowledge, and beliefs about each issue. Some sector leaders may overlap between issues, but you may find that most won't. For example, when interviewing sector leaders about adult tobacco use, you may choose leaders from Health/Medical Profession, Involved Citizen, Government, and Business sectors; when interviewing sector leaders about availability and accessibility of tobacco to youth, you may choose leaders from Civic Association, Education, Involved Citizen, and Law Enforcement sectors. Once the sector leaders complete the brief assessment using the link you provide them, ODH will send you an export of your data from the SurveyMonkey platform. It is the grantee's responsibility to make sure the sector leaders complete the brief assessment and inform the ODH staff member that you are ready for your data extract. You will then calculate an average score for each dimension and each issue. An overall average score will be calculated to determine your community's level of readiness.

Here's an example of how to calculate your issue score for one municipality:

Table 2:

Issue 1: Accessibility and Availability of Tobacco to Youth					
	Dimension 1: Community Knowledge of Efforts	Dimension 2: Leadership	Dimension 3: Community Climate	Dimension 4: Community Knowledge of the Issue	Dimension 5: Resources
Sector 1	5	2	6	7	3
Sector 2	3	1	5	6	4
Sector 3	4	4	3	8	2
Sector 4	7	5	5	5	1
Sector 5	8	3	7	7	4
Average by Dimension	5.4	3	5.2	6.6	2.8
Issue Score	**4.6**				

Based on the issue score, you would select the level of readiness in which you would fall for that issue. For Issue 1, you would fall into the Medium Level of Community Readiness. The level of community readiness for each issue determines which deliverables and activities you will conduct. If you have a score of 4.6 for Issue 1, you would complete the Medium Level of Community Readiness deliverables for Accessibility and Availability of Tobacco to Youth. The table below shows what scores are associated with each level of readiness.

Table 3:

Level of Readiness	Range of Scores
Low Community Readiness	1.0-3.66
Medium Community Readiness	3.67-6.9
High Community Readiness	7.0-9.0

Your overall score and the population within your county determines the level of funding you can apply for.

Overall Score:

Table 4:

	Municipality 1	Municipality 2
Issue 1 Score	4.6	4.0
Issue 2 Score	6.2	3.5
Issue 3 Score	2.8	7.0
Municipality Scores	4.5	4.8
Overall Score	4.65	

Appendix G: Guidance on Conducting an Expanded Community Readiness Assessment

Deliverable: Complete expanded community assessment

During the application period, you will conduct expanded community assessments. The purpose of these expanded community assessments is to reveal qualitative data that will assist you in identifying priorities to address with initial efforts. At the end of the brief assessment, a question will ask participants if they are willing to participate in an interview as a follow up to the survey. Based on sectors leaders that are interested, you will select at least two leaders per issue to conduct expanded community readiness assessments. It is suggested that you conduct key informant interviews with decision makers related to each priority issue. If none of these individuals are interested in participating in the interview or if you feel you need different individuals, you will have to identify those new individuals, quickly. You will want to select decision makers for each issue that will have some knowledge of the community's attitudes, knowledge, and beliefs about each issue. Some decision makers may overlap between issues, but you may find that most won't. For example, when interviewing decision makers about adult tobacco use, you may choose leaders from Health/Medical Profession, Involved Citizen, Government, and Business sectors; when interviewing decision makers about availability and accessibility of tobacco to youth, you may choose leaders from Civic Association, Education, Involved Citizen, and Law Enforcement sectors; when interviewing decision makers about exposure to secondhand smoke, you may choose leaders from Law Enforcement, Government, Education, and Housing sectors.

Expanded community readiness assessments will be conducted as interviews and ODH will provide a list of required questions to use (see below for questions to use for each priority issue). You are welcome to add more with approval from ODH staff. Results from your expanded community readiness assessment should help you identify where gaps in knowledge among the community exist, what resources exist for addressing the issues, leaderships' efforts towards improving the issues, etc. The idea is that the data collected during these expanded community assessments will help you expand your work plan and allow you to think more critically about what activities will help you accomplish the goals and objectives outlined in your expanded work plan, and ultimately move your community to a higher level of readiness to address these issues.

Tips for conducting community readiness interviews (Community Readiness for Community Change Handbook):

When conducting the community readiness interviews, please keep in mind the following:

- It is often best to do these by telephone, when feasible.

When interviews are done in person, there can be a greater tendency of respondents to answer questions in a manner that will be viewed favorably by the interviewer. In addition, when interviews are done in person, there may be a greater likelihood for the interviewer to react verbally or with body language. On the other hand, interviewees may provide less information when on the telephone than when in person; therefore, it is incumbent on the interviewer to probe (using the suggestions in the interview guide) if answers are not informative.

However, keep in mind that in some populations, face-to-face interviews may be the only or the best option. If that is the case, it is important that the interviewer remain objective and unbiased during the interview.

• In order to get an accurate representation of what the interviewee said, **ask the respondent for permission to record the interview.** Make sure you have your recording equipment working and ready to go.

• Each interview takes 20 - 60 minutes.

• Set up an appointment beforehand, giving the respondent some information about the project.

• Do not send the community readiness questions to the interviewee, as they may then do research and prepare their answers.

• Interviewers should be familiar with the rating scales and understand the scoring process. This will help the interviewer know when to re-phrase questions or ask for more information.

During the interview:

• The interviewer should prompt for more detail but should **never** give their opinion. Examples of prompts include:

—*Could you please give me an example?*‖
—*Could you tell me more about what you just said?*‖
—*Could you please tell me what ABC means?*‖

• The interviewer should keep the respondent on track, and ensure that the respondent actually answers the question.

• Do not rephrase the interviewee's answer to validate your understanding of what was said.

For example, do **not** say something like: *Are you saying that the community doesn't really believe that this is an issue and therefore they are not acting to stop it?*

• Practice with another person prior to your first interview.

You may want to transcribe the interviews, tips for transcribing the interviews:

Once an interview is conducted, it should be transcribed. Give each transcriber a copy of the interview questions to make their job easier. The transcriber should transcribe the interviewee's responses word for word, including such things as laughter. Voice recognition software does not typically work well for these interviews.

A free transcription software package can be found at: http://www.nch.com.au/scribe/index.html. This software allows the transcriber to slow the recording down so it is easier to hear and to keep pace with, besides making it easier to rewind, fast forward, and do other common transcribing tasks. Transcribers often find that a foot pedal (e.g., Infinity USB Digital Foot Control) can make transcribing easier.

Next steps:

You will now be able to use the qualitative details from these interviews to expand on your work plan. You should be able to identify priorities to work on based on this information.

Key Informant Interview Questions

Key Informant Interview Questions for Youth

Thank you for agreeing to participate in this interview. It's an important part of helping us to determine the focus of our efforts in a grant being offered by the Ohio Department of Health to address tobacco control in our community. Through these interviews we are trying to assess the community readiness of our community to address a number of different types of tobacco control. There are different types of activities that we would conduct based on the level of community readiness, so it's essential for us to get an accurate idea of where our community stands. Funding does not depend on our level of community readiness, but on how well we improve our community readiness.

Availability and accessibility of tobacco to youth encompasses how tobacco is marketed to youth in your community and how available tobacco is to youth. This includes such things as how easy is it for youth to use tobacco (presence of enforceable policies in areas where they live work and play) as well as how tobacco is targeted with marketing in retail environments and how easy it is for them to buy tobacco despite laws that prohibit the sale of tobacco products to youth.

1. What is your gender?
2. What is your work title?
3. What is your Race/ethnicity?
4. What age range do you fall in?
    a. 18-25
    b. 26-34
    c. 35-43
    d. 44-52
    e. 53-60
    f. 60+
5. Do you live in [community]? If no, which community?
6. How long have you lived in your community?
7. Do you work in [community]? If no, which community?
8. For the following question, please answer keeping in mind your perspective of what community members believe and not what you personally believe.

    On a scale from 1-10, how much of a concern is accessibility and availability of tobacco to youth to members of [community] with 1 being "not a concern at all" and 10 being "a very great concern"?

Can you tell me why you think it's at that level?

*Interviewer: Please ensure that the respondent answers this question in regard to **community members** not in regard to themselves or what they think it should be.*

I'm going to ask you about current community efforts to address accessibility and availability of tobacco to youth. By efforts, I mean programs, activities, or services in your community that address accessibility and availability of tobacco to youth.

9. Are there efforts in [community] that address accessibility and availability of tobacco to youth?

   If yes, can you describe these?

   If no, is anyone in [community] trying to get something started to address accessibility and availability of tobacco to youth? Can you tell me about that?

10. About how many community members are aware of each of the following aspects of the efforts- none, a few, some, many, or most?

	None, A Few, Some, Many, or Most?
Have heard of efforts?	
Can name efforts?	
Know the purpose of efforts?	
Know who the efforts are for?	
Know how the efforts work (e.g. activities or how they're implemented)?	
Know the effectiveness of the efforts?	

11. Thinking back to your answers, why do you think members of your community have this amount of knowledge?

12. Are there misconceptions or incorrect information among community members about the current efforts?

    If yes, what are these?

13. How do community members learn about the current efforts?

14. What are the obstacles to individuals participating in these efforts?

I'm going to ask you how the leadership in [community] perceives accessibility and availability of tobacco to youth. By leadership, we are referring to those who could affect the outcome of this issue and those who have influence in the community and/or who lead the community in helping it achieve its goals.

15. Using a scale from 1-10, how much of a concern is accessibility and availability of tobacco to youth to the leadership of [community], with 1 being "not a concern at all" and 10 being "a very great concern"?

    Can you tell me why it's a____?

16. How much of a priority is addressing accessibility and availability of tobacco to youth to leadership?

    Can you explain why this is?

17. I'm going to read a list of ways that leadership might show its support or lack of support for efforts to address accessibility and availability of tobacco to youth?

    Can you please tell me whether none, a few, some, many, or most leaders would or do show support in this way? Also, feel free to explain your responses as we move through this list.

    How many leaders…

	None, A Few, Some, Many, or Most?
At least passively support efforts without necessarily being active in that support?	
Explanation:	
Participate in developing, improving, or implementing efforts, for example by being a	

member of a group that is working toward these efforts?	
Explanation:	
Support allocating resources to fund community efforts?	
Explanation:	
Play a key role as a leader or driving force in planning, developing, or implementing efforts? How do they do that?	
Explanation:	
Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?	
Explanation:	

18. Does the leadership support **expanded** efforts in the community to address accessibility and availability of tobacco to youth?

    If yes, how do they show this support? For example, by passively supporting, by being involved in developing the efforts, or by being a driving force or key player in achieving these expanded efforts?

COMMUNITY CLIMATE

For the following questions, again please answer keeping in mind your perspective of what community members believe and not what you personally believe.

19. How much of a priority is addressing accessibility and availability of tobacco to youth to community members?

    Can you explain your answer?

20. I'm going to read a list of ways that community members might show their support or their lack of support for community efforts to address accessibility and availability of tobacco to youth.

    Can you please tell me whether none, a few, some, many, or most community members would or do show their support in this way? Also, feel free to explain your responses as we move through the list.

    How many community members…

	None, A Few, Some, Many, or Most?
Al least passively support community efforts without being active in that support?	
Explanation:	
Participate in developing, improving, or implementing efforts, for example by attending group meetings that are working towards these efforts?	
Explanation:	
Play a key role as a leader or driving force in planning, developing, or implementing efforts? How do they do that?	
Explanation:	
Are willing to pay more or devote resources (for example, in taxes, in-kind resources, or time) to help fund community efforts?	
Explanation:	

21. About how many community members would support expanding efforts in the community to address accessibility and availability of tobacco to youth? Would you say none, a few, some, many, or most?

    If more than none:

    How might they show this support? For example, by passively supporting or by being actively involved in developing the efforts?

22. Are there community members who oppose or might oppose addressing accessibility and availability of tobacco to youth? How do or will they show their opposition?

KNOWLEDGE ABOUT THE ISSUE

23. On a scale from 1 to 10 where 1 is no knowledge and a 10 is detailed knowledge, how much do community members know about accessibility and availability of tobacco to youth?

    Why do you say it's a___?

24. Would you say that community members know nothing, a little, some, or a lot about each of the following as they pertain to accessibility and availability of tobacco to youth?

	Nothing, A Little, Some, or A Lot?
Accessibility and availability of tobacco to youth, in general	
The frequency and type of tobacco use by youth	
The health consequences of tobacco use by youth	
How accessible and available tobacco is to youth in [community]	
What can be done to prevent tobacco use by youth	
The effects of tobacco use by youth on family and friends	
The frequency and type of marketing towards youth from tobacco companies	

25. What are the misconceptions among community members about accessibility and availability of tobacco to youth, for example, why it occurs, how much it occurs locally, or what the consequences are?

26. What type of information is available in [community] about accessibility and availability of tobacco to youth (e.g. newspaper articles, brochures, posters)?

    If they list information, ask: Do community members access and/or use this information?

27. Are there current efforts to address accessibility and availability of tobacco to youth locally?

If yes, how are the current efforts funded?

Is this funding likely to continue into the future?

28. I'm now going to read you a list of resources that could be used to address accessibility and availability of tobacco to youth in your community. For each of these, please indicate whether there is none, a little, some, or a lot of resources available in your community that could be used to address accessibility and availability of tobacco to youth?

	None, A Little, Some, or A Lot?
Volunteers?	
Financial donations from organization and/or businesses?	
In-kind donations?	
Grant funding?	
Experts?	
Space?	
Champions?	

29. Would community members and leadership support using these resources to address accessibility and availability of tobacco to youth? Please explain.

30. On a scale of 1 to 5, where 1 is no effort and 5 is a great effort, how much effort are community members and/or leadership putting into doing each of the following things to increase the resources going toward addressing accessibility and availability of tobacco to youth in your community?

	Score from 1 (no effort) to 5 (great effort)?
Seeking volunteers for current or future efforts to address accessibility and availability of tobacco to youth in the community	
Soliciting donations from businesses or other organizations to fund current or expanded community efforts	
Writing grant proposals to obtain funding to address accessibility and availability of tobacco to youth in the community	
Training community members to become experts	
Recruiting experts from the community	

Increase awareness of availability and accessibility of tobacco to youth in [community]	

31. Are you aware of any proposals or action plans that have been submitted for funding to address accessibility and availability of tobacco to youth in [community]?

    If yes, please explain.

32. Is there a need to expand policies, practices, and laws relating to accessibility and availability of tobacco to youth? If so, are there plans to expand them? Please explain.

33. How does the community view these policies, practices, and laws?

Key Informant Interview Questions for Policy

Thank you for agreeing to participate in this interview. It's an important part of helping us to determine the focus of our efforts in a grant being offered by the Ohio Department of Health to address tobacco control in our community. Through these interviews we are trying to assess the community readiness of our community to address a number of different types of tobacco control. There are different types of activities that we would conduct based on the level of community readiness, so it's essential for us to get an accurate idea of where our community stands. Funding does not depend on our level of community readiness, but on how well we improve our community readiness.

1. What is your gender?

2. What is your work title?

3. What is your Race/ethnicity?

4. What age range do you fall in?
    a. 18-25
    b. 26-34
    c. 35-43
    d. 44-52
    e. 53-60
    f. 60+

5. Do you live in [community]? If no, which community?

6. How long have you lived in your community?

7. Do you work in [community]? If no, which community?

8. For the following question, please answer keeping in mind your perspective of what community members believe and not what you personally believe.

    On a scale from 1-10, how much of a concern is exposure to secondhand smoke to members of [community] with 1 being "not a concern at all" and 10 being "a very great concern"?

    Can you tell me why you think it's at that level?

    *Interviewer: Please ensure that the respondent answers this question in regard to **community members** not in regard to themselves or what they think it should be.*

I'm going to ask you about current community efforts to address exposure to secondhand smoke. By efforts, I mean programs, activities, or services in your community that address exposure to secondhand smoke.

9. Are there efforts in [community] that address exposure to secondhand smoke?

   If yes, can you describe these?

   If no, is anyone in [community] trying to get something started to address exposure to secondhand smoke? Can you tell me about that?

10. About how many community members are aware of each of the following aspects of the efforts- none, a few, some, many, or most?

	None, A Few, Some, Many, or Most?
Have heard of efforts?	
Can name efforts?	
Know the purpose of efforts?	
Know who the efforts are for?	
Know how the efforts work (e.g. activities or how they're implemented)?	
Know the effectiveness of the efforts?	

11. Thinking back to your answers, why do you think members of your community have this amount of knowledge?

12. Are there misconceptions or incorrect information among community members about the current efforts?

    If yes, what are these?

13. How do community members learn about the current efforts?

14. What are the obstacles to individuals participating in these efforts?

I'm going to ask you how the leadership in [community] perceives exposure to secondhand smoke. By leadership, we are referring to those who could affect the outcome of this issue and those who have influence in the community and/or who lead the community in helping it achieve its goals.

15. Using a scale from 1-10, how much of a concern is exposure to secondhand smoke to the leadership of [community], with 1 being “not a concern at all” and 10 being “a very great concern”?

    Can you tell me why it’s a____?

16. How much of a priority is addressing exposure to secondhand smoke to leadership?

    Can you explain why this is?

17. I’m going to read a list of ways that leadership might show its support or lack of support for efforts to address exposure to secondhand smoke?

    Can you please tell me whether none, a few, some, many, or most leaders would or do show support in this way? Also, feel free to explain your responses as we move through this list.

    How many leaders…

	None, A Few, Some, Many, or Most?
At least passively support efforts without necessarily being active in that support?	
Explanation:	
Participate in developing, improving, or implementing efforts, for example by being a member of a group that is working toward these efforts?	
Explanation:	
Support allocating resources to fund community efforts?	
Explanation:	

Play a key role as a leader or driving force in planning, developing, or implementing efforts? How do they do that?	
Explanation:	
Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?	
Explanation:	

18. Does the leadership support **expanded** efforts in the community to address exposure to secondhand smoke?

    If yes, how do they show this support? For example, by passively supporting, by being involved in developing the efforts, or by being a driving force or key player in achieving these expanded efforts?

For the following questions, again please answer keeping in mind your perspective of what community members believe and not what you personally believe.

19. How much of a priority is addressing exposure to secondhand smoke to community members?

    Can you explain your answer?

20. I'm going to read a list of ways that community members might show their support or their lack of support for community efforts to address exposure to secondhand smoke.

    Can you please tell me whether none, a few, some, many, or most community members would or do show their support in this way? Also, feel free to explain your responses as we move through the list.

    How many community members…

	None, A Few, Some, Many, or Most?
Al least passively support community efforts without being active in that support?	

Explanation:	
Participate in developing, improving, or implementing efforts, for example by attending group meetings that are working towards these efforts?	
Explanation:	
Play a key role as a leader or driving force in planning, developing, or implementing efforts? How do they do that?	
Explanation:	
Are willing to pay more or devote resources (for example, in taxes, in-kind resources, or time) to help fund community efforts?	
Explanation:	

21. About how many community members would support expanding efforts in the community to address exposure to secondhand smoke? Would you say none, a few, some, many, or most?

    If more than none:

    How might they show this support? For example, by passively supporting or by being actively involved in developing the efforts?

22. Are there community members who oppose or might oppose addressing exposure to secondhand smoke? How do or will they show their opposition?

23. On a scale from 1 to 10 where 1 is no knowledge and a 10 is detailed knowledge, how much do community members know about exposure to secondhand smoke?

    Why do you say it's a___?

24. Would you say that community members know nothing, a little, some, or a lot about each of the following as they pertain to exposure to secondhand smoke?

	Nothing, A Little, Some, or A Lot?
Exposure to secondhand smoke, in general	
The signs and symptoms of exposure to secondhand smoke	
Common areas where people are exposed to secondhand smoke	
The health consequences of exposure to secondhand smoke	
The cost to the community of exposure to secondhand smoke	
How much exposure to secondhand smoke occurs locally	
What can be done to prevent exposure to secondhand smoke	
The health consequences of exposure to secondhand smoke on family and friends	

25. What are the misconceptions among community members about exposure to secondhand smoke, for example, why it occurs, how much it occurs locally, or what the consequences are?

26. What type of information is available in [community] about exposure to secondhand smoke (e.g. newspaper articles, brochures, posters)?

    If they list information, ask: Do community members access and/or use this information?

<u>RESOURCES FOR EFFORTS</u> (time, money, people, space, etc.)

27. Are there current efforts to address exposure to secondhand smoke locally?

    If yes, how are the current efforts funded?

    Is this funding likely to continue into the future?

28. I'm now going to read you a list of resources that could be used to address exposure to secondhand smoke in your community. For each of these, please indicate whether there is none, a little, some, or a lot of resources available in your community that could be used to address exposure to secondhand smoke?

	None, A Little, Some, or A Lot?
Volunteers?	
Financial donations from organization and/or businesses?	
In-kind donations?	
Grant funding?	
Experts?	
Space?	
Champions?	

29. Would community members and leadership support using these resources to address preventing exposure to secondhand smoke? Please explain.

30. On a scale of 1 to 5, where 1 is no effort and 5 is a great effort, how much effort are community members and/or leadership putting into doing each of the following things to increase the resources going toward addressing prevention of exposure to secondhand smoke in your community?

	Score from 1 (no effort) to 5 (great effort)?
Seeking volunteers for current or future efforts to address exposure to secondhand smoke in the community	
Soliciting donations from businesses or other organizations to fund current or expanded community efforts	
Writing grant proposals to obtain funding to address exposure to secondhand smoke in the community	
Training community members to become experts	
Recruiting experts from the community	
Increase awareness of exposure to secondhand smoke in [community]	

31. Are you aware of any proposals or action plans that have been submitted for funding to address exposure to secondhand smoke in [community]?

    If yes, please explain.

<u>POLICY-RELATED QUESTIONS</u>

32. What formal policies, practices, and laws related to this issue are in place in your community? (*Prompt:* An example of a "formal" would be established policies of schools, police, or courts.)

33. Is there a need to expand policies, practices, and laws relating to exposure to secondhand smoke? If so, are there plans to expand them? Please explain.

34. How does the community view these policies, practices, and laws?

Key Informant Interview Questions for Cessation

Thank you for agreeing to participate in this interview. It's an important part of helping us to determine the focus of our efforts in a grant being offered by the Ohio Department of Health to address tobacco control in our community. Through these interviews we are trying to assess the community readiness of our community to address a number of different types of tobacco control. There are different types of activities that we would conduct based on the level of community readiness, so it's essential for us to get an accurate idea of where our community stands. Funding does not depend on our level of community readiness, but on how well we improve our community readiness.

1. What is your gender?

2. What is your work title?

3. What is your Race/ethnicity?

4. What age range do you fall in?
    a. 18-25
    b. 26-34
    c. 35-43
    d. 44-52
    e. 53-60
    f. 60+

5. Do you live in [community]? If no, which community?

6. How long have you lived in your community?

7. Do you work in [community]? If no, which community?

8. For the following question, please answer keeping in mind your perspective of what community members believe and not what you personally believe.

    On a scale from 1-10, how much of a concern is utilization of cessation services to members of [community] with 1 being "not a concern at all" and 10 being "a very great concern"?

    Can you tell me why you think it's at that level?

    *Interviewer: Please ensure that the respondent answers this question in regard to **community members** not in regard to themselves or what they think it should be.*

I'm going to ask you about current community efforts to address utilization of cessation services. By efforts, I mean programs, activities, or services in your community that address utilization of cessation services.

9. Are there efforts in [community] that address utilization of cessation services?

   If yes, can you describe these?

   If no, is anyone in [community] trying to get something started to address utilization of cessation services? Can you tell me about that?

10. Who do each of these efforts serve (e.g. a certain age group, ethnicity, etc.)?

11. About how many community members are aware of each of the following aspects of the efforts- none, a few, some, many, or most?

	None, A Few, Some, Many, or Most?
Have heard of efforts?	
Can name efforts?	
Know the purpose of efforts?	
Know who the efforts are for?	
Know how the efforts work (e.g. activities or how they're implemented)?	
Know the effectiveness of the efforts?	

12. Thinking back to your answers, why do you think members of your community have this amount of knowledge?

13. Are there misconceptions or incorrect information among community members about the current efforts?

    If yes, what are these?

14. How do community members learn about the current efforts?

15. What are the obstacles to individuals participating in these efforts?

I'm going to ask you how the leadership in [community] perceives utilization of cessation services. By leadership, we are referring to those who could affect the outcome of this issue and those who have influence in the community and/or who lead the community in helping it achieve its goals.

16. Using a scale from 1-10, how much of a concern is utilization of cessation services to the leadership of [community], with 1 being "not a concern at all" and 10 being "a very great concern"?

    Can you tell me why it's a____?

17. How much of a priority is addressing utilization of cessation services to leadership?

    Can you explain why this is?

18. I'm going to read a list of ways that leadership might show its support or lack of support for efforts to address utilization of cessation services?

    Can you please tell me whether none, a few, some, many, or most leaders would or do show support in this way? Also, feel free to explain your responses as we move through this list.

    How many leaders…

	None, A Few, Some, Many, or Most?
At least passively support efforts without necessarily being active in that support?	
Explanation:	
Participate in developing, improving, or implementing efforts, for example by being a member of a group that is working toward these efforts?	
Explanation:	
Support allocating resources to fund community efforts?	
Explanation:	

Play a key role as a leader or driving force in planning, developing, or implementing efforts? How do they do that?	
Explanation:	
Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?	
Explanation:	

19. Does the leadership support **expanded** efforts in the community to address utilization of cessation services?

    If yes, how do they show this support? For example, by passively supporting, by being involved in developing the efforts, or by being a driving force or key player in achieving these expanded efforts?

For the following questions, again please answer keeping in mind your perspective of what community members believe and not what you personally believe.

20. How much of a priority is addressing utilization of cessation services to community members?

    Can you explain your answer?

21. I'm going to read a list of ways that community members might show their support or their lack of support for community efforts to address utilization of cessation services.

    Can you please tell me whether none, a few, some, many, or most community members would or do show their support in this way? Also, feel free to explain your responses as we move through the list.

    How many community members…

	None, A Few, Some, Many, or Most?
Al least passively support community efforts without being active in that support?	
Explanation:	
Participate in developing, improving, or implementing efforts, for example by attending group meetings that are working towards these efforts?	
Explanation:	
Play a key role as a leader or driving force in planning, developing, or implementing efforts? How do they do that?	
Explanation:	
Are willing to pay more (for example, in taxes) to help fund community efforts?	
Explanation:	

22. About how many community members would support expanding efforts in the community to address utilization of cessation services? Would you say none, a few, some, many, or most?

    If more than none:

    How might they show this support? For example, by passively supporting or by being actively involved in developing the efforts?

23. Are there community members who oppose or might oppose addressing utilization of cessation services? How do or will they show their opposition?

24. On a scale from 1 to 10 where 1 is no knowledge and a 10 is detailed knowledge, how much do community members know about utilization of cessation services?

    Why do you say it's a____?

25. Would you say that community members know nothing, a little, some, or a lot about each of the following as they pertain to utilization of cessation services?

	Nothing, A Little, Some, or A Lot?
Utilization of cessation services, in general	
The frequency and type of tobacco use in [community]	
The health consequences of tobacco use	
How much utilization of cessation services occurs locally	
What can be done to prevent tobacco use	
The cost of tobacco use to the community (direct and indirect costs)	

26. What are the misconceptions among community members about utilization of cessation services, for example, why it occurs, how much it occurs locally, or what the consequences are?

27. What type of information is available in [community] about utilization of cessation services (e.g. newspaper articles, brochures, posters)?

    If they list information, ask: Do community members access and/or use this information?

28. Are there current efforts to address utilization of cessation services locally?

    If yes, how are the current efforts funded?

    Is this funding likely to continue into the future?

29. I'm now going to read you a list of resources that could be used to address utilization of cessation services in your community. For each of these, please indicate whether there is none, a little, some, or a lot of resources available in your community that could be used to address utilization of cessation services?

	None, A Little, Some, or A Lot?
Volunteers?	
Financial donations from organization and/or businesses?	
In-kind donations?	

Grant funding?	
Experts?	
Space?	
Champions?	

30. Would community members and leadership support using these resources to address utilization of cessation services? Please explain.

31. On a scale of 1 to 5, where 1 is no effort and 5 is a great effort, how much effort are community members and/or leadership putting into doing each of the following things to increase the resources going toward addressing utilization of cessation services in your community?

	Score from 1 (no effort) to 5 (great effort)?
Seeking volunteers for current or future efforts to address utilization of cessation services in the community	
Soliciting donations from businesses or other organizations to fund current or expanded community efforts	
Writing grant proposals to obtain funding to address utilization of cessation services in the community	
Training community members to become experts	
Recruiting experts from the community	
Increase awareness of utilization of cessation services in [community]	

32. Are you aware of any proposals or action plans that have been submitted for funding to address utilization of cessation services in [community]?

    If yes, please explain.

Appendix H: Work Plan Template

(Deliverable Objectives=amounts that go into GMIS; Objectives=lettered and listed in Scope of Work table; Activities=lead to completion of an objective- work can be paid for at activity level, but must be defined in work plan)

2018-2019 Local Tobacco Grant Work Plan

Agency:_____ Jurisdiction Served: _____

Target Community: _____

Grant Initiative (create separate work plan for each initiative):

- ☐ **Cessation**
- ☐ **Prevention**

DO:					
Objective	**Activities toward achieving Objective**	**Person Responsible**	**Dates for Each Activity**		**Budgeted Amount**
			Start	**End**	
A					
Total Cost:					
B					
Total Cost:					
C					
Total Cost:					

EXAMPLE: 2019-2020 Local Tobacco Grant Work Plan

Agency: Healthy Ohio County Health Dept. **Jurisdiction Served: Healthy Ohio County_**

Target Community: Not So Healthy City

Grant Initiative (create separate work plan for each initiative):

___ Cessation
X Prevention

Choose appropriate % based on CR scores

DO:	Decrease the number of people exposed to secondhand smoke in public spaces or multi-unit housing by 8%				
Objective	**Activities toward achieving Objective**	**Person Responsible**	**Dates for Each Activity**		**Budgeted Amount**
			Start	**End**	
A - Conduct Community survey **Total Cost: $1200**	1. Determine sampling method 2. Print or set up electronic survey 3. Conduct survey 4. Analyze results 5. Produce report which indicates how data will be used	Jane Seymore	7/1 7/5 7/15 8/15 8/25	7/5 7/15 8/15 8/25 8/31	1. $0 2. $500 3. $0 4. $500 5. $200
____ other objectives **Total Cost:**					
D – Identify Policy Targets **Total Cost: $1,300**	1. Identify decision makers, stakeholders, member of the targeted population and a champion for the disparate population 2. Using CR and other collected data develop a presentation about the community's readiness and the impact of policy on tobacco use in Not So Healthy City. 3. Hold a meeting and present; discuss potential policy options 4. As a group, choose policy targets	Joe Marlboro	9/1 8/1 10/1 10/1	9/30 8/21 10/1 10/31	1. $100 2. $700 3. $500 4. $0

All paid in first quarter, so could leave as one lump sum under total cost

You figure out what your activities are….

Dividing the cost up by activities, here, let's you bill part of your work in Q1 and part of it in Q2

Be sure to stick to appropriate timeframes as provided by ODH

Appendix I. Ohio Data on Tobacco-Related Disparities and County Characteristics

Tobacco use and health data highlight the need for ongoing efforts to address tobacco-related disparities in Ohio. Tobacco surveillance data show that the populations at the highest risk for smoking in Ohio include residents that are socioeconomically disadvantaged, those with disabilities and/or mental health challenges, African American Ohioans, and those that identify as LGBT. Pregnant women are also a population of special concern due to tobacco-related health impacts.

Data presented in this Appendix focus on tobacco use, tobacco-related morbidity and mortality, and vulnerability to adverse tobacco-related health impacts. However, tobacco-related disparities and priority populations can also be defined and identified in additional ways, such as inequity related to differences in health systems and access to cessation services, or differences in community policy, infrastructure, tobacco market environment, or secondhand smoke exposure.

- **Prevalence** is the rate of tobacco use and describes how much tobacco a group uses. In Ohio, people with low socioeconomic status and educational attainment, people with disabilities, people with mental health and/or substance abuse disorders, and people that identify as lesbian, gay, bisexual, or transgender (LGBT) use tobacco at much higher rates than the general population.
- **Morbidity and mortality** describe illness and death from tobacco use. In addition to being affected by the type and amount of tobacco use, morbidity and mortality are influenced by factors such as access to health care, quality of care, and population-specific risk factors. In Ohio, African American men have disproportionately high rates of mortality compared to white men for several tobacco-related conditions, including cancer, heart disease, and stroke.
- **Populations with increased vulnerability** to tobacco are often particularly impacted by smoking. In Ohio, pregnant women and infants have increased vulnerability because of linkages between maternal smoking and preterm delivery, stillbirth, fetal growth restriction, spontaneous abortion, and sudden infant death syndrome (SIDS).

The Ohio Department of Health (ODH) uses many different data sources to understand and respond to tobacco disparity issues. State-level data on Ohio disparities in current smoking prevalence from the 2016 Behavioral Risk Factor Surveillance System (BRFSS) are presented in Tables 1 and 2. Tables 3 through 11 present county and regional data on additional tobacco-related outcomes and risk factors, as well as basic demographic data, for each of Ohio's 88 counties. Finally, an example of tobacco market research data from Nielsen is provided in Table 12. Market research data provides tobacco use and expenditure information at lower levels of geography such as census tracts and census block groups, which may also aid in targeting local-level program interventions where they are needed the most.

Socioeconomic Status. Ohio tobacco surveillance data from the 2016 Behavioral Risk Factor Surveillance System (BRFSS) clearly show a strong inverse relationship between tobacco use and socioeconomic status (Table 1). The percentage of current cigarette smokers among Ohioans with an annual household income of <$15K is almost triple that seen among those with incomes of $50K or more (42.3% and 13.6%, respectively). Current cigarette smoking prevalence among those who did not graduate from high school (43.0%) is significantly higher than all other educational levels, and more than five times higher than the smoking prevalence among college graduates (7.1%).[1] Related to income and education, substantial disparities in smoking prevalence have also been observed among certain industry and occupational groups such as construction, mining, food preparation and

serving, and transportation.[2] The roles of poverty and education are also evident when looking at geographic patterns of tobacco use in Ohio (Table 2). Regional estimates of smoking prevalence show that many of the highest smoking rates in Ohio are in the state's Appalachian region (e.g., Regions 11 and 14 in Table 2), which is characterized by high poverty and unemployment.[3]

The high burden of smoking among women of childbearing age (18-44 years old) with low socioeconomic status is of particular concern in Ohio due to linkages between maternal smoking and adverse health outcomes for the fetus and infant – including causal associations between perinatal smoking and preterm delivery, stillbirth, fetal growth restriction, spontaneous abortion, and sudden infant death syndrome (SIDS).[4] At 7.4 per 1,000 live births in 2016, Ohio's infant mortality rate is among the worst in the nation; there are also significant disparities in infant mortality in Ohio, with the highest rates in the state occurring among African American babies (15.2 per 1,000 live births) and Ohio's metropolitan and Appalachian counties.[5] In 2016, 14.3 percent of women in Ohio reported smoking at some point during pregnancy.[6] Similar to the overall poverty-related patterns in smoking, perinatal smoking rates are higher in Ohio's Appalachian region and other economically distressed areas (Table 6).

Race/Ethnicity. Although 2016 BRFSS doesn't shows a significant difference between the rates of smoking in white (22.4) and black (23.5) Ohioans, black Ohioans are a population of concern due to disproportionate rates of health conditions associated with smoking. For example, in 2014, African Americans suffered at higher incidence rates than Whites for colon and rectum cancer, lung and bronchus cancer, and prostate cancer. The cancer mortality rate for blacks is 12% higher (197.4 per 100,000) than whites (176.5 per 100,000).[4,7] Additionally, black Ohioans died about twice the rate of white Ohioans from hypertensive heart disease (22.4 and 10.8, respectively) and atherosclerotic cardiovascular disease (23.0 and 14.7, respectively) in 2016. [8] Those who identify as multiracial may also have higher rates of tobacco use, although more data are needed to develop reliable estimates for racial minority groups with smaller populations. There may also be product-specific differences in tobacco use associated with race, such as higher use of smokeless tobacco among white as compared to African Americans.[9]

Disability, Sexual Orientation, and Mental Health. Some of the most pronounced disparities in adult smoking in Ohio are among people with disabilities, mental health challenges, and those who identify as lesbian, gay, bisexual, or transgender (LGBT) (Table 1). Current cigarette smoking prevalence among Ohioans with a disability[i] (29.6%) is significantly higher ($p<0.0001$) than those without a disability (20.6%) and about 3 out of every 5 Ohioans with a disability have been a smoker at some point in their lives (59.2%). The smoking prevalence rates among Ohioans with mental health issues[ii] (41.8%) and LGBT adults (36.8%) are both almost double the smoking rate seen in the general population (22.5%) (Table 1). People with disabilities, mental illnesses, and those that identify as LGBT are distinct communities of individuals who share unique cultures and collective lived experiences that cut across the boundaries of race, ethnicity, age, gender and income-level. Thus, people who find themselves at the intersection of identifying with one or more of the above factors may amplify the risk of smoking even further.

[i] Disability defined as being limited in any way in any activity because of a physical, mental, or emotional problem.
[ii] Mental health issues defined as frequent poor mental health (14 or more days per month), where self-reported mental health was "not good" in terms of stress, depression, or problems with emotions.

Priorities for Reducing Tobacco-Related Disparities in Ohio. Although no single characteristic fully explains an individual's risk for tobacco use or related health impacts, tobacco surveillance data show that the populations in Ohio at highest risk for smoking include residents that are socioeconomically disadvantaged, those with disabilities or mental health challenges, and those that identify as LGBT (Table 1). African American residents and pregnant women are also populations of special interest for intervention efforts in Ohio due to tobacco-related health consequences. These groups represent current priority populations for tobacco-related prevention and cessation interventions in Ohio. [1,6]

Possible factors that contribute to the tobacco-related disparities observed in these populations include: stress from stigma and discrimination related to economic determinants, education, race, homophobia, or disability; the tobacco industry's targeted product marketing to certain groups; and lower-quality health care in some populations due to inadequate access, lack of culturally appropriate tobacco treatment programs, and provider ignorance/bias. Perceived discrimination has been shown to play a role in unhealthy behaviors such cigarette smoking, substance use, improper nutrition, and refusal to seek medical services. In addition, perceived discrimination and stigma may place individuals at an increased risk for mental health disorders, which also contributes to higher rates of externalizing behaviors, such as alcohol, tobacco, and poly-substance use.[10]

Table 1. Current Cigarette Smoking Prevalence among Ohio Adults (18+ years), by Demographic Characteristic, 2016[1]

	Frequency (n)	Weighted Frequency	Smoking Prevalence (%)	95% Confidence Limits	
All Ohio Adults	2,169	1,963,455	22.5	21.3	23.8
Male	978	1,038,322	24.7	22.7	26.6
Female	1,191	925,133	20.5	18.9	22.1
Age 18 to 24	85	178,255	16.5	12.6	20.4
Age 25 to 34	287	454,957	32.0	28.1	35.9
Age 35 to 44	327	381,861	28.4	24.7	32.1
Age 45 to 54	432	368,101	24.9	22.1	27.8
Age 55 to 64	606	383,677	24.8	22.2	27.3
Age 65 or older	432	196,603	10.6	9.1	12.1
White - Non-Hispanic	1,841	1,574,979	22.4	21.1	23.8
Black - Non-Hispanic	179	235,901	23.5	19.3	27.7
Hispanic	30	54,636	22.3	13.7	30.9
Other race only, Non-Hispanic	44	24,214	11.4	5.3	17.5
Multiracial, Non-Hispanic	45	47,476	37.0	25.7	48.3
Less than $15,000	350	321,274	42.3	37.1	47.5
$15,000 to less than $25,000	536	462,088	34.2	30.5	38.0
$25,000 to less than $35,000	275	227,874	26.2	22.2	30.1
$35,000 to less than $50,000	291	273,942	24.8	21.2	28.4
$50,000 or more	474	463,785	13.6	12.0	15.2
Did not graduate High School	282	430,352	43.0	37.6	48.5
Graduated High School	1,005	845,769	28.5	26.3	30.7
Attended College or Technical School	626	539,608	20.2	18.1	22.2
Graduated College or Technical School	254	147,325	7.1	5.9	8.3
Physical, mental, or emotional disability[iii]	395	296,180	29.6	26.0	33.3
No disability	948	845,523	20.6	18.9	22.3
Frequent poor mental health[iv]	504	471,316	41.8	37.6	45.9
Not frequent poor mental health	1,625	1,448,577	19.4	18.1	20.7
Lesbian, Gay, Bisexual, Transgender (LGBT)	83	113,523	36.8	28.7	45.0
Not LGBT	1,870	1,582,016	21.9	20.6	23.2

Source: Ohio Behavioral Risk Factor Surveillance System (BRFSS), 2016

** Interpret smoking prevalence rates for Hispanic, Multiracial, and Other races with caution; rates may be unstable due to small sample sizes.*

[iii] Disability defined as being limited in any way in any activity because of a physical, mental, or emotional problem or need for special equipment due to disability.

[iv] Frequent poor mental health defined as having 14+ days of self-reported mental health as "not good" during the past 30 days, including stress, depression, and problems with emotions.

Table 2. Current Regional Cigarette Smoking Prevalence among Ohio Adults (18+ years), 2016[1]

Region	Frequency (n)	Weighted Frequency	Smoking Prevalence (%)	95% Confidence Limits	
Region 1: Defiance, Fulton, Henry, Lucas, Paulding, Williams, Wood	145	125,792	24.3	19.7	28.9
Region 2: Allen, Auglaize, Hancock, Hardin, Mercer, Putnam, Van Wert	139	49,654	19.7	15.1	24.3
Region 3: Crawford, Erie, Huron, Ottawa, Richland, Sandusky, Seneca, Wyandot	137	80,286	23.3	18.6	28.1
Region 4: Cuyahoga, Geauga, Lake, Lorain	139	255,313	20.6	16.8	24.3
Region 5: Ashland, Holmes, Medina, Stark, Summit, Wayne	135	197,295	21.5	17.3	25.7
Region 6: Ashtabula, Columbiana, Mahoning, Portage, Trumbull	143	155,073	27.9	22.4	33.5
Region 7: Delaware, Knox, Marion, Morrow, Union	102	54,755	19.1	13.8	24.3
Region 8: Fairfield, Franklin, Licking, Madison, Pickaway	221	285,469	24.0	20.7	27.2
Region 9: Champaign, Clark, Darke, Greene, Logan, Miami, Montgomery, Preble, Shelby	145	180,418	23.2	19.0	27.3
Region 10: Butler, Clermont, Clinton, Hamilton, Warren	154	233,410	22.3	18.4	26.1
Region 11: Adams, Brown, Fayette, Highland, Pike, Ross, Scioto	151	57,777	25.7	18.8	32.7
Region 12: Coshocton, Guernsey, Morgan, Muskingum, Noble, Perry, Tuscarawas	151	45,923	19.8	16.1	23.5
Region 13: Belmont, Carroll, Harrison, Jefferson, Monroe, Washington	166	46,431	25.1	20.3	29.9
Region 14: Athens, Gallia, Hocking, Jackson, Lawrence, Meigs, Vinton	151	46,158	26.1	21.2	31.1

Source: Ohio Behavioral Risk Factor Surveillance System (BRFSS), 2016; Regions are assigned based on Ohio BRFSS imputed county identifiers.

Table 3: Population Counts and County Type for Counties in Ohio, 2016

County	Total Pop (Count)[11]	Adult 18+ (Count)[11]	Youth <18 (Count)[11]	County Type[12]
Adams	27,907	21,178	6,729	Appalachian
Allen	103,742	79,566	24,176	Metropolitan
Ashland	53,652	41,456	12,196	Rural, non-Appalachian
Ashtabula	98,231	76,376	21,855	Appalachian
Athens	66,186	56,357	9,829	Appalachian
Auglaize	45,894	34,852	11,042	Suburban
Belmont	68,673	55,599	13,074	Appalachian
Brown	43,759	33,726	10,033	Appalachian
Butler	377,537	287,652	89,885	Metropolitan
Carroll	27,669	21,850	5,819	Appalachian
Champaign	38,747	29,922	8,825	Rural, non-Appalachian
Clark	134,786	104,137	30,649	Suburban
Clermont	203,022	155,109	47,913	Appalachian
Clinton	41,902	31,983	9,919	Rural, non-Appalachian
Columbiana	103,685	82,213	21,472	Appalachian
Coshocton	36,602	27,929	8,673	Appalachian
Crawford	42,083	32,886	9,197	Rural, non-Appalachian
Cuyahoga	1,249,352	984,603	264,749	Metropolitan
Darke	51,778	39,347	12,431	Rural, non-Appalachian
Defiance	38,158	29,363	8,795	Rural, non-Appalachian
Delaware	196,463	143,296	53,167	Suburban
Erie	75,107	59,656	15,451	Rural, non-Appalachian
Fairfield	152,597	116,023	36,574	Suburban
Fayette	28,676	21,962	6,714	Rural, non-Appalachian
Franklin	1,264,518	966,556	297,962	Metropolitan
Fulton	42,514	32,312	10,202	Suburban
Gallia	30,015	23,076	6,939	Appalachian
Geauga	94,060	71,996	22,064	Suburban
Greene	164,765	130,803	33,962	Suburban
Guernsey	39,063	30,331	8,732	Appalachian
Hamilton	809,099	621,065	188,034	Metropolitan
Hancock	75,872	58,682	17,190	Rural, non-Appalachian
Hardin	31,474	24,164	7,310	Rural, non-Appalachian
Harrison	15,307	12,078	3,229	Appalachian
Henry	27,629	21,220	6,409	Rural, non-Appalachian
Highland	43,029	32,692	10,337	Appalachian
Hocking	28,340	22,020	6,320	Appalachian
Holmes	43,936	29,751	14,185	Appalachian
Huron	58,439	44,316	14,123	Rural, non-Appalachian
Jackson	32,505	24,793	7,712	Appalachian
Jefferson	66,704	53,626	13,078	Appalachian
Knox	60,814	46,924	13,890	Rural, non-Appalachian
Lake	228,614	182,041	46,573	Suburban
Lawrence	60,872	47,440	13,432	Appalachian
Licking	172,198	131,756	40,442	Suburban
Logan	45,165	34,516	10,649	Rural, non-Appalachian
Lorain	306,365	237,558	68,807	Metropolitan
Lucas	432,488	332,501	99,987	Metropolitan
Madison	43,419	34,315	9,104	Suburban
Mahoning	230,008	183,339	46,669	Metropolitan
Marion	65,096	51,507	13,589	Rural, non-Appalachian
Medina	177,221	136,587	40,634	Suburban
Meigs	23,125	18,155	4,970	Appalachian
Mercer	40,909	30,507	10,402	Rural, non-Appalachian
Miami	104,679	80,577	24,102	Suburban
Monroe	14,210	11,261	2,949	Appalachian
Montgomery	531,239	413,044	118,195	Metropolitan
Morgan	14,804	11,642	3,162	Appalachian
Morrow	35,036	26,676	8,360	Rural, non-Appalachian
Muskingum	86,068	66,336	19,732	Appalachian
Noble	14,294	11,631	2,663	Appalachian
Ottawa	40,636	32,984	7,652	Rural, non-Appalachian
Paulding	18,865	14,409	4,456	Rural, non-Appalachian
Perry	35,927	27,317	8,610	Appalachian
Pickaway	57,565	45,001	12,564	Suburban
Pike	28,160	21,378	6,782	Appalachian
Portage	161,921	131,248	30,673	Suburban
Preble	41,247	31,814	9,433	Rural, non-Appalachian
Putnam	34,056	25,312	8,744	Rural, non-Appalachian
Richland	121,107	94,944	26,163	Metropolitan
Ross	77,000	60,463	16,537	Appalachian
Sandusky	59,330	45,802	13,528	Rural, non-Appalachian
Scioto	76,088	59,492	16,596	Appalachian
Seneca	55,353	43,048	12,305	Rural, non-Appalachian
Shelby	48,623	36,210	12,413	Rural, non-Appalachian
Stark	373,612	292,382	81,230	Metropolitan
Summit	540,300	425,043	115,257	Metropolitan
Trumbull	201,825	159,940	41,885	Appalachian
Tuscarawas	92,420	71,404	21,016	Appalachian
Union	55,457	41,663	13,794	Suburban
Van Wert	28,362	21,755	6,607	Rural, non-Appalachian
Vinton	12,921	10,025	2,896	Appalachian
Warren	227,063	169,930	57,133	Rural, non-Appalachian
Washington	60,610	48,604	12,006	Appalachian
Wayne	116,470	88,021	28,449	Rural, non-Appalachian
Williams	37,017	28,567	8,450	Rural, non-Appalachian
Wood	130,219	103,551	26,668	Suburban
Wyandot	22,118	17,059	5,059	Rural, non-Appalachian

Table 4: Socioeconomic Measures for Counties in Ohio, 2016

County	All Ages in Poverty (%)[13]	Under Age 18 in Poverty (%)[13]	County Health Rankings: Social & Economic Factors Rank[14]
Adams	20.2	29.6	87
Allen	15.5	21.9	53
Ashland	12.2	17.4	25
Ashtabula	18.2	26.5	76
Athens	28.8	24.5	65
Auglaize	9.2	11.5	4
Belmont	15.7	21.5	50
Brown	16.7	24.3	71
Butler	12.4	15.8	42
Carroll	12.8	18.9	34
Champaign	11.1	16.0	27
Clark	15.7	22.4	66
Clermont	10.6	12.9	24
Clinton	13.4	19.2	60
Columbiana	17.2	26.5	58
Coshocton	12.7	20.7	64
Crawford	13.9	22.1	47
Cuyahoga	18.3	26.4	79
Darke	10.7	14.8	23
Defiance	10.4	15.1	18
Delaware	4.7	4.7	1
Erie	12.5	20.1	46
Fairfield	9.7	13.0	14
Fayette	16.0	23.0	49
Franklin	16.6	23.9	62
Fulton	8.9	11.7	15
Gallia	20.6	29.8	83
Geauga	5.8	8.3	10
Greene	12.1	14.5	17
Guernsey	18.6	25.4	61
Hamilton	16.0	23.2	63
Hancock	10.0	13.1	12
Hardin	13.3	17.2	44
Harrison	16.8	23.9	51
Henry	8.3	11.3	19
Highland	19.8	28.4	77
Hocking	14.5	22.4	54
Holmes	11.7	16.4	13
Huron	12.2	17.9	55
Jackson	18.1	27.2	81
Jefferson	16.3	24.0	70
Knox	12.7	17.5	30
Lake	8.6	12.5	22
Lawrence	17.9	26.5	68
Licking	11.7	17.1	33
Logan	12.2	17.5	45
Lorain	12.4	17.9	52
Lucas	19.8	27.9	86
Madison	11.8	16.0	35
Mahoning	18.7	27.2	72
Marion	14.8	22.7	80
Medina	6.5	8.1	7
Meigs	21.1	28.2	82
Mercer	8.2	10.3	5
Miami	9.5	13.3	16
Monroe	15.2	22.4	74
Montgomery	18.2	27.2	73
Morgan	18.7	27.6	78
Morrow	12.2	19.4	37
Muskingum	14.8	22.7	67
Noble	15.1	18.1	57
Ottawa	10.4	15.0	32
Paulding	10.7	15.4	26
Perry	17.0	23.9	59
Pickaway	13.2	17.8	36
Pike	20.5	29.7	88
Portage	13.5	15.0	29
Preble	11.0	16.8	40
Putnam	8.3	9.5	2
Richland	15.8	22.1	56
Ross	18.6	24.9	69
Sandusky	11.6	16.2	39
Scioto	22.1	31.6	85
Seneca	12.9	17.7	38
Shelby	9.4	12.1	21
Stark	13.2	19.4	43
Summit	13.7	19.7	48
Trumbull	17.6	29.2	75
Tuscarawas	12.7	16.6	31
Union	6.1	7.2	6
Van Wert	8.9	13.1	11
Vinton	20.8	31.8	84
Warren	5.4	6.1	3
Washington	13.7	19.2	41
Wayne	11.9	16.2	20
Williams	9.7	14.3	28
Wood	11.4	10.9	9
Wyandot	8.6	11.3	8

Table 5: Insurance and Health Care Access Measures for Counties in Ohio, 2016

County	Medicaid Recipients (%)[15]	Uninsured (%)[15]	Medically Underserved[16]	County Health Rankings: Clinical Care Rank[17]
Adams	26.78	13.8	Yes	86
Allen	18.70	5.7	Yes	28
Ashland	16.36	8.1	No	19
Ashtabula	20.87	8.6	Yes	80
Athens	21.69	8.4	Yes	40
Auglaize	11.27	4.6	No	21
Belmont	19.55	5.5	Yes	69
Brown	15.17	NA	Yes	65
Butler	16.38	6.9	Yes	44
Carroll	19.29	5.1	Yes	58
Champaign	20.80	NA	No	46
Clark	22.00	8.6	Yes	63
Clermont	14.10	8.9	Yes	23
Clinton	16.43	7.8	Yes	35
Columbiana	18.63	9.5	Yes	66
Coshocton	23.26	10.0	Yes	85
Crawford	16.51	11.4	No	55
Cuyahoga	23.85	6.1	Yes	5
Darke	10.74	9.8	Yes	33
Defiance	10.64	6.7	Yes	41
Delaware	9.25	7.3	No	1
Erie	16.69	4.4	Yes	15
Fairfield	16.24	6.8	Yes	11
Fayette	25.19	NA	Yes	52
Franklin	18.39	8.8	Yes	18
Fulton	15.18	NA	No	14
Gallia	24.15	7.7	No	37
Geauga	10.20	5.8	No	12
Greene	14.39	5.0	Yes	9
Guernsey	24.15	4.8	Yes	68
Hamilton	20.09	6.6	Yes	3
Hancock	13.86	7.1	No	7
Hardin	18.77	9.4	Yes	73
Harrison	30.35	NA	Yes	87
Henry	10.57	NA	No	8
Highland	25.02	9.3	Yes	82
Hocking	24.51	6.4	Yes	62
Holmes	10.35	14.3	Yes	88
Huron	13.78	4.9	No	54
Jackson	19.59	5.8	Yes	75
Jefferson	27.57	4.9	Yes	72
Knox	15.14	6.8	Yes	50
Lake	11.87	7.6	Yes	16
Lawrence	24.96	8.1	Yes	78
Licking	17.39	5.7	No	24
Logan	21.42	9.9	Yes	38
Lorain	17.03	7.0	Yes	29
Lucas	24.29	8.6	Yes	51
Madison	18.77	4.7	Yes	36
Mahoning	22.07	6.1	Yes	13
Marion	23.26	4.5	Yes	59
Medina	8.66	5.9	Yes	6
Meigs	27.00	9.4	Yes	77
Mercer	11.31	3.7	No	53
Miami	12.48	7.3	Yes	34
Monroe	19.97	4.7	Yes	81
Montgomery	22.08	7.0	Yes	17
Morgan	21.17	8.6	Yes	79
Morrow	14.23	6.1	Yes	74
Muskingum	25.68	7.4	Yes	45
Noble	15.35	13.9	Yes	84
Ottawa	11.29	NA	Yes	49
Paulding	24.13	NA	Yes	64
Perry	29.13	11.2	Yes	67
Pickaway	19.21	NA	Yes	61
Pike	18.74	NA	Yes	76
Portage	15.81	7.9	Yes	39
Preble	17.61	10.2	No	57
Putnam	13.69	NA	Yes	4
Richland	20.83	8.3	Yes	47
Ross	23.26	5.0	Yes	30
Sandusky	14.98	6.3	Yes	48
Scioto	23.91	10.4	Yes	70
Seneca	15.65	NA	No	42
Shelby	14.00	5.0	No	27
Stark	18.63	6.9	Yes	10
Summit	18.77	6.7	Yes	22
Trumbull	18.66	6.5	Yes	56
Tuscarawas	17.74	5.7	Yes	71
Union	13.59	NA	Yes	25
Van Wert	16.12	3.9	Yes	60
Vinton	20.52	11.8	Yes	83
Warren	9.39	6.6	Yes	2
Washington	17.82	5.9	Yes	43
Wayne	12.18	7.1	No	31
Williams	7.90	1.9	No	20
Wood	13.06	6.3	Yes	26
Wyandot	19.39	NA	No	32

Table 6: Smoking Prevalence and Health Risk Behavior Measures for Counties in Ohio, 2016

County	Current Adult Smokers (%) (County Health Rankings, Modeled County Est.)[18]	Current Youth Smokers (%) 12-17 Years (NSDUH Modeled Regional Est.)[19]	Births to Mothers that Smoked During Pregnancy (%)[6]	County Health Rankings: Health Behaviors Sub Rank[20]
Adams	23.0	13.4	23.8	65
Allen	21.2	10.6	19.2	75
Ashland	20.1	11.0	12.7	26
Ashtabula	22.1	12.5	25.3	68
Athens	22.9	15.5	24.6	72
Auglaize	19.5	10.6	15.4	38
Belmont	20.6	14.1	24.1	66
Brown	20.9	9.3	25.4	76
Butler	19.5	10.1	13.4	30
Carroll	20.2	14.1	17.4	49
Champaign	19.6	10.6	14.0	46
Clark	19.9	10.3	20.8	48
Clermont	18.6	9.3	15.9	16
Clinton	20.4	9.3	25.6	69
Columbiana	20.9	14.1	24.0	56
Coshocton	20.8	15.5	21.0	63
Crawford	18.1	9.6	24.0	13
Cuyahoga	18.3	8.0	9.2	39
Darke	18.8	10.6	17.9	29
Defiance	19.1	11.1	16.7	42
Delaware	14.0	9.6	6.4	1
Erie	20.0	11.5	16.2	43
Fairfield	17.5	11.5	14.9	9
Fayette	20.7	13.4	26.9	58
Franklin	18.7	7.4	10.3	37
Fulton	18.2	11.1	12.3	17
Gallia	22.9	13.4	23.0	80
Geauga	16.1	9.2	7.8	2
Greene	18.3	10.3	9.1	14
Guernsey	21.0	15.5	25.3	81
Hamilton	19.6	7.5	11.5	59
Hancock	19.0	11.1	15.3	22
Hardin	20.7	10.6	18.8	62
Harrison	20.1	14.1	24.7	27
Henry	18.5	11.1	17.6	18
Highland	22.0	13.4	24.2	74
Hocking	21.4	15.5	25.4	70
Holmes	20.2	11.0	4.7	23
Huron	18.3	9.6	22.5	35
Jackson	22.3	13.4	23.8	85
Jefferson	21.1	14.1	31.0	71
Knox	20.0	11.5	17.6	50
Lake	17.6	9.2	11.5	6
Lawrence	20.9	13.4	23.1	78

Table 6: Smoking Prevalence and Health Risk Behavior Measures for Counties in Ohio, 2016

County	Current Adult Smokers (%) (County Health Rankings, Modeled County Est.)[18]	Current Youth Smokers (%) 12-17 Years (NSDUH Modeled Regional Est.)[19]	Births to Mothers that Smoked During Pregnancy (%)[6]	County Health Rankings: Health Behaviors Sub Rank[20]
Licking	18.2	11.5	16.8	19
Logan	20.1	10.6	20.8	47
Lorain	18.2	8.0	16.9	20
Lucas	20.2	9.4	14.2	73
Madison	19.0	10.3	16.7	25
Mahoning	20.3	9.4	22.0	52
Marion	21.6	9.6	27.1	87
Medina	15.9	11.0	9.4	5
Meigs	22.6	13.4	29.9	86
Mercer	15.9	11.1	10.9	3
Miami	18.9	10.6	15.5	24
Monroe	18.1	14.1	19.4	28
Montgomery	20.6	9.2	11.1	55
Morgan	21.2	15.5	21.7	64
Morrow	19.5	9.6	17.7	53
Muskingum	22.2	15.5	18.7	83
Noble	20.2	15.5	15.2	67
Ottawa	17.4	11.5	14.2	8
Paulding	19.0	11.1	22.6	21
Perry	21.3	15.5	26.1	82
Pickaway	19.1	13.4	18.7	57
Pike	23.5	13.4	27.7	77
Portage	19.9	9.2	16.2	15
Preble	19.4	10.6	17.0	33
Putnam	16.5	11.1	8.4	10
Richland	19.8	9.6	22.7	61
Ross	21.7	13.4	27.9	79
Sandusky	19.5	11.5	18.4	45
Scioto	25.0	13.4	28.9	88
Seneca	19.3	11.5	23.1	34
Shelby	19.2	10.6	21.5	44
Stark	19.4	9.4	17.4	36
Summit	20.1	9.3	13.3	40
Trumbull	20.4	12.5	24.9	54
Tuscarawas	17.7	14.1	12.3	31
Union	18.4	9.6	10.0	12
Van Wert	19.0	11.1	24.3	41
Vinton	22.8	15.5	26.9	84
Warren	16.1	9.3	8.1	4
Washington	20.7	14.1	19.9	51
Wayne	18.6	11.0	12.0	7
Williams	20.2	11.1	18.0	60
Wood	18.0	11.5	8.3	11
Wyandot	17.1	11.5	16.3	32

Table 7: Age-Adjusted Death Rates (per 100,000 Population) for Selected Tobacco-Associated Chronic Diseases, by County, Ohio

County	Cancer Death Rate[21]	Heart Disease Death Rate[22]	Stroke Death Rate[22]	COPD/CLRD Death Rate[22]
Adams	230.1	253.9	35.4	75.7
Allen	201.8	192.1	37.7	50.6
Ashland	160.2	199.5	45.1	56.8
Ashtabula	186.7	196.5	35.4	60.4
Athens	198.2	175.1	36.2	67.4
Auglaize	171.9	212.0	44.2	45.5
Belmont	178.1	230.0	35.9	61.6
Brown	193.1	181.0	46.5	67.1
Butler	169.6	170.4	43.8	49.1
Carroll	223.8	158.3	38.8	60.8
Champaign	212.4	169.9	43.9	65.5
Clark	192.6	207.0	65.7	63.2
Clermont	178.5	169.3	55.4	48.1
Clinton	203.9	203.9	59.8	62.3
Columbiana	177.2	230.5	46.3	50.5
Coshocton	206.4	221.5	28.7	55.2
Crawford	203.1	188.5	52.3	68.4
Cuyahoga	178.3	196.6	34.5	37.3
Darke	192.6	211.4	41.9	35.8
Defiance	163.4	163.3	31.0	55.7
Delaware	151.2	131.6	37.1	35.1
Erie	182.6	171.4	45.5	64.1
Fairfield	161.9	168.1	35.7	48.8
Fayette	206.2	280.3	50.5	62.6
Franklin	172.1	172.3	44.4	47.0
Fulton	165.4	140.1	36.2	43.5
Gallia	198.0	244.3	64.3	76.7
Geauga	133.1	164.6	22.6	35.6
Greene	171.0	162.4	33.5	34.4
Guernsey	208.9	200.9	31.8	71.9
Hamilton	180.1	169.1	48.9	40.8
Hancock	184.8	158.9	40.3	45.3
Hardin	231.0	258.7	37.6	54.7
Harrison	233.9	224.1	28.7	58.9
Henry	128.5	134.8	38.2	51.8
Highland	171.7	229.5	45.4	67.0
Hocking	214.3	205.0	24.9	57.9
Holmes	160.4	200.9	46.4	25.5
Huron	199.6	175.8	31.8	65.2
Jackson	232.6	279.6	38.4	83.1
Jefferson	192.8	253.1	42.6	49.3
Knox	144.6	174.7	47.1	52.7
Lake	176.6	192.0	35.7	46.5
Lawrence	210.2	195.3	55.2	66.6

County	Cancer Death Rate[21]	Heart Disease Death Rate[22]	Stroke Death Rate[22]	COPD/CLRD Death Rate[22]
Licking	182.3	166.4	36.3	55.9
Logan	197.0	188.4	61.5	49.0
Lorain	167.6	161.1	32.1	56.9
Lucas	190.7	205.2	43.2	60.7
Madison	171.9	173.7	50.0	68.7
Mahoning	171.8	211.3	40.3	40.7
Marion	191.9	211.4	38.0	59.7
Medina	151.9	148.1	28.3	35.8
Meigs	220.1	210.1	60.5	69.3
Mercer	182.4	272.8	42.0	27.7
Miami	168.1	211.2	43.5	41.4
Monroe	206.5	177.6	42.4	41.9
Montgomery	176.7	173.8	49.7	49.6
Morgan	197.8	124.4	49.6	58.1
Morrow	150.0	197.3	29.9	53.0
Muskingum	205.5	181.2	44.0	67.0
Noble	100.6	176.7	42.2	25.5
Ottawa	158.8	200.4	30.7	42.5
Paulding	180.4	170.0	37.7	54.0
Perry	248.0	218.8	31.4	60.6
Pickaway	174.4	217.6	37.1	60.7
Pike	142.8	206.0	47.4	97.3
Portage	169.9	191.5	36.5	45.3
Preble	184.8	211.9	39.0	47.4
Putnam	114.3	123.4	28.2	44.1
Richland	177.7	188.0	42.6	44.6
Ross	212.1	204.8	48.4	74.2
Sandusky	181.0	187.6	38.8	47.2
Scioto	206.9	279.6	28.5	84.2
Seneca	203.0	216.4	39.1	51.1
Shelby	185.1	179.2	38.0	49.2
Stark	167.5	177.8	33.6	48.4
Summit	179.0	177.8	38.7	46.1
Trumbull	168.3	207.9	41.1	43.6
Tuscarawas	154.1	181.8	34.6	58.9
Union	165.4	146.1	30.1	50.1
Van Wert	184.5	177.5	33.6	39.5
Vinton	191.9	226.4	47.1	56.2
Warren	168.4	163.9	35.5	39.4
Washington	196.4	152.6	38.2	55.5
Wayne	163.8	175.2	41.8	45.4
Williams	197.2	164.3	33.9	65.1
Wood	178.1	191.4	46.4	52.6
Wyandot	174.7	149.2	74.2	51.9

Table 8: Incidence and Regional Prevalence Rates for Selected Tobacco-Associated Chronic Diseases for Counties in Ohio

County	Lung & Bronchus Cancer Incidence (Cases per 100,000)[23]	Cancer Prevalence (Regional %) [24]	Heart Disease Prevalence (Regional %)[24]	Stroke Prevalence (Regional %)[24]	COPD/CLRD Prevalence (Regional %)[24]	County Health Rankings: Health Outcomes Sub Rank[25]
Adams	87.1	5.8	9.8	4.5	14.8	87
Allen	70.4	6.6	10.7	3.5	5.5	36
Ashland	61.2	7.2	6.4	2.8	9.7	21
Ashtabula	79.2	7.1	8.8	3.6	9.4	62
Athens	76.4	9.0	9.3	4.4	10.0	68
Auglaize	68.1	6.6	10.7	3.5	5.5	11
Belmont	60.9	8.1	11.0	4.0	10.8	51
Brown	106.5	5.8	9.8	4.5	14.8	69
Butler	75.0	7.3	6.5	3.7	8.0	44
Carroll	79.7	8.1	11.0	4.0	10.8	42
Champaign	64.0	8.2	7.3	3.0	9.8	35
Clark	76.7	8.2	7.3	3.0	9.8	67
Clermont	85.2	7.3	6.5	3.7	8.0	31
Clinton	86.6	7.3	6.5	3.7	8.0	70
Columbiana	68.5	7.1	8.8	3.6	9.4	57
Coshocton	74.0	7.6	10.3	4.1	9.5	55
Crawford	66.6	9.3	8.7	5.4	9.1	43
Cuyahoga	68.7	6.5	7.0	3.2	7.4	64
Darke	66.0	8.2	7.3	3.0	9.8	28
Defiance	67.3	6.1	9.8	4.6	8.8	18
Delaware	61.0	7.7	5.8	1.7	9.1	1
Erie	66.0	9.3	8.7	5.4	9.1	56
Fairfield	73.3	6.4	5.0	3.9	7.4	14
Fayette	87.4	5.8	9.8	4.5	14.8	76
Franklin	70.3	6.4	5.0	3.9	7.4	58
Fulton	48.4	6.1	9.8	4.6	8.8	26
Gallia	88.2	9.0	9.3	4.4	10.0	86
Geauga	51.5	6.5	7.0	3.2	7.4	2
Greene	60.9	8.2	7.3	3.0	9.8	17
Guernsey	82.2	7.6	10.3	4.1	9.5	66
Hamilton	75.1	7.3	6.5	3.7	8.0	61
Hancock	58.3	6.6	10.7	3.5	5.5	13
Hardin	72.9	6.6	10.7	3.5	5.5	72
Harrison	71.8	8.1	11.0	4.0	10.8	59
Henry	55.3	6.1	9.8	4.6	8.8	10
Highland	75.8	5.8	9.8	4.5	14.8	78
Hocking	77.0	9.0	9.3	4.4	10.0	63
Holmes	40.6	7.2	6.4	2.8	9.7	8
Huron	78.2	9.3	8.7	5.4	9.1	34
Jackson	82.3	9.0	9.3	4.4	10.0	84
Jefferson	78.9	8.1	11.0	4.0	10.8	81
Knox	69.8	7.7	5.8	1.7	9.1	39
Lake	73.0	6.5	7.0	3.2	7.4	15

Table 8: Incidence and Regional Prevalence Rates for Selected Tobacco-Associated Chronic Diseases for Counties in Ohio

County	Lung & Bronchus Cancer Incidence (Cases per 100,000)[23]	Cancer Prevalence (Regional %) [24]	Heart Disease Prevalence (Regional %)[24]	Stroke Prevalence (Regional %)[24]	COPD/CLRD Prevalence (Regional %)[24]	County Health Rankings: Health Outcomes Sub Rank[25]
Lawrence	83.4	9.0	9.3	4.4	10.0	82
Licking	78.5	6.4	5.0	3.9	7.4	23
Logan	70.7	8.2	7.3	3.0	9.8	49
Lorain	70.7	6.5	7.0	3.2	7.4	30
Lucas	61.9	6.1	9.8	4.6	8.8	73
Madison	74.8	6.4	5.0	3.9	7.4	33
Mahoning	69.4	7.1	8.8	3.6	9.4	75
Marion	82.9	7.7	5.8	1.7	9.1	60
Medina	62.0	7.2	6.4	2.8	9.7	5
Meigs	73.0	9.0	9.3	4.4	10.0	79
Mercer	52.9	6.6	10.7	3.5	5.5	7
Miami	73.7	8.2	7.3	3.0	9.8	24
Monroe	60.3	8.1	11.0	4.0	10.8	50
Montgomery	76.4	8.2	7.3	3.0	9.8	80
Morgan	78.6	7.6	10.3	4.1	9.5	77
Morrow	80.1	7.7	5.8	1.7	9.1	37
Muskingum	80.6	7.6	10.3	4.1	9.5	71
Noble	48.6	7.6	10.3	4.1	9.5	41
Ottawa	66.0	9.3	8.7	5.4	9.1	27
Paulding	87.6	6.1	9.8	4.6	8.8	29
Perry	78.5	7.6	10.3	4.1	9.5	54
Pickaway	77.5	6.4	5.0	3.9	7.4	48
Pike	91.3	5.8	9.8	4.5	14.8	88
Portage	72.0	7.1	8.8	3.6	9.4	22
Preble	72.8	8.2	7.3	3.0	9.8	46
Putnam	45.5	6.6	10.7	3.5	5.5	3
Richland	71.4	9.3	8.7	5.4	9.1	53
Ross	85.2	5.8	9.8	4.5	14.8	74
Sandusky	69.2	9.3	8.7	5.4	9.1	38
Scioto	97.8	5.8	9.8	4.5	14.8	83
Seneca	71.8	9.3	8.7	5.4	9.1	47
Shelby	55.7	8.2	7.3	3.0	9.8	25
Stark	68.1	7.2	6.4	2.8	9.7	45
Summit	67.2	7.2	6.4	2.8	9.7	52
Trumbull	80.8	7.1	8.8	3.6	9.4	65
Tuscarawas	60.9	7.6	10.3	4.1	9.5	32
Union	68.9	7.7	5.8	1.7	9.1	4
Van Wert	56.2	6.6	10.7	3.5	5.5	19
Vinton	114.2	9.0	9.3	4.4	10.0	85
Warren	65.8	7.3	6.5	3.7	8.0	6
Washington	76.3	8.1	11.0	4.0	10.8	40
Wayne	57.0	7.2	6.4	2.8	9.7	16
Williams	66.0	6.1	9.8	4.6	8.8	20

Table 8: Incidence and Regional Prevalence Rates for Selected Tobacco-Associated Chronic Diseases for Counties in Ohio

County	Lung & Bronchus Cancer Incidence (Cases per 100,000)[23]	Cancer Prevalence (Regional %) [24]	Heart Disease Prevalence (Regional %)[24]	Stroke Prevalence (Regional %)[24]	COPD/CLRD Prevalence (Regional %)[24]	County Health Rankings: Health Outcomes Sub Rank[25]
Wood	53.3	6.1	9.8	4.6	8.8	9
Wyandot	74.4	9.3	8.7	5.4	9.1	12

Table 9: Tobacco Retail Environment Measures for Counties in Ohio

County	Total Number of Tobacco Retailers[26]	Number of Tobacco Retailers within 0Walking Distance of a School[26]	Number of Tobacco Retailers within Walking Distance of a Public Park[26]	Number of Tobacco Retailers with Pharmacy Counters[26]	Tobacco Retailer Density (No. per 1,000 Residents)[26]
Adams	42	5	0	0	1.5
Allen	122	26	0	7	1.1
Ashland	60	7	0	1	1.1
Ashtabula	125	4	0	12	1.2
Athens	77	9	0	3	1.2
Auglaize	51	7	0	1	1.1
Belmont	96	25	0	0	1.4
Brown	51	5	0	0	1.1
Butler	279	35	222	14	0.8
Carroll	25	2	0	3	0.9
Champaign	42	2	0	0	1.0
Clark	144	25	0	13	1.0
Clermont	163	18	152	7	0.8
Clinton	21	1	0	0	0.5
Columbiana	126	19	0	7	1.2
Coshocton	39	3	0	2	1.1
Crawford	54	12	0	1	1.2
Cuyahoga	1337	343	772	92	1.0
Darke	57	6	0	1	1.1
Defiance	38	4	0	3	1.0
Delaware	106	8	12	7	0.6
Erie	101	5	0	2	1.3
Fairfield	107	13	5	13	0.7
Fayette	41	2	0	1	1.4
Franklin	1111	224	716	54	1.0
Fulton	55	3	0	4	1.3
Gallia	35	4	0	2	1.1
Geauga	79	6	1	11	0.8
Greene	96	18	0	6	0.6
Guernsey	67	8	0	1	1.7
Hamilton	801	235	796	36	1.0
Hancock	78	9	0	5	1.0
Hardin	32	6	0	1	1.0
Harrison	23	5	0	2	1.4
Henry	29	4	0	1	1.0
Highland	29	4	0	1	1.0
Hocking	29	0	0	2	1.0
Holmes	27	3	0	0	0.6
Huron	62	5	0	6	1.0
Jackson	54	4	0	2	1.6
Jefferson	86	8	0	7	1.2
Knox	60	5	0	2	1.0
Lake	223	30	3	16	1.0
Lawrence	73	6	0	3	1.2

Table 9: Tobacco Retail Environment Measures for Counties in Ohio

County	Total Number of Tobacco Retailers[26]	Number of Tobacco Retailers within 0Walking Distance of a School[26]	Number of Tobacco Retailers within Walking Distance of a Public Park[26]	Number of Tobacco Retailers with Pharmacy Counters[26]	Tobacco Retailer Density (No. per 1,000 Residents)[26]
Licking	114	14	0	14	0.7
Logan	43	0	0	3	0.9
Lorain	287	26	2	14	1.0
Lucas	500	88	0	39	1.1
Madison	17	1	0	0	0.4
Mahoning	270	23	0	17	1.1
Marion	72	10	0	5	1.1
Medina	128	20	0	5	0.7
Meigs	38	1	0	1	1.6
Mercer	65	5	0	0	1.6
Miami	96	7	0	1	0.9
Monroe	24	3	0	1	1.6
Montgomery	561	81	0	44	1.0
Morgan	17	0	0	0	1.1
Morrow	37	4	0	1	1.1
Muskingum	105	10	0	7	1.2
Noble	24	0	0	0	1.6
Ottawa	84	5	0	3	2.0
Paulding	24	0	0	1	1.2
Perry	48	7	0	3	1.3
Pickaway	48	4	0	0	0.9
Pike	54	7	0	3	1.9
Portage	135	19	0	6	0.8
Preble	53	3	1	1	1.3
Putnam	31	5	0	1	0.9
Richland	151	29	0	8	1.2
Ross	89	8	0	2	1.1
Sandusky	79	4	0	6	1.3
Scioto	86	8	0	0	1.1
Seneca	73	17	0	1	1.3
Shelby	59	5	0	2	1.2
Stark	366	49	0	34	1.0
Summit	474	98	0	41	0.9
Trumbull	254	28	0	20	1.2
Tuscarawas	107	24	0	9	1.2
Union	39	2	0	2	0.7
Van Wert	25	2	0	0	0.9
Vinton	12	1	0	0	0.9
Warren	141	11	127	4	0.7
Washington	77	8	0	4	1.2
Wayne	93	10	0	4	0.8
Williams	54	4	0	2	1.4
Wood	121	18	0	5	1.0
Wyandot	41	2	0	1	1.8

Table 10: Tobacco Policy Environment Measures for Counties in Ohio

County	Tobacco Policy Score, Avg. of all School Districts[27]	No. of Youth in Public School (preK-12)[28]	No. of low SES Youth in Public School (PreK-12)[32]	Number of 2- and 4-year Colleges & Universities[29]	Number of Occupied Multi-housing Units[30]	Adults with Smoke Free Home Rules (%, Regional Est.)[31]
Adams	77.5	4,835	2,919	0	675	73.0
Allen	80.2	15,382	8,439	4	9,168	79.4
Ashland	79.0	6,089	2,173	1	4,134	77.1
Ashtabula	67.9	13,429	8,700	1	7,521	70.8
Athens	86.0	7,162	4,155	3	6,898	73.4
Auglaize	68.0	7,657	2,452	0	3,059	79.4
Belmont	69.8	8,821	3,164	2	5,082	70.0
Brown	60.5	7,065	3,537	1	2,011	73.0
Butler	74.7	56,324	24,524	4	37,501	75.5
Carroll	100.0	2,640	1,226	0	906	70.0
Champaign	75.0	6,735	2,397	1	2,287	78.1
Clark	76.0	19,969	12,343	2	13,584	78.1
Clermont	76.7	27,017	10,093	2	19,146	75.5
Clinton	57.8	7,590	3,218	1	3,268	75.5
Columbiana	72.3	13,790	7,809	4	7,500	70.8
Coshocton	66.3	4,732	3,200	0	1,630	80.5
Crawford	74.5	6,357	3,419	0	3,601	75.3
Cuyahoga	80.2	144,355	81,306	27	251,030	70.9
Darke	66.7	7,830	2,783	0	3,245	78.1
Defiance	64.8	6,214	2,584	1	2,480	75.0
Delaware	80.6	31,582	2,640	3	14,160	78.9
Erie	81.5	11,267	5,778	4	9,166	75.3
Fairfield	81.4	24,687	8,197	2	11,656	76.0
Fayette	83.5	4,795	2,379	0	2,341	73.0
Franklin	87.4	174,236	91,428	29	242,481	76.0
Fulton	87.4	7,640	2,575	0	2,196	75.0
Gallia	64.3	4,409	3,393	2	1,080	73.4
Geauga	78.2	10,184	1,815	1	3,987	70.9
Greene	81.8	21,459	7,856	9	17,741	78.1
Guernsey	91.7	4,413	2,536	0	2,134	80.5
Hamilton	69.5	102,486	52,406	24	157,294	75.5
Hancock	79.3	11,772	3,774	5	8,234	79.4
Hardin	73.3	4,157	2,110	1	2,021	79.4
Harrison	82.0	1,954	1,053	0	528	70.0
Henry	76.6	4,287	1,433	0	1,347	75.0
Highland	76.8	7,173	3,759	1	2,122	73.0
Hocking	100.0	3,777	1,944	0	1,454	73.4
Holmes	70.5	3,830	1,314	0	1,249	77.1
Huron	65.0	9,689	4,310	1	5,127	75.3
Jackson	75.0	5,021	3,152	0	1,543	73.4
Jefferson	74.8	8,761	5,848	3	4,908	70.0
Knox	72.5	7,511	3,075	2	4,007	78.9
Lake	71.5	31,196	11,446	6	26,014	70.9
Lawrence	53.9	9,202	7,379	3	3,125	73.4

Table 10: Tobacco Policy Environment Measures for Counties in Ohio

County	Tobacco Policy Score, Avg. of all School Districts[27]	No. of Youth in Public School (preK-12)[28]	No. of low SES Youth in Public School (PreK-12)[32]	Number of 2- and 4-year Colleges & Universities[29]	Number of Occupied Multi-housing Units[30]	Adults with Smoke Free Home Rules (%, Regional Est.)[31]
Licking	87.3	26,574	10,097	5	13,417	76.0
Logan	71.6	6,342	2,515	0	3,178	78.1
Lorain	70.3	41,085	19,153	5	29,608	70.9
Lucas	80.0	52,276	22,284	11	59,411	75.0
Madison	77.2	6,568	2,225	0	2,842	76.0
Mahoning	67.4	28,443	14,157	4	24,880	70.8
Marion	99.0	9,077	6,160	2	4,990	78.9
Medina	77.6	27,608	5,463	1	14,351	77.1
Meigs	90.7	3,343	2,644	0	662	73.4
Mercer	67.7	7,974	1,923	1	2,465	79.4
Miami	67.9	15,666	5,180	2	9,337	78.1
Monroe	100.0	2,167	1,316	0	396	70.0
Montgomery	92.9	67,028	36,159	15	78,720	78.1
Morgan	62.0	1,904	1,055	0	449	80.5
Morrow	69.8	5,143	2,084	0	1,185	78.9
Muskingum	72.3	14,074	8,730	3	7,614	80.5
Noble	71.0	1,691	754	0	385	80.5
Ottawa	54.0	5,146	1,841	0	4,400	75.3
Paulding	67.3	3,047	1,192	0	847	75.0
Perry	69.8	5,784	4,332	0	1,363	80.5
Pickaway	86.3	9,264	4,146	1	3,068	76.0
Pike	66.6	4,658	4,153	0	1,255	73.0
Portage	77.8	20,407	8,363	4	18,628	70.8
Preble	69.0	6,022	2,699	0	2,032	78.1
Putnam	67.7	5,912	1,354	0	1,364	79.4
Richland	71.3	16,564	8,283	3	12,037	75.3
Ross	77.1	10,687	7,448	1	4,303	73.0
Sandusky	68.0	9,112	4,569	1	4,093	75.3
Scioto	61.8	11,140	6,847	3	4,674	73.0
Seneca	77.9	7,256	3,188	3	4,098	75.3
Shelby	62.4	8,322	2,946	0	4,207	78.1
Stark	75.4	56,728	28,178	9	38,759	77.1
Summit	80.3	70,509	34,122	7	69,679	77.1
Trumbull	81.5	26,640	15,198	4	19,272	70.8
Tuscarawas	78.0	13,650	5,667	1	6,417	80.5
Union	100.0	7,721	1,921	1	3,136	78.9
Van Wert	83.5	3,756	1,581	0	1,243	79.4
Vinton	88.0	2,070	1,652	0	263	73.4
Warren	82.1	36,849	6,185	2	18,260	75.5
Washington	77.7	7,698	3,448	3	3,772	70.0
Wayne	61.2	15,022	5,922	3	9,406	77.1
Williams	67.1	5,521	2,396	0	2,353	75.0
Wood	81.5	16,724	5,056	3	14,913	75.0
Wyandot	77.7	3,349	1,130	0	1,553	75.3

Table 11: Estimated Potential Impacts of Smoke-Free Policy Interventions for Counties in Ohio

County	Medical care cost savings, Community-wide Smoke Free/clean air policies (10-yr cumulative rate, $/per 100K residents)[32]	Medical care cost savings (Total) from community-wide Smoke Free/clean air policies (10-yr cumulative $/per County Total Population) [32]
Adams	-$8,558,000	-$2,121,000
Allen	-$11,396,000	-$10,450,000
Ashland	-$8,170,000	-$3,731,000
Ashtabula	-$11,284,000	-$9,866,000
Athens	-$5,704,000	-$3,366,000
Auglaize	-$6,721,000	-$2,641,000
Belmont	-$9,724,000	-$5,805,000
Brown	-$8,660,000	-$3,385,000
Butler	-$8,638,000	-$28,124,000
Carroll	-$8,843,000	-$2,196,000
Champaign	-$8,448,000	-$2,962,000
Clark	-$8,622,000	-$10,213,000
Clermont	-$8,622,000	-$15,360,000
Clinton	-$8,632,000	-$3,177,000
Columbiana	-$12,342,000	-$11,421,000
Coshocton	-$8,584,000	-$2,712,000
Crawford	-$11,167,000	-$4,141,000
Cuyahoga	-$8,221,000	-$90,285,000
Darke	-$8,616,000	-$3,876,000
Defiance	-$8,001,000	-$2,697,000
Delaware	-$5,364,000	-$8,402,000
Erie	-$9,376,000	-$6,177,000
Fairfield	-$5,825,000	-$7,535,000
Fayette	-$8,594,000	-$2,151,000
Franklin	-$6,442,000	-$66,957,000
Fulton	-$8,470,000	-$3,143,000
Gallia	-$10,147,000	-$2,705,000
Geauga	-$5,510,000	-$4,474,000
Greene	-$5,341,000	-$7,572,000
Guernsey	-$8,570,000	-$2,956,000
Hamilton	-$7,353,000	-$51,330,000
Hancock	-$8,431,000	-$5,469,000
Hardin	-$7,331,000	-$2,058,000
Harrison	-$9,064,000	-$1,221,000
Henry	-$8,483,000	-$2,049,000
Highland	-$8,458,000	-$3,181,000
Hocking	-$9,062,000	-$2,322,000
Holmes	-$7,219,000	-$2,654,000
Huron	-$9,050,000	-$4,703,000
Jackson	-$8,619,000	-$2,496,000
Jefferson	-$11,334,000	-$6,684,000
Knox	-$6,251,000	-$3,300,000
Lake	-$6,409,000	-$12,716,000
Lawrence	-$9,096,000	-$4,913,000

Table 11: Estimated Potential Impacts of Smoke-Free Policy Interventions for Counties in Ohio

County	Medical care cost savings, Community-wide Smoke Free/clean air policies (10-yr cumulative rate, $/per 100K residents)[32]	Medical care cost savings (Total) from community-wide Smoke Free/clean air policies (10-yr cumulative $/per County Total Population) [32]
Licking	-$6,651,000	-$9,737,000
Logan	-$8,536,000	-$3,391,000
Lorain	-$10,375,000	-$27,212,000
Lucas	-$7,949,000	-$30,633,000
Madison	-$9,079,000	-$3,497,000
Mahoning	-$10,789,000	-$21,707,000
Marion	-$8,873,000	-$5,144,000
Medina	-$6,094,000	-$9,268,000
Meigs	-$8,782,000	-$1,808,000
Mercer	-$5,090,000	-$1,769,000
Miami	-$8,841,000	-$7,839,000
Monroe	-$9,097,000	-$1,126,000
Montgomery	-$8,057,000	-$37,130,000
Morgan	-$8,632,000	-$1,105,000
Morrow	-$8,982,000	-$2,750,000
Muskingum	-$11,870,000	-$8,810,000
Noble	-$9,362,000	-$1,150,000
Ottawa	-$9,210,000	-$3,248,000
Paulding	-$8,487,000	-$1,440,000
Perry	-$12,065,000	-$3,830,000
Pickaway	-$6,075,000	-$2,994,000
Pike	-$8,529,000	-$2,121,000
Portage	-$8,106,000	-$11,626,000
Preble	-$8,640,000	-$3,163,000
Putnam	-$8,358,000	-$2,471,000
Richland	-$9,308,000	-$9,912,000
Ross	-$8,806,000	-$6,051,000
Sandusky	-$5,616,000	-$2,944,000
Scioto	-$9,262,000	-$6,343,000
Seneca	-$8,659,000	-$4,234,000
Shelby	-$8,664,000	-$3,741,000
Stark	-$9,234,000	-$29,692,000
Summit	-$8,442,000	-$39,632,000
Trumbull	-$10,793,000	-$19,312,000
Tuscarawas	-$7,055,000	-$5,568,000
Union	-$8,988,000	-$4,234,000
Van Wert	-$8,565,000	-$2,095,000
Vinton	-$8,998,000	-$1,062,000
Warren	-$5,959,000	-$11,309,000
Washington	-$8,646,000	-$4,570,000
Wayne	-$6,569,000	-$6,502,000
Williams	-$8,592,000	-$2,779,000
Wood	-$4,963,000	-$5,522,000
Wyandot	-$8,696,000	-$1,673,000

Table 12. Example Nielsen Market Research Data on Tobacco-Related Products and Behaviors

The Ohio Department of Health uses many different data sources to understand and respond to tobacco use issues. One of those data sources is market research data from Nielsen. Market research data provide tobacco use and expenditure information at lower levels of geography such as census tracts and census block groups. The use of market research data in conjunction with demographic data can greatly facilitate the identification of communities and groups who experience tobacco related disparities, which helps to target program interventions where they are needed the most. Applicants may use this data to help justify the geographic scope of interventions proposed and who is targeted.

Nielsen Market Research Profiles on expenditures, use habits, and the propensity of households to purchase and/or use tobacco products and other relevant products (e.g., smoking cessation aids) are available down to the census tract level. Examples of the types of data available include the following.

- Smoking product expenditures (consumers concentration reports) and estimated users (cigarettes, menthol cigarettes, cigars, pipes, smokeless tobacco)
- Propensity indexes for use of smoking products (relative estimated/expected likelihood a household or adult will use a product or service)
- Smoking levels (number of packs in past week, heavy smokers (7+ packs/week))
- Smoking cessation behaviors (use of smoking cessation aids, nicotine patch, or cold turkey method to stop smoking in past year)

Data are available upon request to the Ohio Department Health Tobacco Program. For additional information on Nielsen market research data for Ohio counties, contact the ODH Tobacco Program at TobaccoPrevention@odh.ohio.gov or (614) 728-2429.

*Estimated/Projected Smoking Product Expenditures and Index Score[v]**
Source: Nielsen Market Potential/PRIZM® 2016

Consumer Concentration Report-Tobacco RFP Applicants

Analysis Area Parent	Analysis Area Census Tract Code	Analysis Area Name	2016 Smoking Products & Supplies (2016 Households)					
			Base Count	Base % Comp	Count	% Comp	% Pen	Index
Adams County, OH	39001770600	Manchester village, OH	1,395	0.03%	$688,418	0.04%	49348.96%	122
Adams County, OH	39001770500	Brush Creek township, OH	1,345	0.03%	$659,927	0.03%	49065.20%	121
Adams County, OH	39001770300	Liberty township, OH	2,581	0.06%	$1,268,429	0.07%	49144.87%	121
Adams County, OH	39001770200	Scott township, OH	1,758	0.04%	$861,012	0.05%	48976.79%	121
Adams County, OH	39001770400	West Union village, OH	1,928	0.04%	$927,872	0.05%	48126.14%	119
Adams County, OH	39001770100	Meigs township, OH	1,991	0.04%	$936,610	0.05%	47042.19%	116
Adams County, OH		Change in value: Adams County, OH	10,998	0.24%	$5,342,268	0.28%	48574.90%	120
Allen County, OH	39003010100	Bluffton village, OH	1,517	0.03%	$824,255	0.04%	54334.54%	134
Allen County, OH	39003011500	Auglaize township, OH	1,052	0.02%	$518,577	0.03%	49294.39%	122
Allen County, OH	39003010900	American township, OH	1,791	0.04%	$881,714	0.05%	49230.26%	121
Allen County, OH	39003010200	Monroe township, OH	1,482	0.03%	$712,609	0.04%	48084.28%	119
Allen County, OH	39003011200	Lima city, OH	521	0.01%	$248,924	0.01%	47778.12%	118
Allen County, OH	39003011300	Bath township, OH	2,890	0.06%	$1,357,414	0.07%	46969.34%	116
Allen County, OH	39003013900	Delphos city, OH	1,323	0.03%	$621,417	0.03%	46970.29%	116
Allen County, OH	39003011400	Jackson township, OH	1,188	0.03%	$557,398	0.03%	46919.02%	116
Allen County, OH	39003010600	Spencer township, OH	1,873	0.04%	$880,250	0.05%	46996.80%	116
Allen County, OH	39003010300	Sugar Creek township, OH	626	0.01%	$295,221	0.02%	47159.90%	116
Allen County, OH	39003012400	Lima city, OH	1,008	0.02%	$468,062	0.03%	46434.72%	116

[v] Index score in this table is the likelihood (relative to a national average of 100) that the households/adults in the area are expected to use a smoking product; for example, an index score of 120 for a particular area can be interpreted as households in the area are 20% more likely to use tobacco than the average household/adult.

Data Sources

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[6] 2016 Final Birth Files. Ohio Department of Health, Bureau of Vital Statistics. Percentage of mothers that smoked, among births with known maternal smoking status.

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[14] County Health Rankings 2016: Social & Economic Factors Sub Ranks for Ohio. Robert Wood Johnson Foundation (RWJF). http://www.countyhealthrankings.org/rankings/data/OH; Social & Economic Factors Sub Rank includes data on education, employment, income, family/social support, and community safety (higher rank indicates lower socioeconomic status).

[15] Ohio Medicaid Assessment Survey (OMAS), 2015; Data accessed via the OSU Government Resource Center, OMAS Adult Dashboard. http://grcapps.osu.edu/dashboards/OMAS/adult/

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primary care, dentists, and mental health providers, as well as quality of care (higher rank indicates poorer care quality and access).

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[31] Ohio Behavioral Risk Factor Surveillance System (BRFSS), 2016. Ohio Department of Health. Percent of Ohio adults that live in a home with smoke-free rules where smoking is not allowed anytime or anywhere. (Regional rate assigned to all counties within an assigned region).

[32] Community Health Advisor: Estimated 10-year medical care cost savings as a result of enacting community-wide clean air policies, adult-focused media campaigns, free smoking cessation aids, large tobacco tax increase, and small tobacco tax increase. Robert Wood Johnson Foundation (RWJF). http://www.communityhealthadvisor.org/. Estimated cost-savings from a public-sector (community-wide, state and local) ordinance. Public-sector ordinances establish smoke-free standards for all, or for designated, indoor workplaces, indoor spaces, and outdoor public places. Private-sector smoke-free policies, such as those that ban tobacco use on private property or restrict smoking to designated outdoor locations, are not included in the CHA Tool estimates.

Factors Associated with Youth Tobacco Use

- Social and physical environments
  - The way mass media show tobacco use as a normal activity can promote smoking among young people.
  - Youth are more likely to use tobacco if they see that tobacco use is acceptable or normal among their peers.
  - High school athletes are more likely to use smokeless tobacco than their peers who are non-athletes.
  - Parental smoking may promote smoking among young people.
- Biological and genetic factors
  - There is evidence that youth may be sensitive to nicotine and that teens can feel dependent on nicotine sooner than adults.
  - Genetic factors may make quitting smoking more difficult for young people.
  - A mother's smoking during pregnancy may increase the likelihood that her offspring will become regular smokers.
- Mental health: There is a strong relationship between youth smoking and depression, anxiety, and stress.
- Personal perceptions: Expectations of positive outcomes from smoking, such as coping with stress and controlling weight, are related to youth tobacco use.

- Other influences that affect youth tobacco use include:
  - Lower socioeconomic status, including lower income or education
  - Lack of skills to resist influences to tobacco use
  - Lack of support or involvement from parents
  - Accessibility, availability, and price of tobacco products
  - Low levels of academic achievement
  - Low self-image or self-esteem
  - Exposure to tobacco advertising

Taken from: CDC Office of Smoking and Health, Youth and Tobacco Use Webpage
https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm