Ohio Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor

Amy Acton, M.D., MPH, Director

MEMORANDUM

Date: June 18, 2019

To: Subrecipient agencies

From: Ann Weidenbenner
Office of Health Improvement and Wellness
Ohio Department of Health

Subject: Notice of Availability of Funds for Creating Healthy Communities Competitive Grant- Applications for Fiscal Year 2020– 1/1/20-12/31/24

The Ohio Department of Health (ODH), Office of Health Improvement and Wellness announces the availability of grant funds.

All electronic applications and attachments are due by **4:00 p.m., July 29, 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.

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 **competitive 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. The competitive Solicitation for this grant program can be found on the ODH website (https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/ODH-Grants/ODH-Grants). Allotments will be established in GMIS by ODH. Please refer to the GMIS bulletin board for current allotment percentage.

If you have questions, please contact Ann Weidenbenner at 614-644-7035 or e-mail at ann.weidenbenner@odh.ohio.gov.

Bidders Conference

A Bidders Conference is scheduled for **Tuesday, June 25, 2019** from **1:00-3:00 pm**, via webinar. If you have questions or need assistance in completing this grant application, every effort should be made to participate in the conference call.

Please **RSVP** by **Friday, June 21, 2019** using the registration link below. Also submit any RFP questions at this time. Responses to questions received will be discussed at the Bidders Conference.

https://www.surveymonkey.com/r/CHCBiddersCall

Notice of Intent to Apply for Funding (NOIAF)

All interested parties must submit a Notice of Intent to Apply for Funding (NOIAF) form (attached to this RFP, page 19), no later than **4:00 pm July 2, 2019** to be eligible to apply for funding.

Once the Notice of Intent to Apply for Funding form is received by ODH, the Grants Administration Unit (GAU) will:

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

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

Submit your NOIAF form to Ann Weidenbenner, Program Manager, via email at ann.weidenbenner@odh.ohio.gov by **July 2, 2019.**

Workplan and attachment templates will be sent via email to all applicants after submitting their NOIAF.

ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

OFFICE OF
Health Improvement and Wellness

Creating Healthy Communities
SOLICITATION
FOR
FISCAL YEAR 2020
(1/1/2020 – 12/31/2020)

Local Public Applicant Agencies
Non-Profit Applicants

COMPETITIVE GRANT APPLICATION INFORMATION

x___Base Only Funding ___Base and Deliverable Funding

Revised 02/11/2019
For grant starts 10/1/2019 and thereafter

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I. APPLICATION SUMMARY and GUIDANCE

An application for an Ohio Department of Health (ODH) grant consists of a number of required components including an electronic portion submitted via the Internet website "ODH Application Gateway" and various paper forms and attachments. All the required components of a specific application must be completed and submitted by the application due date. **If any of the required components are not submitted by the due date indicated in sections D, G and 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, July 2, 2019 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. Potential applicants and current subrecipients are required to maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form and current address.

This information is maintained on the following website: http://supplier.ohio.gov/

Note: Subrecipients future payments will be held if the agency receives a paper check due to the EFT information not being properly maintained in the supplier portal.

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: *https://odh.ohio.gov/wps/portal/gov/odh/home*.

(Click on Grant/Contracts, ODH Grants, Grants Administrative Policies and Procedures Manual (OGAPP)) or copy and paste the following link into your web browser: *https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/resources/grants-administrative-policies-and-procedures-manual*

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).
- Sub-recipient'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: Creating Healthy Communities Program

C. Purpose: .

Vision: Making the Healthy Choice the Easy Choice;

Mission: Creating Healthy Communities (CHC) is committed to preventing and reducing chronic disease statewide. Through cross-sector collaboration, we are activating communities to improve access to and affordability of healthy food and increase opportunities for physical activity where Ohioans live, work and play. By implementing sustainable evidence-based strategies, CHC is creating a culture of health.

D. Qualified Applicants:

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

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).

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, July 29, 2019.**

E. Service Area: Service area for the Creating Healthy Communities grant will be the recipient health department's jurisdiction. For non-profit applicants, the service area will be the jurisdiction of the partnered local health department(s). Multi-county regions may not apply as a single service area.

F. Number of Grants and Funds Available: The CHC Program anticipates having approximately $2.3 million for local grant awards and funding approximately 23 local awards. No more than one application per county will be funded. Funding supporting the subgrant program is from the Centers for Disease Control and Prevention, Preventive Health and Health Services Block Grant. Applicants may apply for a maximum award of $100,000.

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

*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 by **4:00 p.m. by Monday, 7/29/2019.** Applications and required attachments received after this deadline will not be considered for review.

Contact Ann Weidenbenner, 614-644-7035, ann.weidenbenner@odh.ohio.gov with any questions. All questions will be answered via a FAQ page on the Creating Healthy Communities website- www.odh.ohio.gov/chc

H. Authorization: Authorization of funds for this purpose is contained in Amended Substitute House Bill and/or the *Catalog of Federal Domestic Assistance (CFDA) Number 93.991.*

I. Goals: The scope of work is specifically designed to improve population health while addressing health equity in populations experiencing health disparities. Applicants will be required to work comprehensively on healthy eating and active living strategies through the

implementation of policy, systems and environmental (PSE) changes. Healthy People 2020 and Ohio's State Health Improvement Plan (SHIP) serve as the basis for the CHC program. CHC 5-year outcomes include the following: increase the number of Ohioans following the Physical Activity Guidelines for Americans; and increase the number of Ohioans following the U.S. Dietary Guidelines for Americans.

J. Program Period and Budget Period: The program period will begin (1/1/2020) and end on (12/31/2024). The budget period for this application is 1/1/2020 through 12/31/2020.

K. Public Health Accreditation Board (PHAB) Standard(s): Identify the PHAB Standard(s) version 1.5 that will be addressed by grant activities.

Standard 1.1: Participate in or Conduct a Collaborative Process Resulting in a Comprehensive Community Health Assessment
Standard 1.3: Analyze Public Health Data to Identify Trends in Health Problems, Environmental Public Health Hazards, and Social and Economic Factors That Affect the Public's Health
Standard 1.4: Provide and Use the Results of Health Data Analysis to Develop Recommendations Regarding Public Health Policy, Processes, Programs, or Interventions
Standard 3.1: Provide Health Education and Health Promotion Policies, Programs, Processes, and Interventions to Support Prevention and Wellness
Standard 3.2: Provide Information on Public Health Issues and Public Health Functions through Multiple Methods to a Variety of Audiences
Standard 4.1: Engage with the Public Health System and the Community in Identifying and Addressing Health Problems through Collaborative Processes
Standard 4.2: Promote the Community's Understanding of and Support for Policies and Strategies that will Improve the Public's Health
Standard 10.1: Identify and Use the Best Available Evidence for Making Informed Public Health Practice Decisions
Standard 10.2: Promote Understanding and Use of Research Results, Evaluations, and Evidence-based Practices with Appropriate Audiences

The PHAB standards are available at the following website:

https://www.phaboard.org/wp-content/uploads/2019/01/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:

   Public Health Accreditation Board (PHAB) Standard(s) to be addressed by grant activities. Please select from the following:
   - 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 Intervention.
- Standard 2.2: Contain/Mitigate Health Problems and Environmental Public Health Hazards.
- 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 10.2: Promote Understanding and Use of the Current Body of Research Results, Evaluations, and Evidence-Based Practices with Appropriate Audiences.

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**.**

3. *Evidence of Health Equity Strategies*

   The ODH is committed to the elimination of health disparities and health inequities. All applicants are required to:

1) Identify specific groups who experience a disproportionate burden of disease, health condition or health outcome targeted by this solicitation.

2) Identify specific social and environmental conditions (social determinants of health) associated with health disparities and health inequities. This must be based on data and include geographic reference points (i.e., census tracts, census block groups) to specify where program activities are focused.

3) Identify measurable health equity targets to be achieved through program activities. This information must also be supported by data.

4) Outline specific evaluation strategies to measure the impact of program activities to decrease and/or eliminate health disparities and health inequities.

5) Link proposed activities to health equity strategies identified in local, state or national planning documents. These documents include, but not limited to, current Healthy People goals and objectives; local Community Health Assessments; State Health Improvement Plan (SHIP); National Stakeholder Strategy for Achieving Health Equity; The Health Opportunity and Equity (HOPE) Initiative.

6) The above items should be explicitly incorporated into key components of the application (i.e., Goals, Program Narrative, Objectives, Deliverables and Review Criteria). The applicant cannot decide where to insert this information. Care should be taken to avoid repetition to keep the responses focused and specific.

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

The following information is provided to explain key health equity concepts and terms.

Racial and ethnic minorities, people with disabilities, the LGBTQ community and Ohio's economically disadvantaged residents do not have the same opportunities as other groups to achieve and sustain optimal health. 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 occur because of low 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, safe housing, quality education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as **social determinants of health (SDOH)**. SDOH are the root cause of health disparities. The systematic nature of health disparities is considered unjust and is referred to as **health inequities**. The ability of everyone to have the same opportunity to achieve the best health possible is referred to as **health equity**. Public health programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to advancing health equity.

M. GMIS Health Equity Module:

1) The GMIS Health Equity Module links important program interventions in grant proposals to health equity strategies identified in local, state or national strategies. These include, but are not limited to, the most current Healthy People goals and objectives; health equity targets in the State Health Improvement Plan (SHIP); National Stakeholder Strategy for Achieving Health Equity; Ohio Health Opportunity Index and/or the Health Opportunity and Equity (HOPE) Initiative. 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.

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 (Creating Healthy Communities)

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 (Ann Weidenbenner; 614-644-7035, ann.weidenbenner@odh.ohio.gov)

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

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, July 29, 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, Measureable, Attainable, Realistic & Time-Phased (S.M.A.R.T.) objectives, activities, milestones and outcomes with respect to time-lines and resources;
5. Estimates reasonable cost to the ODH, considering the anticipated results;
6. Indicates that program personnel are well qualified by training and/or experience for their roles in the program and the applicant organization has adequate facilities and personnel;
7. Provides an evaluation plan, including a design for determining program success;
8. Is responsive to the special concerns and program priorities specified in the Solicitation;
9. Has demonstrated acceptable past performance in areas related to programmatic and financial stewardship of grant funds;
10. Has demonstrated compliance to OGAPP;
11. Explicitly identifies specific groups in the service area who experience a disproportionate burden of the diseases; health condition(s); or who are at an increased risk for problems addressed by this funding opportunity; and,
12. Describe activities which support the requirements outlined in sections I. thru M. of this Solicitation.
13. Provide three letters of support from community partners who will assist in completion of workplan activities. One letter must come from a community planner at the municipal, county or regional level. Applicants are encouraged, but not required, to seek the additional letters from partners from the following fields: disability inclusion, food access, community organizing, healthcare systems, and nonprofit organizations promoting healthy eating and/or active living.

See **Appendix C** for further details of scoring

The ODH will make the final determination and selection of successful/unsuccessful applicants and reserves the right to reject any or all applications for any given 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 publication (journal article, etc.) was supported by the Grant or Cooperative Agreement Number, NB01OT009211-01-00 funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services."

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:

a. Program Reports: Subrecipients Program Reports must be completed and submitted via GMIS, as required by the subgrant program by the following dates. **Program reports that do not include required attachments (non-Internet submitted) will not be approved**. All program report attachments must clearly identify the authorized program name and grant number.

__X__Program Reports Required _____No Program Reports Required

Period	*Report Due Date*
1st Quarter, January 1- March 31	*April 10, 2020*
2nd Quarter, April 1-June 30	*July 10, 2020*
3rd Quarter, July 1- September 30	*October 10, 2020*
4th Quarter, October 1-December 31	*January 10, 2021*

Submission of Subrecipient Program Reports via GMIS indicates acceptance of the OGAPP. Monthly conference calls, 3 CHC All-Project meetings in Columbus, OH and 1 additional training (as determined by ODH) are required for all grantees.

b. 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*
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*
July 1 – 31, 2020	*August 10, 2020*

August 1 – 31, 2020	*September 10, 2020*
September1 – 30, 2020	*October 10, 2020*
October 1 – 31, 2020	*November 10, 2020*
November 1 – 30, 2020	*December 10, 2020*
December 1 – 31, 2020	*January 10, 2021*

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

Period	*Report Due Date*
January 1 – March 31, 2020	*April 10, 2020*
April 1 – June 30, 2020	*July 10, 2020*
July 1 – September 30, 2020	*October 10, 2020*
October 1 – December 31, 2020	*January 10, 2021*

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

1. **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 *February 5, 2021)*. 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.

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

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. Travel and meals over the current state rates (see OBM website: http://obm.ohio.gov/MiscPages/Memos/default.aspx for the most recent Mileage Reimbursement memo.)
16. Costs related to out-of-state travel, unless otherwise approved by ODH, and described in the budget narrative;
17. Training longer than one week in duration, unless otherwise approved by ODH;
18. Contracts for compensation with advisory board members;
19. Grant-related equipment costs greater than $1,000, unless justified in the budget narrative and approved by ODH;
20. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants;
21. Promotional Items;
22. Office Furniture (including but not limited to desks, chairs, file cabinets) unless otherwise stated;
23. Food and beverages for coalition and partner meetings.

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. Client Incentives and Client Enablers:
Client incentives are an unallowable cost.
Client Enablers are an unallowable cost.

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

AB. 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.

AC. 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 20 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
   - Primary Reason
   - Funding

- Justification
- Personnel
- Other Direct Costs
- Equipment
- Contracts
- Compliance Section
- Summary

5. Civil Rights Review Questionnaire
6. Assurances Certification
7. Federal Funding Accountability and Transparency Act (FFATA) reporting form
8. Change request in writing on agency letterhead **(Existing agency with tax identification number, name and/or address change(s)).**
9. Health Equity Module
10. Public Health Impact Statement Summary (non-health department only)
11. Statement of Support from the Local Health Districts (non-health department only)
12. Attachments as required by Program **(1. Personnel/Position Form; 2. CV/Resume; 3. Workplan; 4. Letters of Support; 5. Coalition Member Form)**

One copy of the following document(s) must be e-mailed 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 Notice of Intent to Apply for Funding for is submitted to ODH.

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 11-12 of the Solicitation for unallowable costs

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

1. **Primary Reason and Justification Pages:** Provide a detailed budget justification narrative that describes how the categorical costs are derived. Discuss the necessity, reasonableness, and allocability of the proposed costs. Describe the specific functions of the personnel, consultants and collaborators. Explain and justify equipment, travel, (including any plans for out-of-state travel), supplies and training costs. (A budget justification example can be found on GMIS).

2. **Personnel, Other Direct Costs, Equipment and Contracts:** Submit a budget with these sections and form(s) completed as necessary to support costs for the period January 1, 2020 to December 31, 2020.

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

   Each funded county is required to employee one (1) full-time staff assigned as the Creating Healthy Communities Program Coordinator whose sole duties are to administer the Creating Healthy Communities Program.

   The applicant shall retain all original fully executed contracts on file. A completed "Confirmation of Contractual Agreement" (CCA) must be submitted via GMIS for each contract once it has been signed by both parties. All contracts must be signed and dated by all parties prior to any services being rendered and must be attached to the CCA section in GMIS. The submitted CCA and attached contract must be approved by ODH before contractual expenditures are authorized. **CCAs and attached contracts cannot be submitted until the first quarter grant payment has been issued.**

   Please refer to the memorandum issued by the Director on November 26, 2013 Subject: Contracts. The memorandum was posted on the GMIS Bulletin Board on 11/27/2013.

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

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

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

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

Base the budget solely upon direct costs.

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

4. **Compliance Section:** Answer each question on this form in GMIS as accurately as possible. ***Completion of the form ensures your agency's compliance with the administrative standards of ODH and federal grants.***

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

D. Project Narrative: [limit of 20 pages]

1. **Executive Summary:**

- Identify if the application is for capacity building or implementation and the amount of funding requested and rationale for this selection
- Identify three priority communities to be served and rationale for selection
- Provide a one-page summary of the plan for 2020, including a brief overview of the impact objectives and a description of how activities will be evaluated

2. **Description of Applicant Agency/Documentation of Eligibility/Personnel:**
Briefly discuss the applicant agency's eligibility to apply. Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program.

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

Note any personnel or equipment deficiencies that will need to be addressed in order to carry out this grant. Describe plans for hiring and training, as necessary. Delineate all personnel who will be directly involved in program activities. Include the relationship between program staff members, staff members of the applicant agency, and other partners and agencies that will be working on this program. Include position descriptions for these staff.

3. **Problem/Need:** Identify and describe the local health status concern(s) that will be addressed by the program. Only restate national and state data if local data is not available. The specific health status concerns that the program intends to address may be stated in terms of health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which the evaluation will be based. Clearly identify the target population.

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

   Address the Health Equity Component found on page 6-7 of the RFP here

   Methodology:

   - **Strategy Selection:** Describe, in narrative form, the process of selecting healthy eating and active living strategies for 2020.
   - **Partnerships:** Describe one partnership in each priority community (see **Appendix G**) that is integral to accomplishing the goals and objectives of CHC. Describe other agencies, organizations and programs in your county or priority communities who also address the same risk factors and how CHC will collaborate and not duplicate this work.
   - **Inclusion:** Describe how people with disabilities will be involved in the planning and implementation of healthy eating and activity living strategies to ensure that program activities are accessible to people with disabilities.
   - **Community Engagement:** Describe how priority community residents will be involved in the planning, implementation, and evaluation of CHC goals and objectives.
   - **Assessment and Evaluation:** Describe the applicant agency's experience with program assessment and evaluation. How will this be applied to CHC goals and objectives?
   - **Implementation Grants Only:** Provide a brief summary of the current efforts and progress made in the past 3 years related to successful implementation of healthy eating and active living PSE strategies. Include outcomes and successes.
   - **Implementation Grants Only:** Describe the current coalition and any subcommittees that exist. Explain if there are plans to restructure the coalition.
   - **Capacity Building Grants Only:** Describe how a new coalition will be formed for this program or how an existing coalition will be expanded.

   Work Plan: Using the template provided in **Attachment 3** develop a Work Plan that includes the required Impact Objectives as identified in **Appendix N**. The Work Plan does not count towards the 20 page limit.

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 www.dnb.com. For information about System for Award Management (SAM) go to https://beta.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 https://www.whitehouse.gov/.

(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 July 29, 2019**.

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

III. APPENDICES

- **A.** Notice of Intent to Apply for Funding
- **B.** GMIS Training Form
- **C.** Application Review Form
- **D.** Scope of Work
- **E.** State Priorities
- **F.** Applicant Options
- **G.** Priority Community Selection
- **H.** Capacity Building Grant Requirements
- **I.** Implementation Grant Requirements
- **J.** Training and Technical Assistance (TA)
- **K.** Communication
- **L.** Guidelines for Completing the Workplan
- **M.** Sample Workplan
- **N.** Strategies
- **O.** Assessment
- **P.** County Health Rankings-Health Factors
- **Q.** County Data Indicators
- **R.** Glossary of Terms
- **S.** Attachments

Reimbursement Type
Select one of the options below:

☐ Monthly
OR
☐ Quarterly

NOTICE OF INTENT TO APPLY FOR FUNDING

Ohio Department of Health
Office of Health Improvement and Wellness

ODH Program Title:
Creating Healthy Communities

ALL INFORMATION REQUESTED MUST BE COMPLETI

Appendix A

Submission Required

See Due Date Below

New Applicants must submit the GMIS Training form with the Notice of Intent to Apply for Funding Form

County of Applicant Agency _____ **Federal Tax Identification Nun**

Geographic Area Applying to Cover_____

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) and Proof of Liability Coverage (if applicable). Potential applicants and current subrecipients are required to set-up and maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form and current address.

This information must be set-up and maintained in the following website: http://supplier.ohio.gov/

Note: Subrecipients future payments will be held if the agency receives a paper check due to the EFT information not being properly maintained in the supplier portal.

Forms are only required for NEW AGENCIES or if UPDATES are needed for current agencies. THE NOIAF AND REQUIRED FORMS MUST BE EMAILED TO ann.weidenbenner @odh.ohio.gov BY July 2, 2019

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

If new applicant, this form must be submitted with the Notice of Intent to Apply for Funding Form.

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: https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/ODH-Grants/. 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

Appendix C

Reviewer Number: _____
Date: _____

Capacity Building Reviewer Rating Form

Applicant Agency:_____ Total Requested Budget $_____

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

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

Does Not Meet (0): Response does not comply substantially with requirements or is not provided
Weak (1): Response was poor related to meeting the objectives
Weak to Meets (2): Response indicates the objectives will not be completely met or at a level that will be below average
Meets (3): Response generally meets the objectives (or expectations)
Meets to Strong (4): Response indicates the objectives will be exceeded
Strong (5): Response significantly exceeds objectives or expectations

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

Section	Maximum Pts	Score
Executive Summary	**13**	
Description of Applicant Agency	**21**	
Problem/Need	**25**	
Methodology	**35**	
Work Plan	**98**	
Budget	**18**	
Required Attachments	**12**	
Health Factors Points*		

*For Internal Use Only (refer to Appendix P)

Total Points	**222**	

General Comments on this Application:

Approval of Application as Submitted

Approval of Application with Special Conditions: (Please List)

Disapproval of Application: (Statement of Rationale)

Category	Max	Score	Comments: Strengths, Weaknesses
Executive Summary			
Identified as a Capacity Building Grant, amount of funding requested	**3**		
Identified 3 priority communities and provides rationale for selection	**5**		
Provided a one-page summary of the plan for 2020, including a brief overview of the impact objectives and a description of how activities will be evaluated	**5**		
Executive Summary Total	**13**		
Description of Applicant Agency/ Documentation of Eligibility/Personnel			
Adequately summarized the agency's structure as related to this program and how the agency will manage the program	**5**		
Described capacity to communicate in a manner easily understood by diverse audiences	**5**		
Noted personnel and/or equipment deficiencies	**3**		
Described plans for hiring and training	**3**		
Delineated all personnel who will be involved in the program activities on the grant	**5**		
Description of Application Agency Total	**21**		

Problem/Need			
Identified and clearly described local health status concerns that will be addressed by the program	**5**		
Local data discussed. Only restates national and state data if local data is not available.	**5**		
Clearly described segments of the target population who have disproportionate burden of health concern	**5**		
Explained and identified how specific social and environmental conditions (social determinants of health) put groups who are already disadvantaged at increased risk for health inequities	**5**		
Clearly described how program activities will address health disparities.	**5**		
Problem/Need Total	**25**		
Methodology			
Described the process the applicant went through to select strategies	**5**		
Described one partnership in each priority community that is integral to accomplishing the goals and objectives of CHC.	**5**		
Described other agencies or organizations in the county or priority communities who also address the same risk factors and how CHC will collaborate and not duplicate this work	**5**		
Described the process used to engage people with disabilities in the planning and	**5**		

implementation of healthy eating and active living strategies to ensure program activities are accessible to people with disabilities.			
Described how priority community residents will be involved in planning, implementing, and evaluating CHC goals and objectives	**5**		
Described agency's experience with program assessment and evaluation, and how this will be applied to CHC goals and objectives	**5**		
Described how a new coalition will be formed or existing coalition will be expanded for this program	**5**		
Methodology Total	**35**		
Capacity Building Work Plan (Attachment 3)			
The Work Plan includes 4 impact objectives: 1. Coalition Development and Evaluation 2. One Active Living SPAN strategy in 1 priority community 3. One Food Service Guidelines strategy in 1 priority community 4. One additional Healthy Eating or Active Living strategy in 1 priority community	**3**		
Work Plan includes required long term objectives, required impact objectives and related strategies	**3**		
One Impact Objective is selected for an in-depth evaluation and success story	**3**		
Outcome evaluations address behavior change and are measurable through an identified data collection method	**5**		

Impact Objective #1			
Coalition strategy selected from RFP menu	**3**		
Adequate number of Process Objectives to accomplish Impact Objective	**5**		
Process Objectives and Related Activities are tailored to the selected strategy	**5**		
Timeline contains specific dates and is feasible	**3**		
Evaluation measures match activities	**5**		
Impact Objective #2			
SPAN Active Living strategy selected from RFP menu; priority community identified	**3**		
Adequate number of Process Objectives to accomplish Impact Objective	**5**		
Process Objectives and Related Activities are tailored to the selected strategy	**5**		
Timeline contains specific dates and is feasible	**3**		
Evaluation measures match activities	**5**		
Impact Objective #3			
Food Service Guidelines strategy selected; priority community identified	**3**		
Adequate number of Process Objectives to accomplish Impact Objective	**5**		
Process Objectives and Related Activities are tailored to the selected strategy	**5**		

Timeline contains specific dates and is feasible	**3**		
Evaluation measures match activities	**5**		
Impact Objective #4			
Healthy Eating or Active Living strategy selected from RFP menu; priority community identified	**3**		
Adequate number of Process Objectives to accomplish Impact Objective	**5**		
Process Objectives and Related Activities are tailored to the selected strategy	**5**		
Timeline contains specific dates and is feasible	**3**		
Evaluation measures match activities	**5**		
Other Objectives (not required- not scored)			
Impact Objective and strategy selected from RFP menu; priority community identified			
Adequate number of Process Objectives to accomplish Impact Objective			
Process Objectives and Related Activities are tailored to the selected strategy			
Timeline contains specific dates and is feasible			
Evaluation measures match activities			
Work Plan Total	**98**		
Budget			
Does not exceed the maximum award	**3**		
Personnel, Other Direct costs, Equipment,	**3**		

and Contracts are identified and appropriate to program scope of work			
Adequately explains and justifies equipment, travel, supplies, and training costs	**3**		
Program Coordinator is 100% time on CHC Program (refer to personnel form if needed)	**3**		
Budget is reasonable and adequate to meet the goals and objectives of the project	**3**		
Travel included for 3 mandatory CHC All-Projects meetings	**3**		
Budget Total	**18**		
Required Attachments			
Personnel/Position (Attachment 1)	**3**		
CV/Resume and Job Description (Attachment 2)	**3**		
Three Letters of Support (Attachment 4)	**3**		
Coalition Member Form (Attachment 5)	**3**		
Required Attachment Total	**12**		
Additional Requirements (For Internal Use Only)			
GMIS application requirements such as Civil Rights Review, Assurances Certification, FFATA			
Completed GMIS Health Equity Module			

Other **Yes** **No**

□ Statement of Intent to Pursue Health Equity Strategies (Attachment 6) ____ ____ *non local health districts only

Reviewer Number: _____
Date: _____

Implementation Reviewer Rating Form

Applicant Agency:_____ Total Requested Budget $_____

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

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

DOES NOT MEET (0): Response does not comply substantially with requirements or is not provided
WEAK (1): Response was poor related to meeting the objectives
WEAK TO MEETS (2): Response indicates the objectives will not be completely met or at a level that will be below average
MEETS (3): Response generally meets the objectives (or expectations)
MEETS TO STRONG (4): Response indicates the objectives will be exceeded
STRONG (5): Response significantly exceeds objectives or expectations

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

Section	Maximum Pts	Score
Executive Summary	**13**	
Description of Applicant Agency	**21**	
Problem/Need	**25**	
Methodology	**40**	
Work Plan	**161**	
Budget	**18**	
Required Attachments	**12**	
Health Factors Points*		
Total Points	**290**	

*For Internal Use Only (refer to Appendix P)

General Comments on this Application:

Approval of Application as Submitted

Approval of Application with Special Conditions: (Please List)

Disapproval of Application: (Statement of Rationale)

Category	Max	Score	**Comments:** Strengths, Weaknesses
Executive Summary			
Identified as an Implementation Grant, amount of funding requested	**3**		
Identified 3 priority communities and provides rationale for selection	**5**		
Provided a one-page summary of the plan for 2020, including a brief overview of the impact objectives and a description of how activities will be evaluated	**5**		
Executive Summary Total	**13**		
Description of Applicant Agency/ Documentation of Eligibility/Personnel			
Adequately summarized the agency's structure as related to this program and how the agency will manage the program	**5**		
Described capacity to communicate in a manner easily understood by diverse audiences	**5**		
Noted personnel and/or equipment deficiencies	**3**		
Described plans for hiring and training	**3**		
Delineated all personnel who will be involved in the program activities	**5**		
Description of Applicant Agency Total	**21**		
Problem/Need			
Identified and clearly described local health status concerns addressed with this program	**5**		
Local data discussed. Only restates national and state data if local data is not available.	**5**		

Clearly described segments of the target population who have disproportionate burden of health concern	**5**		
Explained and identified how specific social and environmental conditions (social determinants of health) put groups who are already disadvantaged at increased risk for health inequities	**5**		
Clearly described how program activities will address health disparities.	**5**		
Problem/Need Total	**25**		
Methodology			
Described the process the applicant went through to select strategies	**5**		
Described one partnership in each priority community that is integral to accomplishing the goals and objectives of CHC.	**5**		
Described other agencies or organizations in your county or priority communities who also address the same risk factors and how CHC will collaborate and not duplicate this work	**5**		
Described the process used to engage people with disabilities in the planning and implementation of healthy eating and active living strategies to ensure program activities are accessible to people with disabilities.	**5**		
Described how priority community residents will be involved in planning, implementing, and evaluating CHC goals and objectives	**5**		

Described the agency's experience with program assessment and evaluation, and how this will be applied to CHC goals and objectives	**5**		
Provided a brief summary of the current efforts and progress made in the past 3 years related to successful implementation of PSE strategies relating to healthy eating and active living; include outcomes and successes	**5**		
Described the current coalition and any subcommittees that exist; explain if there are plans to restructure the coalition	**5**		
Methodology Total	**40**		
Implementation Work Plan (Attachment 3)			
The Work Plan includes 7 impact objectives: 1. Coalition Development and evaluation 2-4. One Active Living strategy in each of the 3 priority communities (one must be a SPAN strategy). 5-7. One Healthy Eating strategy in each of the 3 priority communities (one must be Food Service Guidelines).	**3**		

Work Plan includes required long term objectives, required impact objectives and related strategies	**3**		
One Impact Objective is selected for an in-depth evaluation and success story	**3**		
Outcome evaluations address behavior change and are measurable through an identified data collection method	**5**		
Impact Objective #1			
Coalition strategy selected from RFP menu	**3**		
Adequate number of Process Objectives to accomplish Impact Objective	**5**		
Process Objectives and Related Activities are tailored to the selected strategy	**5**		
Timeline contains specific dates and is feasible	**3**		
Evaluation measures match activities	**5**		
Impact Objective #2			
Active Living Impact Objective and strategy selected from RFP menu; priority community identified	**3**		
Adequate number of Process Objectives to accomplish Impact Objective	**5**		
Process Objectives and Related Activities are tailored to the selected strategy	**5**		
Timeline contains specific dates and is feasible	**3**		
Evaluation measures match activities	**5**		
Impact Objective #3			

Active Living Impact Objective and strategy selected from RFP menu; priority community identified	**3**		
Adequate number of Process Objectives to accomplish Impact Objective	**5**		
Process Objectives and Related Activities are tailored to the selected strategy	**5**		
Timeline contains specific dates and is feasible	**3**		
Evaluation measures match activities	**5**		
Impact Objective #4			
Active Living impact objective and strategy selected from RFP menu; priority community identified	**3**		
Adequate number of process objectives to accomplish impact objective	**5**		
Process objectives and related activities and tailored to the selected strategy	**5**		
Timeline contains specific dates and is feasible	**3**		
Evaluation measures match activities	**5**		
Impact Objective #5			
Healthy Eating Impact Objective and strategy selected from RFP menu; priority community identified	**3**		
Adequate number of Process Objectives to accomplish Impact Objective	**5**		
Process Objectives and Related Activities are tailored to the selected strategy	**5**		
Timeline contains specific dates and is feasible	**3**		
Evaluation measures match activities	**5**		

Impact Objective #6			
Healthy Eating Impact Objective and strategy selected from RFP menu; priority community identified	**3**		
Adequate number of process objectives to accomplish impact objective	**5**		
Process Objectives and Related Activities are tailored to the selected strategy	**5**		
Timeline contains specific dates and is feasible	**3**		
Evaluation measures match activities	**5**		
Impact Objective #7			
Healthy Eating impact objective and strategy selected from RFP menu; priority community identified	**3**		
Adequate number of Process Objectives to accomplish Impact Objective	**5**		
Process Objectives and Related Activities are tailored to the selected strategy	**5**		
Timeline contains specific dates and is feasible	**3**		
Evaluation measures match activities	**5**		
Other Objectives (not required – not scored)			
Impact objective and strategy selected from RFP menu; priority community(ies) identified			
Adequate number of Process Objectives to accomplish Impact Objective			
Process Objectives and Related Activities are tailored to the selected strategy			
Timeline contains specific dates and is feasible			

Evaluation measures match activities			
Work Plan Total	**161**		
Budget			
Does not exceed the maximum award	**3**		
Personnel, Other Direct costs, Equipment, and Contracts are identified and appropriate to program scope of work	**3**		
Adequately explains and justifies equipment, travel, supplies, and training costs	**3**		
Program Coordinator is 100% time on CHC Program (refer to personnel form if needed)	**3**		
Budget is reasonable and adequate to meet the goals and objectives of the project	**3**		
Travel included for 3 mandatory CHC All-Projects meetings	**3**		
Budget Total	**18**		
Required Attachments			
Personnel/Position (Attachment 1)	**3**		
CV/Resume and Job Description (Attachment 2)	**3**		
Three Letters of Support (Attachment 4)	**3**		
Coalition Member Form (Attachment 5)	**3**		
Required Attachment Total	**12**		
Additional Requirements (For Internal Use Only)			
GMIS application requirements such as Civil Rights Review, Assurances Certification, FFATA			
Completed GMIS Health Equity Module			

Other **Yes** **No**

□ Statement of Intent to Pursue Health Equity Strategies (Attachment 6) ____ ____ *non local health districts only

Appendix D

Scope of Work

Overview

The scope of work is specifically designed to improve population health while addressing health equity in populations experiencing health disparities. Applicants will be required to work comprehensively on healthy eating and active living strategies in the community, school, and worksite settings.

Healthy People 2020 and Ohio's State Health Improvement Plan serve as the basis for the following 5-Year outcomes:

ODH 5-Year Outcomes

- Decrease the mortality rate of heart disease
- Decrease the prevalence of coronary heart disease among adults (ages 18+)
- Decrease the prevalence of stroke among adults (ages 18+)
- Decrease the prevalence of diabetes among adults (ages 18+)
- Decrease the prevalence of obesity among adults (ages 18+)
- Decrease the prevalence of obesity among high school students (grades 9-12)
- Decrease the prevalence of multiple chronic diseases (2 or more) among adults (ages 18+)

CHC 5-Year Outcomes

- Increase the number of Ohioans following the Physical Activity Guidelines for Americans.
- Increase the number of Ohioans following the U.S. Dietary Guidelines for Americans.

Appendix E

State Priorities

There are multiple strategies listed in the RFP **(Appendix N)** where additional statewide support is available. For example, ODH contracts with an active living services vender to provide expertise and technical assistance for active living strategies. Toolkits and branded materials for healthy food retail and food service guidelines have also been created. In addition, CHC state staff supports grant objectives within the CDC State Physical Activity and Nutrition (SPAN) grant, https://www.cdc.gov/nccdphp/dnpao/state-local-programs/span-1807/index.html. A full list of strategies and support is provided in the table on the following page. Refer to the Creating Healthy Communities website, www.odh.ohio.gov/chc, for updated resources.

Priority	Additional Support
Complete Streets*	Active Living Services Vendor, Ohio Active Transportation Emphasis Area Team
Active Transportation Planning*	Active Living Services Vendor, ODOT
Land Use interventions*	Active Living Services Vendor
Your Move Ohio	ODH and ODOT http://www.dot.state.oh.us/Divisions/Planning/ProgramManagement/HighwaySafety/ActiveTransportation/Pages/choose.aspx
Healthy Food Retail	Good Food Here branded materials and toolkits
Food Service Guidelines*	Good Food Here branded materials and toolkit
SNAP Incentive Programs	Ohio Nutrition Incentive Network, Produce Perks Midwest
Disability Inclusion	Ohio Disability and Health Program

* denotes SPAN strategy

Appendix F

Applicant Options

1. **Capacity Building Grants**

   Applicants who need time to build their infrastructure, including identifying and convening a CHC coalition, assessing partnerships, and hiring staff, should consider applying for a Capacity Building grant. Current Creating Healthy Communities grantees (2015-2019) are not eligible to apply for Capacity Building grants. All Capacity Building subgrantees must apply for an Implementation grant for the 2021 Continuation Grant Application.

2. **Implementation Grants**

   Applicants are eligible to apply for an Implementation grant if within the last 3 years they have maintained strong partnerships and a functional coalition; completed a current community needs assessment; and successfully implemented PSE strategies related to healthy eating or active living.

   Both Capacity Building and Implementation grants will be required to hire a full-time CHC Coordinator who works exclusively on the CHC grant.

Appendix G

Priority Community Selection

Both Capacity Building and Implementation grants are required to complete strategies in **3** Priority Communities. A priority community is defined as a specific group of people, often living in a defined geographical area (city or county jurisdiction, villages, townships, zip codes, census tracts, or school districts), who share a common culture, values, and norms and are arranged in a social structure according to relationships the community has developed over time. Impact is maximized when people have healthy choices available where they live, work, learn and play. Selection of priority communities should consider the following variables:

1. Presence of health inequities
2. Readiness of the priority community to advance change
3. Stakeholder buy-in
4. Total reach (i.e., how many people will be impacted by the change)
    a. City and county-wide policy adoption is encouraged
5. Adequate infrastructure for change

If applicants would like more technical assistance regarding priority community selection the ODH Office of Health Equity is able to assist in providing Market Potential Reports (MPR). MPRs provide the capability to simultaneously analyze different profiles (i.e., risk factors for chronic disease) at once to determine the best areas to focus program efforts. The MPR provides information on behaviors, consumption patterns, lifestyles or media habits of specific census geographies (i.e., census tract, census block groups).

All applicants may choose their entire jurisdiction as one of the three required priority communities.

Appendix H

Capacity Building Grant Requirements

1. Create a 1-year Work Plan Including the following Impact Objectives (total of 4)
    - Impact Objective #1: Coalition – Organize and coordinate a multi-disciplinary coalition of key stakeholders representing the 3 identified priority communities. Include an annual evaluation of the coalition.
    - Impact Objective #2: 1 Active Living SPAN strategy in Priority Community 1 (choose one of the following options)
        i. Complete Streets
        ii. Active Transportation Planning
        iii. Land Use Intervention
    - Impact Objective #3: 1 Healthy Eating SPAN strategy in Priority Community 2
        i. Food Service Guidelines
    - Impact Objective #4: 1 Healthy Eating or Active Living strategy in Priority Community 3 (see **Appendix N** for list of strategies)
2. Submit an annual success story per guidance from ODH
3. Attend all required in-person and online meetings/conference calls
4. Submit quarterly program reports via GMIS
5. Complete Implementation grant requirements in years 2021-2024

Appendix I

Implementation Grant Requirements

1. Create a 1-year Work Plan including the following Impact Objectives (total of 7)
    - Impact Objective #1: Coalition – Organize and coordinate a multi-disciplinary coalition of key stakeholders representing the 3 identified Priority Communities. Include an annual evaluation of the coalition.
    - Impact Objective #2-4: 1 Active Living strategy in each Priority Community
        - Applicants must pursue at least one SPAN Active Living Strategy
            1. Complete Streets
            2. Active Transportation Planning
            3. Land Use Intervention
        - See **Appendix N** for full list of Active Living Strategies
    - Impact Objective #5-7: 1 Healthy Eating strategy in each Priority Community
        - Applicants must pursue the SPAN Food Service Guidelines Strategy in at least one Priority Community
        - See **Appendix N** for full list of Healthy Eating Strategies
2. Submit an annual success story per guidance from ODH
3. Attend all required in-person and online meetings/conference calls
4. Submit quarterly reports via GMIS

Appendix J

Training and Technical Assistance (TA)

The purpose of training and TA is to build the capacity of CHC grantee staff and partners (as appropriate and as funding allows) to ensure they have the foundational skills and resources they need to successfully implement CHC strategies. ODH's approach to training and TA will support both strategy-specific and foundational skills to advance PSE changes to improve access to and affordability of healthy food, to increase opportunities for physical activity, and to reduce rates of chronic disease.

Each subgrantee will be assigned an ODH Program Consultant. Program Consultants will conduct quarterly site visits (in person or via conference call) and provide verbal and written feedback on quarterly program and expenditure reports. Sub-grantees are encouraged to call or e-mail their Program Consultant at any time for programmatic or budgetary questions.

Training and TA will be delivered by ODH in the following ways:

1. Statewide in-person meetings
2. Train-the-trainer opportunities
3. Webinars, conference calls, etc.
4. Printed and digital materials and other resources (e.g., toolkits, policy templates, etc.)
5. CHC Engagement Hub (internal program website with library of resources and discussion forum)

Grantees are required to:

1. Attend trainings, which include the following:
    a. 3 CHC All-Project Meetings in Columbus, OH
    b. 1 Additional training (to be determined by ODH)
2. Participate in monthly All-Project conference calls
    a. Participation in monthly conference calls requires access to Skype
3. Remain in regular contact with their Program Consultant in between quarterly reporting
4. Participate in the CHC Engagement Hub

Appendix K

Communication

Communication is critical to building support with the public and connecting with stakeholders. All grants will be expected to follow CHC communications procedures. ODH will provide informal and formal training on communications and media.

Grantees will be required to:

1. Collect and submit at least one print success story per year.
2. Create an account on the CHC Engagement Hub and ensure technological capability to access the site.
3. Communicate with ODH regarding creation of original education materials for approval and ensure that communication pieces funded by CHC such as advertisements, signage, printed materials, and websites, conform to uniform communication standards that will be provided by ODH. These standards include visual cues such as logos, graphics, PowerPoint templates, colors and fonts, as well as standardized terminology and key messages, to create a consistent look and message for the CHC brand across the state.
4. Utilize local health department resources to ensure that program information (both print and electronic) is accessible to all individuals, including people with disabilities.
5. Subgrantees will be expected to represent the CHC program throughout the state by using the above materials. When programs are identified in the public such as through media articles it is required to clearly state "The Creating Healthy Communities Program at the (health department name)".
6. CHC project logos are required on all forms of communication.
7. Create and/or maintain a webpage for the local CHC program which is housed within the applicant agency's website.
8. The CDC funding statement must be placed on all educational materials developed by CHC subgrantees (see Ownership Copyright section and funding statement on pages 9-10 of the RFP).

Guidelines for Completing the Work Plan

Guidelines for how to complete the various parts of the Work Plan are described below. Specific examples of each component can be found in the sample Work Plan in **Appendix L**.

Long-Term Objective

For consistency and evaluation purposes, all subgrantees are required to use the provided Long-Term Objectives, found in **Appendix N**, throughout the 5-year grant cycle.

Impact Objective

For consistency and evaluation purposes, all grantees are required to use the provided Impact Objectives, found in **Appendix M**. One Impact Objective should be selected and identified for an in-depth evaluation and the creation of a success story.

Outcome Evaluation

Identify the ultimate outcome for the PSE change that occurs for each Impact Objective. These Outcome Evaluations should **address the *behavior change*** that occurs as a result of the intervention. The impact should be measurable through data collection and the **method of collection should be identified.**

Process Objectives

For each Impact Objective, write the intermediate steps or specific, measurable actions that need to be completed in a specific timeframe. Process Objectives explain what is to be done and when it is going to be completed. There should be a minimum of **five** Process Objectives to accomplish each Impact Objective.

Related Activities

List steps to accomplish each Process Objective. Related Activities should be unique to each Strategy and priority community.

Agency or Person Responsible

Identify the person(s) and/or agency (ies) responsible for each Process Objective.

Specific Dates

List specific beginning and ending dates throughout the year for planning and measuring progress. Process Objectives and Related Activities should be properly tailored to each strategy. *Having Process Objectives that span a full year is discouraged.*

Evaluation Measure(s)

Evaluation can help identify needed changes, find out how well objectives are being met, determine the effects of the program, and identify ways to improve to the program. In the Work Plan, include a brief description of the Evaluation Measures for each Process Objective. After the measures are developed, gather and record the data. This information will be included in Quarterly Reports and may be shared with stakeholders.

Progress

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

Appendix M

SAMPLE: 2019 CREATING HEALTHY COMMUNITIES WORK PLAN

Priority Community: Riverport

Long-Term Objective: By December 31, 2024, Hampton County will increase the number of Ohioans following the U.S. Physical Activity Guidelines for Americans.	
Program Impact Objective: By December 31, 2020, Riverport will increase the number of adults/youth who have access to places for physical activity as evidenced by an increase in 1 Worksite Active Commute Support.	
4th Quarter Only: Has this Impact Objective been met? (Please indicate Yes/No, if No explain):	
# of Process Objectives: 7	**# of Process Objectives Met:**
Outcome Evaluation: An increase in the number of employees walking, biking, or taking transit to work and an increase in employee noted physical activity as evidenced by a worksite commute survey of staff and observation of infrastructure. *Selected as success story	

Process Objectives	Related Activities	Agency or Person Responsible	Specific Dates for Each Activity		Evaluation Measures
			Start	End	
1. Identify a worksite with the potential to support active commute in a community where physical activity is limited	● Work with coalition to identify potential worksites ● Contact/meet with worksite representative to assess interest ● Provide introductory packet of information regarding active commute ● Set time to assess current commute infrastructure, policies, etc.	-CHC Staff -Coalition Members -Worksite HR/Wellness point person	1/1/20	3/31/20	Meeting notes List of recourses from introductory packet.
Q1:					
Q2:					
Q3:					

Q4:					
2. Meet with HR to develop plan and timeline to implement active commute strategies	● Schedule meeting with HR or representative ● Share tools and best practices for making improvements such as the Ohio Active Commute Toolkit ● Discuss on-road bike training opportunities ● Develop timeline for strategy implementation ● Discuss survey of staff and visitors ● Sign MOU	CHC Staff Worksite HR/Wellness point person	2/1/20	3/31/20	Implementation plan Implementation timeline Signed MOU
Q1:					
Q2:					
Q3:					
Q4:					

3. Conduct pre-assessment of commute infrastructure and staff.	• Set time for assessment of worksite infrastructure and possible location for needed additions • Meet with members of the disability community to identify and remedy barriers to accessibility • Implement survey of staff and visitors and review • Share results of survey and infrastructure assessment with HR Representative	CHC Staff CHC Coalition Disability community Worksite Wellness/HR/Champion/Staff	4/1/20	6/1/20	Observations and documentation of infrastructure, policies, etc. Survey results (# who report ever actively commuting, etc.) Meeting notes
Q1:					
Q2:					
Q3:					
Q4:					
4. Provide TA to facilitate infrastructure changes needed for actively commuting	• Purchase infrastructure (bike racks, lockers, fix-it stations, etc.) • Assistance in placement and utilization of new infrastructure • Arrange for installation of infrastructure as needed • Confirm installation	CHC Staff Worksite Staff/HR/Bldg mgmt	5/1/20	8/1/20	Pre Photos Meeting notes Purchase orders Post Photos

Q1:					
Q2:					
Q3:					
Q4:					
5. Provide education to staff on active commute	● Promote new infrastructure via worksite newsletter, signage and social media ● Schedule an educational Lunch and Learn ● Organize a Bike to Work Day ● Provide Ride Buddy opportunity to staff members ● Promote and recruit participation for events ● Share resources related to route-planning or anything else that will help (riding tips, rules of the road, how to put bike on bus, how to use certain infrastructure)	CHC Staff Local active transportation advocacy group Worksite staff/HR/champion	5/1/20	8/1/20	Post in newsletter Photos Lunch and Learn sign in Ride Buddy Sign Up and Sign in Sheet
Q1:					
Q2:					
Q3:					
Q4:					

6. Provide TA in adoption of active commute policy	• Review current policy that could impact commute choice (clothing, flex time, breaks) • Provide model policy language and revise with worksite staff to fit needs. • Present final policy to board or administration meeting for adoption.	CHC Staff Worksite HR/Staff	6/1/20	8/1/20	Signed Policy
Q1:					
Q2:					
Q3:					
Q4:					
7. Evaluate active commute policy and systems changes within the worksite.	• Conduct pre and post surveys for ride buddy program participants • Conduct follow-up survey for all employees • Assist worksite in applying for the Bicycle Friendly Business Award	CHC Staff	9/1/20	12/31/20	Survey Results Award application

Appendix N

Strategies

Many of the strategies below require extensive planning and collaboration with partners and therefore may take more than one year to complete. **If necessary, an Impact Objective may take 2 years to complete.**

A complete list of references is included at the end of the appendix. Evidence-based sources include the following:

- CDC Community Guide
- CDC Community Measures for Obesity Prevention (COCOMO)
- CDC A Practitioner's Guide for Advancing Health Equity
- Institute of Medicine (IOM) Accelerating Progress in Obesity Prevention
- Robert Wood Johnson Foundation (RWJF) Action Strategies Toolkit
- NACCHO Mobilizing for Action through Planning and Partnerships (MAPP) Resource Guide for Disability Inclusion

Please reference the glossary for more information on certain strategies.

Coalition

Long-Term Objective

- By December 31, 2024, the (x county) CHC Coalition will be a high functioning coalition.

Impact Objective

- By December 31, 2020, the (x county) CHC Coalition will increase (choose from below) as evidenced by a coalition assessment and evaluation.
    - Membership (diversity, number, and participation)
    - Member satisfaction
    - Funding leveraged
    - PSE knowledge and skills

Active Living

Long-Term Objective
By December 31, 2024, x county will increase the number of Ohioans following the Physical Activity Guidelines for Americans.

Impact Objectives

- By December 31, 2020, x priority community will increase the number of adults/youth who have access to places for physical activity as evidenced by an increase in (include number) (of specify strategy).
    - Strategies
        - New/Repaired Parks and Playgrounds
        - Worksite Active Commute Support
        - Bike Infrastructure
        - Pedestrian Infrastructure
        - Public Transit Improvements
        - Multi-Use Trails
        - Safe Routes to School

- By December 31, 2020, x priority community will implement and/or enforce physical activity policies/practices as evidenced by an increase in (include number) (of specify strategy).
    - Strategies
        - Complete Streets Policy
        - Bicycle/Pedestrian Master Planning
        - Land Use Policy

Healthy Eating

Long-Term Objective

- By December 31, 2024, x county will increase the number of Ohioans following the U.S. Dietary Guidelines for Americans.

Impact Objectives

- By December 31, 2020, x priority community will increase access to healthy food options as evidenced by an increase in (include number) (of specify strategy).
    - Strategies
        - Farmers' Markets
        - Healthy Food Retail
        - Food Bank/Pantries
        - Community Gardens
        - Farm-to-Institution
        - Community Supported Agriculture (CSA)
        - Safe Routes to Healthy Food
        - Produce Prescriptions

- By December 31, 2020, x priority community will implement and/or enforce healthy eating policies/practices as evidenced by an increase in (include number) (of specify strategy).
    - Strategies
        - Food Service Guidelines
        - Food Access Policy & Planning

Appendix O

Assessment

Survey of Community-Based Policy, Systems, and Environmental (PSE) Supports for Healthy Eating and Active Living

The survey on the following pages has been provided to applicants as a reference tool to reflect on the current state of healthy eating and active living PSE supports within potential priority communities. Only successfully awarded applicants will be required to complete the survey in its entirety for each priority community. **This survey is not a part of the CHC application and should not be submitted with other application materials.**

These questions ask about specific policies, systems, and environmental supports present in the priority community(ies) that promote healthy eating and active living. To gather all of the information covered in this survey, it will be necessary that partners from the public and private sectors are consulted to provide the most accurate and complete information on local healthy eating and active living PSE supports.

Adapted by the Creating Healthy Communities (CHC) program from a survey conducted by the U.S. Centers for Disease Control and Prevention (CDC).

SECTION 1. COMMUNITY-WIDE PLANNING EFFORTS FOR HEALTHY EATING AND ACTIVE LIVING

1. Is this priority community covered by a comprehensive, general, master, neighborhood, or area plan?

(a). Yes

(b). No

1B. If YES, provide name of plan and year of adoption or latest revision.

---

2. Is this priority community covered by any of the following types of master plan(s) or other plan(s)? This can include stand-alone plans that are not a part of the Comprehensive/General Plan. **CHOOSE ALL THAT APPLY:**

(a). Land use plan (for new development and growth management)

(b). Transportation plan

(c). Parks and recreation plan

(d). Bicycle/pedestrian or active transportation plan

(e). Transit plan

(f). School Travel Plan

(g). This priority community is not covered by any planning documents related to these topics

3. Are any of the following objectives included in the plan(s) that cover this priority community, even if the objectives have not yet been implemented? **CHOOSE ALL THAT APPLY:**

(a). Implementation of a Complete Streets policy (as defined by the National Complete Streets Coalition) for new and retrofit projects

(b). Development regulations that promote street connectivity

(c). New parks, green spaces, or recreational walking and bicycling paths

(d). Encouragement of mixed-use development

(e). Support for farmers' markets, community gardens, or agricultural uses

(f). Support for the inclusion of people with disabilities and/or older adults within the community

(g). None of these objectives are included

SECTION 2. THE BUILT ENVIRONMENT AND POLICIES THAT SUPPORT PHYSICAL ACTIVITY

4. Is this priority community covered by a formal Complete Streets policy, as defined by the National Complete Streets Coalition, for designing and operating streets with safe access for all users?

(a). Yes

(b). No

5. Does this priority community have a written requirement or official objective to install bicycle racks at public facilities, such as public parks, government buildings, or transit stations?

(a). Yes

(b). No

6. Which of the following features are included in community development policy (including zoning codes and design/development guidelines) for new or retrofit development covering this priority community? **CHOOSE ALL THAT APPLY:**

(a). Requiring short to medium pedestrian-scale block sizes (for example, less than 600' x 600')

(b). Requiring continuous sidewalk coverage

(c). Requiring minimum sidewalk widths to promote walking in groups (for example, at least 5 feet wide)

(d). Requiring that buildings relate to the street (for example, entrances facing streets, reduced building setbacks, or reduced parking requirements)

(e). Requiring that street trees or street furniture separate pedestrian zones from streets

(f). Requiring audible and visual crosswalk beacons and tactile warning surfaces at crosswalks

(g). Allowing mixed land uses (for example, zoning that combines residential land use with one or more commercial, institutional, or public land uses

(h). Other (specify): _____

(i). This priority community is not covered by policies for new or infill development

7. Does a planning and/or zoning commission have jurisdiction over this priority community?
(a). Yes

(b). No **(If no, move to question 8)**

7B. Is there a designated health/public health representative on the planning and/or zoning commission?
(a). Yes

(b). No

8. Does your priority community have a bicycle and/or pedestrian advisory committee?
(a). Yes

(b). No **(If no, move to question 9)**

8B. Is there a designated health/public health representative on the bicycle and/or pedestrian advisory committee?
(a). Yes

(b). No

9. Is accessible public transportation available in this priority community?
(a). Yes
(b). No (**If no, move to question 10**)

9B. If so, is it:
(a). On demand
(b). Fixed route
(c). Other (specify)_____

10. Does this priority community have recreational or mixed-use trails?
(a). Yes
(b). No (**If no, move to question 11**)

10B. If yes, are any of these trails accessible to all community members, including aging individuals and people with disabilities?

(a). Yes
(b). No

11. Have any school districts in this priority community applied for Safe Routes to School funding in the past 5 years?

(a). Yes
(b). No

12. Does your largest worksite have active commute supports and/or policies that allow employees to walk, bike, or take transit to and/or during work?
(a). Yes, provide name of worksite: _____

(b). No **(If no, move to question 13)**

12B. If Yes, which supports and/or policies does this worksite have? **CHOOSE ALL THAT APPLY:**

(a). Bike racks

(b). Bike share

(c). Showers

(d). Lockers

(e). Educational opportunities such as ride buddy, lunch and learn, signage, etc.

(f). Bike repair stations

(g). Flexible work schedules

(h). Pre-tax benefits or subsidies

(i). Guaranteed ride home programs

13. Are there any ADA compliant or accessible playgrounds with adapted equipment available in this priority community?

(a). Yes

(b). No

SECTION 3. POLICIES AND PRACTICES THAT SUPPORT ACCESS TO HEALTHY FOOD AND HEALTHY EATING

14. Does your local government have written nutrition standards for foods sold or served in local government buildings or worksites, including meals, a la carte items, or vending machines? Examples of nutrition standards include provisions for reduced sodium content or for inclusion of fresh fruit and vegetable selections. Do **not** include public school district or school-level policies in your response.

(a). Yes

(b). No **(If no, move to question 15)**

14B. Do these standards address any of the following? **CHOOSE ALL THAT APPLY:**

(a). Limiting foods high in added sugar (for example, cookies and candies)

(b). Limiting sugar-sweetened beverages (for example, soda, sports drinks, and sweetened tea)

(c). Limiting foods high in trans fats

(d). Limiting foods high in sodium/salt content

(e). Limiting foods high in fat (for example, fried foods)

(f). Increasing availability of fruits and vegetables

(g). Providing lower calorie options

(h). Other (specify):_____

14C. To which locations do the standards apply? **CHOOSE ALL THAT APPLY:**

(a). Local government facilities that serve foods and beverages to local government employees

(b). Local government facilities that serve foods and beverages to the general public

(d). Other (specify):_____

14D. Does your local government have pricing incentives (for example, intentionally pricing less healthy items to be more expensive) to promote the purchase of healthier foods and beverages sold in local government buildings, including cafeterias or vending machines? Do not include public school district or school-level policies in your response.

(a). Yes

(b). No

15. In this priority community, does the largest worksite have written nutrition standards for foods sold or served, including meals, a la carte items, or vending machines?

(a). Yes, provide name of worksite:_____
(b). No (**If no, move to question 16**)

15B. Do these standards address any of the following? **CHOOSE ALL THAT APPLY:**

(a). Limiting foods high in added sugar (for example, cookies and candies)

(b). Limiting sugar-sweetened beverages (for example, soda, sports drinks, and sweetened tea)

(c). Limiting foods high in trans fats

(d). Limiting foods high in sodium/salt content

(e). Limiting foods high in fat (for example, fried foods)

(f). Increasing availability of fruits and vegetables

(g). Providing lower calorie options

(h). Other (specify):_____

15C. To which locations do the standards apply? **CHOOSE ALL THAT APPLY:**

(a). Worksite facilities that serve foods and beverages to employees
(b). Worksite facilities that serve foods and beverages to the general public
(d). Other (specify):_____

15D. Does this worksite have pricing incentives (for example, intentionally pricing less healthy items to be more expensive) to promote the purchase of healthier foods and beverages sold in local government buildings, including cafeterias or vending machines?

(a). Yes
(b). No

16. In this priority community, do community settings (for example, parks, swimming pools, sports facilities) have written nutrition standards for foods sold or served, including meals, a la carte items, or vending machines?

(a). Yes
(b). No (**If no, move to question 17**)

16B. Do these standards address any of the following? **CHOOSE ALL THAT APPLY:**

(a). Limiting foods high in added sugar (for example, cookies and candies)

(b). Limiting sugar-sweetened beverages (for example, soda, sports drinks, and sweetened tea)

(c). Limiting foods high in trans fats

(d). Limiting foods high in sodium/salt content

(e). Limiting foods high in fat (for example, fried foods)

(f). Increasing availability of fruits and vegetables

(g). Providing lower calorie options

(h). Other (specify):_____

16C. To which locations do the standards apply? **CHOOSE ALL THAT APPLY:**

(a). Community facilities that serve foods and beverages to employees
(b). Community facilities that serve foods and beverages to the general public
(d). Other (specify):_____

16D. Does this community setting have pricing incentives (for example, intentionally pricing less healthy items to be more expensive) to promote the purchase of healthier foods and beverages sold in local government buildings, including cafeterias or vending machines?

(a). Yes
(b). No

17. In this priority community, do community food pantries provide healthy food options through a client choice model?

(a). Yes
(b). No

18. Does this priority community currently use any of the following to encourage supermarkets and other full-service grocery stores to open stores? **CHOOSE ALL THAT APPLY:**

(a). Tax incentives (for example, tax abatement, tax credit, or property tax exemption)
(b). Grant or loan programs to provide funding to encourage store openings
(c). Waivers of certain zoning or ordinance requirements
(d). Other (specify): _____
(e). This priority community does not have policies or programs that incentivize supermarkets and other full-service grocery stores to open in our community **(If so, move to question 19)**

18B. Do any of these policies or programs explicitly prioritize low income or economically depressed areas?
(a). Yes
(b). No

19. In addition to supermarkets and full-service grocery stores, food can be sold in smaller venues such as convenience or corner stores. Does this priority community currently have any of the following programs to help convenience or corner stores sell healthier foods? **CHOOSE ALL THAT APPLY:**

(a). Grant or low-interest loan programs to purchase/upgrade store equipment or furnishings to properly store and sell healthy foods and beverages (for example, fresh produce, low fat milk, or whole grains)

(b). Technical assistance or training programs that increase the ability to sell healthier foods (for example, marketing, promotion materials, and/or product placement)

(c). Programs to link stores to broader neighborhood revitalization projects (for example, improvements to lighting, signage, safety, accessibility, or walkability in the surrounding commercial corridor).

(d). Other (specify): _____

(e). This priority community does not provide these types of programs or assistance to convenience or corner stores

20. Some residents may not have easy access to supermarkets or full-service grocery stores because they do not have access to a car or public transportation or cannot easily walk to them. Is there dedicated accessible transportation (for example, community vans or shuttle buses) to supermarkets, other full-service grocery stores, or farmers' markets for residents of this priority community? Do not include public transportation options in your response.

(a). Yes

(b). No

21. Does your transit agency consider accessibility to supermarkets or other full-service grocery stores in their assessment of public transportation routes?

(a). Yes

(b). No

(c). This priority community does not have public transportation

22. Does this priority community have a farmers' market?

(a). Yes

(b). No (**If no, move to question 23)**

22B. Is the farmers' market accessible to people with disabilities and older adults?

(a). Yes

(b). No

22C. Does the farmers' market provide any of the following assistance programs?

(a). Acceptance of SNAP/EBT

(b). Produce Perks

(c). WIC Farmers Market Nutrition Program

(d). Senior Farmers Market Nutrition Program

(e) Other (specify):_____

23. Are methods available for schools, restaurants, worksites, parks/recreation centers, and/or residents in the priority community to obtain locally grown and produced foods from local farms and vendors?

(a). Yes

(b). No (**If no, move to question 24**)

23B. Which methods are available in this priority community?
(a). Farm to institution
(b). Community Supported Agriculture (CSA)
(c). Community Gardens

23C. If you answered yes to any of the above, are they offered in a manner that is accessible to people with disabilities and older adults?
(a). Yes
(b). No

24. Does your priority community have any of the following policies related to farmers' markets, farm stands, or green/produce carts? **CHOOSE ALL THAT APPLY:**

(a). Operating a farmers' markets or allowing the sale of fresh produce on city property

(b). Offering streamlined processes for obtaining health and food safety permits and licenses

(c). Extending waivers of required business permits or retail licensing fees or taxes

(d). Encouraging or incentivizing fresh food vending locations in areas lacking supermarkets and full-service grocery stores

(e). Providing funds or in-kind services for personnel, signage, or advertising

(f). Offered at locations that are ADA compliant, accessible to people with disabilities, and older adults

(g). Other (specify):_____

25. Are there any healthcare institutions in this priority community that offer produce prescription to their patients?
(a). Yes
(b). No

26. Does this priority community have a local or regional food policy council, food security coalition, or similar entity?
(a). Yes

(b). No **(If no, move to question 27)**

26B. Is there a designated health/public health representative on the regional food policy council, food security coalition, or similar entity?

(a). Yes

(b). No

SECTION 4. CONCLUDING INFORMATION

The last set of questions asks about your experience in completing the pilot survey. CHC would like to obtain a greater understanding of the types of local government staff who provided input for completion of the instrument and the level of effort required.

27. Including yourself, how many other partners in this priority community were asked to contribute a response to this survey? Only include those who provided an answer to a survey item in your response.

Number of respondents _____

28. Please list the individuals that have contributed by their job titles (not their names) and a reference to the specific survey section or questions that they were involved in completing. Include your own title in your response.

Job Title	Section 1: Community-wide planning	Section 2: Built Environment and Physical Activity	Section 3: Healthy Food and Healthy Eating	Section 4: Concluding Information

29. How would you describe the level of effort required to complete the survey?

(a). Required an extremely high level of effort (for example, required multiple sittings and consultation with more than 3 or 4 additional staff, or additional research to locate answers)

(b). Required a high level of effort (for example, required some dedicated time and consultation with additional staff to complete)

(c). Required a moderate level of effort

(d). Required a minimal level of effort

30. Of the items you answered, what technical assistance would be most useful for improving this priority community's ability to support community-level improvements in healthy eating and active living for residents?

_____
_____
_____
_____
_____
_____

31. If you have any additional comments about the survey, please share your comments below.

_____
_____
_____
_____
_____

THANK YOU FOR COMPLETING THIS SURVEY

Appendix P

County Health Rankings–Health Factors

Applications will be reviewed and scored by CHC program staff at ODH, and external reviewers based on the review criteria listed in Appendix C. Grants with scores of 70% or higher will be ranked and considered for funding. For those grants scoring 70% or higher, additional points will be awarded based on the county's high need population.

Health factors in the County Health Rankings represent what influences the health of a county. The four measured types of health factors are: health behaviors, clinical care, social and economic, and physical environment. For example, food environment index, adult obesity, physical inactivity, access to exercise opportunities, and adult smoking are all factors that are used to determine the health factors ranking. Counties with greater need to improve health outcomes will receive additional points on their application. Listed below are Ohio's counties ranked by quartiles. Counties ranked 1-22 will be receive 0 additional points, 23-44 will receive 5 additional points, 45-66 will receive 10 additional points and 67-88 will receive 15 additional points.

0 POINTS		5 POINTS		10 POINTS		15 POINTS	
Delaware	1	Knox	23	Hamilton	45	Guernsey	67
Warren	2	Ottawa	24	Hocking	46	Harrison	68
Geauga	3	Sandusky	25	Morrow	47	Clark	69
Putnam	4	Defiance	26	Tuscarawas	48	Highland	70
Medina	5	Logan	27	Carroll	49	Perry	71
Mercer	6	Portage	28	Crawford	50	Lawrence	72
Union	7	Darke	29	Lorain	51	Brown	73
Wood	8	Williams	30	Richland	52	Fayette	74
Van Wert	9	Preble	31	Clinton	53	Monroe	75
Henry	10	Paulding	32	Huron	54	Jefferson	76
Greene	11	Seneca	33	Noble	55	Trumbull	77
Lake	12	Clermont	34	Muskingum	56	Gallia	78
Auglaize	13	Holmes	35	Ross	57	Lucas	79
Hancock	14	Madison	36	Allen	58	Morgan	80
Fulton	15	Champaign	37	Belmont	59	Ashtabula	81
Fairfield	16	Franklin	38	Columbiana	60	Jackson	82
Wyandot	17	Erie	39	Coshocton	61	Pike	83
Wayne	18	Pickaway	40	Athens	62	Scioto	84
Licking	19	Summit	41	Mahoning	63	Marion	85
Miami	20	Washington	42	Hardin	64	Vinton	86
Ashland	21	Butler	43	Montgomery	65	Meigs	87
Shelby	22	Stark	44	Cuyahoga	66	Adams	88

http://www.countyhealthrankings.org/app/ohio/2019/overview

Appendix Q

County	Population (2017)	% Black (2017)	% Hispanic (2017)	Disability Prevalence (2013-2017)	Below Poverty Line (2013-2017)	Physical Inactivity (2013-2017)*	Obesity Prevalence (2013-2017)	Diabetes Prevalence (2013-2017)	Hypertension Prevalence (2013-2017)	SSB Soda (2013, 2015-2017)+	Fruit Consumption (2013,2015)^	Veg Consumption (2013,2015)#	Age-Adjusted Heart Disease Mortality (2017)	Age-Adjusted Stroke Mortality (2016-2017)
Adams	27,726	0.4	1.0	21.1	23.8	39.9	27.5	12.2	30.6	27.0	39.5	29.0	226.7	46.3
Allen	103,198	12.3	3.1	15.3	15.0	31.0	33.9	10.8	35.3	24.8	46.9	31.2	182.0	37.2
Ashland	53,628	0.8	1.4	13.8	14.2	34.2	27.8	8.2	29.5	28.6	40.5	31.5	173.1	46.5
Ashtabula	97,807	3.5	4.2	15.8	19.8	33.2	30.5	9.8	34.5	17.0	49.0	29.3	210.2	40.7
Athens	66,597	2.8	1.9	15.9	30.2	26.5	29.2	11.9	33.1	11.7	41.7	25.7	159.2	37.3
Auglaize	45,778	0.6	1.7	11.2	9.0	33.1	35.5	9.3	38.1	22.7	27.6	16.2	176.9	43.2
Belmont	68,029	4.1	1.0	16.8	14.1	32.0	36.5	15.2	39.4	25.0	44.4	29.9	225.9	38.3
Brown	43,576	0.9	1.0	17.0	17.8	32.9	25.1	13.3	42.1	33.2	53.5	27.2	211.7	52.6
Butler	380,604	8.3	4.7	11.9	12.9	25.3	32.7	10.9	32.6	21.2	43.4	27.4	173.0	47.3
Carroll	27,385	0.7	1.4	13.3	14.8	26.3	32.3	10.0	29.2	27.6	49.6	38.1	200.7	41.2
Champaign	38,840	2.1	1.6	16.2	11.1	35.0	35.5	12.3	42.7	22.2	41.6	20.1	178.9	44.3
Clark	134,557	8.8	3.3	16.4	16.6	33.9	34.6	12.7	35.6	21.5	45.8	43.6	210.7	72.2
Clermont	204,214	1.5	2.0	13.1	9.8	24.9	32.8	10.1	40.0	21.3	41.3	17.0	168.9	48.1
Clinton	42,009	2.2	1.6	15.1	14.7	29.8	30.3	11.0	29.0	48.5	58.1	42.4	205.3	43.4
Columbiana	103,077	2.3	1.7	16.2	15.4	28.1	32.4	10.7	34.3	12.0	54.3	33.9	209.9	39.1
Coshocton	36,544	1.2	1.1	14.7	15.0	32.3	33.3	12.7	34.9	16.8	41.3	31.2	161.0	38.1
Crawford	41,746	1.0	1.7	17.1	16.2	26.9	33.7	9.7	30.7	18.0	42.4	33.4	233.6	52.0
Cuyahoga	1,248,514	29.6	5.9	15.0	18.3	26.1	30.1	11.1	33.8	16.7	39.0	24.9	197.9	34.8
Darke	51,536	0.6	1.6	14.2	11.6	31.3	40.3	10.5	37.7	20.6	57.3	32.1	170.0	41.7
Defiance	38,156	1.6	9.9	12.7	11.0	26.6	30.1	12.1	35.2	33.4	42.7	33.7	184.5	37.4
Delaware	200,464	3.5	2.6	7.5	5.1	17.9	25.4	8.5	30.9	16.8	29.0	17.1	139.2	34.0
Erie	74,817	8.6	4.4	14.5	13.0	29.3	36.6	11.2	41.3	20.0	39.8	27.5	199.0	41.0
Fairfield	154,733	7.9	2.1	13.3	9.9	23.8	31.4	11.1	33.7	20.4	46.1	26.1	165.3	33.1
Fayette	28,752	2.2	2.1	16.0	17.7	30.4	33.9	13.0	29.7	21.9	63.7	35.5	302.1	44.8
Franklin	1,291,981	22.6	5.5	11.5	16.7	24.9	31.0	9.9	31.6	19.8	43.0	25.3	171.1	43.5
Fulton	42,289	0.6	8.8	13.0	10.6	25.9	33.4	13.3	30.5	34.2	50.3	24.4	226.9	43.3
Gallia	29,973	2.3	1.5	19.8	20.9	33.1	33.9	15.9	40.3	24.1	56.1	38.1	255.6	60.5

* % of population that reported no physical activity
+ % of population that consumed more than 1 sugar sweetened soda per day
^ % of population that consumed less than 1 serving of fruit per day (includes 100% fruit juice)
# % of population that consumed less than 1 serving of vegetables per day (includes dark green, orange, beans, and non-fried white potatoes)

County	Population (2017)	% Black (2017)	% Hispanic (2017)	Disability Prevalence (2013-2017)	Below Poverty Line (2013-2017)	Physical Inactivity (2013-2017)*	Obesity Prevalence (2013-2017)	Diabetes Prevalence (2013-2017)	Hypertension Prevalence (2013-2017)	SSB Soda (2013, 2015-2017)+	Fruit Consumption (2013,2015)^	Veg Consumption (2013,2015)#	Age-Adjusted Heart Disease Mortality (2017)	Age-Adjusted Stroke Mortality (2016-
Geauga	93,918	1.3	1.5	10.3	6.5	23.2	25.0	8.0	23.2	N/A	23.6	20.2	139.2	23.6
Greene	166,752	7.0	2.8	12.5	12.3	19.1	27.7	10.4	29.5	24.0	40.5	21.7	148.0	38.0
Guernsey	39,093	1.5	1.1	18.2	20.2	30.2	36.2	10.8	41.2	23.8	47.8	30.5	242.6	31.7
Hamilton	813,822	26.2	3.3	12.7	17.0	23.3	28.7	10.3	32.9	18.0	41.9	29.8	180.6	49.7
Hancock	75,754	1.6	5.4	11.4	12.1	24.9	32.6	8.2	26.7	21.9	49.3	24.2	174.4	39.4
Hardin	31,364	0.9	1.7	14.2	16.6	37.4	40.6	12.4	45.2	31.0	49.9	34.9	232.2	42.5
Harrison	15,216	2.1	1.1	16.8	15.7	26.8	33.2	14.0	37.6	31.4	40.6	35.5	216.0	25.0
Henry	27,185	0.7	7.7	13.3	9.0	28.5	30.6	8.8	37.8	12.4	42.8	18.6	190.6	38.5
Highland	42,971	1.4	1.1	19.0	21.6	27.4	35.3	9.1	39.4	22.4	55.8	20.6	214.8	45.4
Hocking	28,474	0.7	0.9	18.0	14.2	29.0	41.7	15.2	43.0	41.1	51.7	28.1	182.3	17.9
Holmes	43,957	0.4	0.9	8.3	12.0	32.4	32.8	8.7	31.4	31.4	45.7	28.3	168.0	44.1
Huron	58,494	1.2	6.6	13.3	14.2	29.9	34.4	13.0	34.4	21.2	56.6	38.4	188.1	42.3
Jackson	32,449	0.7	1.1	18.9	20.6	35.7	37.0	15.0	40.9	42.6	50.0	36.2	242.4	46.6
Jefferson	66,359	5.4	1.4	18.4	17.6	31.8	35.8	15.3	38.1	19.2	42.4	27.8	256.9	44.5
Knox	61,261	0.9	1.5	13.1	13.8	28.8	25.9	12.2	41.2	31.7	38.5	17.6	182.4	48.4
Lake	230,117	4.2	4.3	12.6	8.3	23.5	25.2	8.9	34.4	8.3	30.2	19.9	177.4	36.4
Lawrence	60,249	2.1	1.0	21.7	18.6	34.9	38.5	16.2	42.6	24.3	56.6	33.4	206.7	47.2
Licking	173,448	3.9	1.9	14.6	11.8	27.6	32.6	11.0	31.1	24.7	40.5	27.2	165.9	36.8
Logan	45,325	1.8	1.5	13.9	13.7	30.5	45.9	4.8	30.0	30.8	46.7	27.1	224.9	60.9
Lorain	307,924	7.8	10.0	15.3	13.7	27.9	34.0	13.3	35.8	18.9	41.7	21.6	152.8	35.3
Lucas	430,887	19.4	7.1	15.2	19.8	30.8	34.9	11.7	36.0	19.6	42.5	27.0	208.3	44.5
Madison	44,036	6.4	2.0	15.8	10.2	28.5	32.0	9.9	31.4	N/A	47.6	27.8	144.6	51.9
Mahoning	229,796	15.0	5.9	15.6	17.6	30.0	30.1	11.6	31.6	15.7	38.3	24.7	220.3	41.6
Marion	64,967	6.4	2.6	19.6	16.6	36.9	38.1	12.4	33.8	28.5	51.3	31.9	183.4	32.1
Medina	178,371	1.4	2.1	10.7	6.2	21.8	27.3	9.0	34.7	28.5	47.6	25.9	156.0	31.3
Meigs	23,080	0.9	0.8	22.7	22.5	38.6	38.0	17.3	44.5	46.6	50.0	26.0	175.2	53.2
Mercer	40,873	0.4	1.9	10.2	7.4	24.9	32.3	10.7	34.6	19.7	34.7	24.5	247.2	39.0

* % of population that reported no physical activity
+ % of population that consumed more than 1 sugar sweetened soda per day
^ % of population that consumed less than 1 serving of fruit per day (includes 100% fruit juice)
# % of population that consumed less than 1 serving of vegetables per day (includes dark green, orange, beans, and non-fried white potatoes)
N/A - The estimate does not meet the reliablity criteria for reporting set by the CDC

County	Population (2017)	% Black (2017)	% Hispanic (2017)	Disability Prevalance (2013-2017)	Below Poverty Line (2013-2017)	Physical Inactivity (2013-2017)*	Obesity Prevalence (2013-2017)	Diabetes Prevalence (2013-2017)	Hypertension Prevalence (2013-2017)	SSB Soda (2013, 2015-2017)+	Fruit Consumption (2013,2015)^	Veg Consumption (2013,2015)#	Age-Adjusted Heart Disease Mortality (2017)	Age-Adjusted Stroke Mortality (2016-
Miami	105,122	2.3	1.7	13.8	9.9	26.1	36.0	13.7	31.1	10.0	37.6	35.8	190.6	49.2
Monroe	13,946	0.6	0.6	19.5	19.7	32.1	36.1	16.3	45.5	16.5	31.7	22.2	159.7	29.4
Montgomery	531,542	21.1	2.9	15.2	17.9	28.0	32.5	12.8	36.0	17.2	42.0	22.7	179.9	53.9
Morgan	14,709	3.2	0.9	21.6	21.5	32.6	37.1	15.5	58.2	29.2	42.0	20.6	170.8	60.8
Morrow	34,994	0.6	1.4	13.9	9.7	32.0	34.0	13.4	38.4	5.2	48.3	20.1	212.3	30.8
Muskingum	86,149	3.8	1.1	16.4	16.6	34.4	35.5	14.9	39.4	26.2	52.3	30.4	191.8	49.6
Noble	14,406	2.7	0.6	17.4	12.9	34.3	38.4	7.7	31.4	14.2	48.1	40.0	129.7	51.7
Ottawa	40,657	0.8	5.1	15.6	10.5	34.4	33.8	11.2	42.0	13.2	40.0	21.9	196.2	41.6
Paulding	18,845	1.0	4.6	17.0	10.7	31.3	28.4	9.9	39.4	40.9	38.3	27.2	178.7	50.1
Perry	36,024	0.4	0.9	17.6	19.2	28.0	36.0	13.6	39.2	24.7	49.9	25.8	254.9	27.4
Pickaway	57,830	3.8	1.4	15.0	12.0	32.6	39.6	17.8	42.5	34.3	42.6	23.2	233.3	44.6
Pike	28,270	1.0	1.1	22.5	20.0	36.5	34.3	11.8	36.9	27.4	48.3	23.6	217.0	38.5
Portage	162,277	4.4	1.8	13.2	14.5	24.0	26.0	9.2	29.4	18.3	45.5	25.9	200.2	32.9
Preble	41,120	0.6	0.8	16.3	12.4	30.4	25.6	13.5	41.1	N/A	43.8	23.7	183.8	41.0
Putnam	33,878	0.3	6.2	10.5	7.2	30.1	34.1	6.7	26.7	25.1	46.0	21.0	159.4	41.4
Richland	120,589	9.2	1.9	15.9	15.6	29.5	31.4	10.1	33.0	22.3	45.9	32.9	187.4	39.8
Ross	77,313	6.0	1.2	20.0	18.2	31.9	34.5	11.7	36.2	17.1	37.4	26.7	157.6	47.2
Sandusky	59,195	3.0	9.9	15.3	13.6	31.4	34.3	12.6	33.7	26.9	46.6	29.7	197.5	34.7
Scioto	75,929	2.6	1.3	21.3	23.9	34.9	35.4	15.0	38.2	27.6	51.1	34.1	300.3	31.8
Seneca	55,243	2.3	5.1	13.9	15.2	26.5	35.5	12.4	39.3	30.3	39.0	24.2	225.8	36.4
Shelby	48,759	2.2	1.5	12.4	8.9	29.5	33.5	9.0	29.2	21.4	31.4	18.1	209.5	48.5
Stark	372,542	7.8	2.1	13.4	14.0	27.5	32.3	12.3	31.9	21.1	45.1	29.0	165.8	39.3
Summit	541,228	14.7	2.1	12.6	13.6	27.6	30.0	10.2	35.3	17.7	38.3	20.3	178.0	42.1
Trumbull	200,380	8.4	1.8	14.6	17.2	25.3	31.5	11.3	36.2	21.8	44.2	31.2	224.1	40.6
Tuscarawas	92,297	0.8	2.6	14.0	13.8	29.2	32.3	11.8	34.0	18.3	41.4	28.5	188.1	34.2
Union	56,741	2.6	1.7	11.0	7.4	25.2	33.3	6.3	27.7	20.1	39.8	27.9	187.0	25.7
Van Wert	28,217	1.0	3.2	14.6	12.7	36.4	40.4	15.1	40.2	17.7	61.7	26.4	199.4	38.5
Vinton	13,092	0.5	0.8	20.0	21.1	30.7	29.2	16.8	37.3	14.1	52.2	30.8	198.1	69.5
Warren	228,882	3.5	2.7	9.6	5.1	21.7	29.7	9.3	33.3	17.2	42.2	17.9	144.4	43.5

* % of population that reported no physical activity
+ % of population that consumed more than 1 sugar sweetened soda per day
^ % of population that consumed less than 1 serving of fruit per day (includes 100% fruit juice)
# % of population that consumed less than 1 serving of vegetables per day (includes dark green, orange, beans, and non-fried white potatoes)
N/A - Estimate does not meet the reliablity criteria for reporting set by the CDC

County	Population (2017)	% Black (2017)	% Hispanic (2017)	Disability Prevalance (2013-2017)	Below Poverty Line (2013-2017)	Physical Inactivity (2013-2017)*	Obesity Prevalence (2013-2017)	Diabetes Prevalence (2013-2017)	Hypertension Prevalence (2013-2017)	SSB Soda (2013, 2015-2017)+	Fruit Consumption (2013,2015)^	Veg Consumption (2013,2015)#	Age-Adjusted Heart Disease Mortality (2017)	Age-Adjusted Stroke Mortality (2016-2017)
Washington	60,418	1.2	1.1	20.1	15.5	32.9	36.1	14.9	40.1	23.6	44.7	28.0	138.7	42.2
Wayne	116,038	1.6	2.0	11.6	13.0	23.5	29.4	12.4	38.9	17.5	50.9	26.8	178.7	37.4
Williams	36,784	1.2	4.5	14.4	13.5	40.6	35.5	12.8	26.3	19.0	44.1	28.3	149.4	32.9
Wood	130,492	2.7	5.6	11.1	13.4	21.0	31.5	11.0	29.4	17.6	43.4	27.5	216.4	41.6
Wyandot	22,029	0.3	2.9	13.7	11.3	28.6	38.7	12.3	45.4	N/A	42.0	26.1	180.6	67.1

* % of population that reported no physical activity
+ % of population that consumed more than 1 sugar sweetened soda per day
^ % of population that consumed less than 1 serving of fruit per day (includes 100% fruit juice)
# % of population that consumed less than 1 serving of vegetables per day (includes dark green, orange, beans, and non-fried white potatoes)
N/A - Estimate does not meet the reliability criteria for reporting set by the CDC

Glossary of Terms

Active Transportation	Refers to any form of transportation that involves increased physical activity levels –notably walking, biking, or taking transit. (According to Active Living Research, public transportation users take 30% more steps per day and are less likely to be sedentary and obese.)
Active Commute Support	Active Commute Support creates PSE changes that encourage employees to replace car trips to work with alternative modes that increase physical activity. Employers can incentivize walking, biking, or taking transit to increase their employees' physical activity. Examples of commute support include: changing rooms or lockers with showers, bicycle parking, bicycle racks/shelters in safe, convenient, and accessible locations.
Bike and Pedestrian Infrastructure	Ensures that a network of infrastructure is in place to make bicycling or walking viable modes of travel. It also means ensuring that the infrastructure is safe and comfortable to use. This approach can promote health by providing added opportunity for physical activity from transportation. This strategy is related to, and supportive of, the Safe Routes to School, Complete Streets, and encouraging bicycling and walking programs. Elements of bicycle and pedestrian infrastructure may include: •Bicycle lanes •Bicycle parking and storage facilities •Curb extensions •Intersection treatments for bicycles – bicycle boxes, stop bars, lead signal indicators •Landscaping •Paved shoulders •Pedestrian and bicyclist-scale lighting •Pedestrian overpass or underpass •Separation/buffers •Shared-lane markings ("sharrows") •Sidewalks •Signage, especially high-visibility signage •Signalized pedestrian crossings and mid-block crossings •Trails or shared-use paths https://www.transportation.gov/mission/health/Expand-and-Improve-Bicycle-and-Pedestrian-Infrastructure

Active Transportation Planning	Active Transportation plans establish a framework to increase walking and biking trails and improve connectivity of non-auto paths and trails in a particular locality. Plans typically include policies and planning methods to encourage alternative modes of travel, land use plans, bicycle and pedestrian infrastructure development, and address traffic and safety concerns. Bicycle and pedestrian master plans can be developed and implemented by city, county, regional, and state governments and are often implemented in stages over time.
Built Environment	Human-made (versus natural) resources and infrastructure designed to support human activity, such as buildings, roads, parks, restaurants, grocery stores and other amenities.
Coalition	A formal alliance of organizations or an organized group of people in a community that come together to work for a common goal. The coalition can have individual, group, institutional, community, and/or public policy goals.
Community	A group of people who have common characteristics or shared identity. Communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar common bonds. Ideally, there would be available assets and resources, as well as collective discussion, decision-making and action.
Community Supported Agriculture (CSA)	Community supported agriculture is a system that connects the producer and consumers within the food system more closely by allowing the consumer to subscribe to the harvest of a certain farm or group of farms. Consumers pay in advance for a weekly/bi-weekly share of the harvest through the growing season. CSA subscriptions can be set up to accept SNAP as a form of payment.
Complete Streets Policy	A resolution, ordinance or other organizational policy which provides a framework for street design that supports all road users emphasizing safety for those walking, biking and taking public transportation.
Dietary Guidelines for Americans	Evidence-based nutrition information and advice for people age two and older. The Guidelines serve as the basis of Federal food and nutrition education programs. The Dietary Guidelines for Americans, 2015-2020 are the current Federal policy.
Disability	Disability as an umbrella term for impairments, activity limitations, and participation restrictions. Disability is the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports). Disability is extremely diverse, and may include people with physical, functional, cognitive, sensory, or invisible disabilities. While some health conditions associated with disability result in poor health and extensive health

	care needs, others do not. However, all people with disabilities can benefit from community assets and resources, if they are accessible. Therefore, it is critical to consider accessibility and inclusion in the scope of work for this grant.
Environmental Change	Changes in both the social, cultural, and political environment, as well as the physical environment at the community level; a change in organizational practice or policy. Examples: sidewalks, walking paths, and recreation areas are included into community development design; or worksite vending machines contain only healthy snacks and beverages.
Evaluation	The systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future program development.
Evidence-Based Strategies	Effective approaches based on principles of scientific evidence, including systematic uses of data and information systems, and appropriate use of behavioral science theory.
Farm to Institution	One approach to align food service operations with health and sustainability guidelines. Programs and policies that support sourcing local and regional foods for schools, hospitals, faith-based organizations, worksites, and other public service venues that can benefit institutional customers and their families, farmers, the local community, and the economy.
Farmers' Market	A farmers' market is a public and recurring assembly of farmers or their representatives selling the food that they produced directly to consumers. Markets can be set up to accept SNAP, WIC Farmers' Market Nutrition Program Vouchers, and Senior Vouchers as forms of payment, as well as, offer nutrition incentives (Produce Perks) where SNAP shoppers can receive a $1 – for – $1, up to $20 per day match to spend on fruits and vegetables. https://produceperks.org/
Food Access Policy and Planning	Transforms the local food systems by working on the following: identifying and filling gaps in local food system infrastructure, campaigning for public-policy change, and strategizing to cultivate a policy landscape that cultivates sustainable, equitable local food systems. http://ohiofpn.org/ https://www.planning.org/policy/guides/adopted/food.htm
Food Bank/Pantry	A food pantry is an individual site that distributes food directly to those in need who reside in a specified area. A food pantry is a member agency of, and obtains food from, a food bank. CHC promotes the Client Choice Pantry model, which allows clients to select their food from the pantry's food stock instead of receiving a pre-packed or standard bag of groceries.

Food Service Guidelines	Improving food and beverage offerings in the following venues; vending machines, catered meetings, cafés, cafeterias, snack carts, and micro markets in community and worksite settings including libraries, parks and recreation facilities, higher education campuses, hospitals, and city and county buildings through adoption of food and beverage guidelines policies. Ohio Food and Beverage Guidelines are based on American Heart Association Standards.
Health Disparities	A difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have progressively experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, disability status, or geographic location. Other characteristics include cognitive, sensory, or physical disability.
Health Equity	Health equity is achieved when all people in a community have access to affordable, inclusive, and quality infrastructure and services that, despite historical and contemporary injustices, allows them to reach their full health potential.
Healthy Food Retail	A retail store that sells nutritious food such as fruits and vegetables (fresh, canned and frozen), whole grains, lean meats, and low fat dairy. Healthy Food Retail interventions can include assisting a corner or convenience store to sell a variety of healthy food items, establishing a healthy checkout lane in a full service grocery store, or supporting the opening of a new full service grocery store in a food desert area.
High-Risk Populations	Groups of individuals that experience disparities in the social determinants of health, quality of life, and/or health outcomes. Disparities are related to race, ethnicity, economic status, age, sex, sexual orientation, disability, and geographic location.
Implementation	The process of developing, adopting, executing, enforcing, maintaining, and evaluating CHC strategies.
Indicators	A measurable index that shows progress in meeting desired outcomes. • Population: percent of individuals who report/exhibit some change • Threshold: minimum progress to confirm that outcomes are being achieved • Timeline: period in which this will be reported
Land Use Policy	Land Use policies are used by communities to protect the health and safety of residents while safeguarding the community's economic, social, and environmental well-being. Communities with balanced, self-contained neighborhoods which have a sufficient mix of land uses (such as residential,

	commercial, industrial, and green space) and incomes to support the housing, employment, shopping, and recreational needs of the community provide increased opportunities for physical activity. https://www.thecommunityguide.org/findings/physical-activity-built-environment-approaches https://americas.uli.org/research/centers-initiatives/building-healthy-places-initiative/
Monitoring	The ongoing tracking of achieving the plan's goals and the initiation of corrective action if needed.
Observations	A way of gathering data by watching behaviors, events, or noting physical characteristics in their natural setting. Observations can be either direct or indirect. Direct observation is when you watch interactions, processes, or behaviors as they occur. Indirect observations are when you watch the results of interactions, processes, or behaviors. Examples include: • Behavior (smoking on grounds, bike helmet usage, food choices, amount of time spent in activity during physical education class, plate waste, purchasing healthy vending items) • Environment (educational messages, posters, cleanliness, safety, improved lighting) • Photographs (before and after pictures of walking paths/ recreation areas)
Ordinance	A formally-adopted law, rule or regulation that is enacted by the governing body of a city or county.
Outcomes	The intended/desired or unintended changes in individuals, policies, or environments. A major component of an objective that describes what will change as a result of the program.
Partnerships	A collaborative alliance or union of businesses, organizations, policy makers, individuals etc., concerned with similar goals and strategies that cooperates in joint action and unites together for a common purpose or cause. Partnerships allow members to combine resources and become more impactful than when they each act alone.
Physical Activity Guidelines for Americans	Science-based guidance to help Americans age six and older improve their health through appropriate physical activity. The 2018 Physical Activity Guidelines for Americans is the current document.
Policy Change	A shift in the formal operations of organizations and/or governmental institutions that allows new or different activities to occur. These shifts may arise from information-sharing, community participation, professional input, compromise, and consensus-building, and are usually the result of effective advocacy.
Policy Strategies	A law, ordinance, resolution, mandate, regulation, or rule (both formal and informal). Examples are laws and regulations that restrict smoking in public buildings and organizational rules that provide time off during work hours for physical activity. Sub-types of policies include: • Public Policy: A set of agreements about how government shall address societal needs and

	spend public funds that are articulated by leaders in all three branches of government and embedded in many different policy instruments (e.g., ordinances and resolutions). • Organizational Policies: A set of rules and understandings that govern behavior and practice within a business, nonprofit or government agency. • Regulatory Policies: Rules and regulations created, approved, and enforced by governmental agencies, generally at a federal or state level.
Policy, System and Environmental (PSE) Changes	Increases widespread and sustainable community change with regard to public health, reaching beyond individual behavior change by creating multi-level interactions to significantly impact a community's norms and values. Focuses on improving socioeconomic factors as well as physical and social environments and has a greater impact on a community's health and economic vitality.
Population-Based Health	A health promotion approach that aims to address social and structural factors that affect behaviors. Population-based approaches focus on communities, neighborhoods, cities, states and even entire nations instead of concentrating solely on individual responsibility and behavior. This approach seeks to alter our environment through policy, regulation, changes in practices, or forging new social norms to create a culture of wellness and an environment that support healthy choices.
Population-Based Interventions	Planned and systematic activities that create change in social systems and environmental conditions at the community level that will influence and support individual behavior change.
Produce Prescriptions	Produce Prescription Programs leverage clinical care systems to improve the health of patients suffering from chronic diet-related disease by increasing access to healthy foods and providing healthy eating and nutrition counseling. The program allows practitioners to "prescribe" fruits and vegetables for select patients, redeemable at participating farmers' markets and grocery retail.
Public Transit Improvements	Enhancements to existing transportation system or development of new systems that can support a healthy lifestyle. Examples may include: providing trips to grocery stores in rural areas for people with limited mobility, allowing bicycles to be placed on the front of busses, adding bus stops in areas where fresh food is sold, bike share programs, etc.
Safe Routes to Healthy Foods	Safely connecting people to places to buy and obtain healthy food. https://www.saferoutespartnership.org/healthy-communities/101/safe-routes-healthy-food
Safe Routes to School	Safe Routes to School programs aim to make it safer for students to walk and bike to school and encourage more walking and biking where safety is not a barrier. http://www.saferoutesinfo.org/
SMART Objectives	**Specific**–Identifies a specific event or action that will take place or change that will occur. Who is expected to change or benefit? **Measurable**–Quantifies the number of events or the amount of

	change to be achieved. What or how much is expected? Measurable objectives use action verbs such as, “establish,” “enact,” train,” “adopt,” “commit,” “institute,” or “organize.” **Achievable**–Realistic given available resources and plans for implementation yet challenging enough to accelerate program efforts. Uses baseline measures to assist in estimating potential success. **Relevant**–Logical and relates to the program’s goals. It is sufficiently meaningful and important. Considers the financial and human resources and the cost benefit of the intervention. **Time**–Specifies a time by which the objective will be achieved. When will the event or change occur?
Social Determinants of Health	Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a range of health, functioning, and quality-of-life outcomes and risks. • Availability of resources to meet daily needs, such as educational and job opportunities, living wages, or healthful foods • Social norms and attitudes, such as discrimination • Exposure to crime, violence, and social disorder, such as the presence of trash • Social support and social interactions • Exposure to mass media and emerging technologies, such as the Internet or cell phones • Socioeconomic conditions, such as concentrated poverty • Quality schools • Transportation options • Public safety • Residential segregation
Stakeholders	Any person or organization with a vested interest in a common initiative. Usually decision makers, program partners, or clients. Individuals or groups affected by the issue.
Sustainability	Ensuring that an effort or change lasts. Sustainability is often misunderstood as securing further or ongoing funding for a program that otherwise would end. Note that sustainability can be achieved without ongoing funding by changing policies, norms, attitudes, etc. For example, a health day that discourages smoking at a park will likely not effect permanent change, whereas a tobacco-free park policy will create a sustainable change without future investments/resources.

System	A group of independent but interrelated and interacting elements etc., individuals, institutions or infrastructures that form a unified whole or network system. A system may include structure, behavior, procedures, or processes. Examples include: • A classification or arrangement • A network or communication, transportation or distribution • A method or process of doing things • An assembly of interdependent units • A point of view or doctrine used to interpret knowledge
Systems Change	A permanent change to the policies, practices, and decisions of related organizations or institutions in the public and/or private sector. Changes that impact all elements of an organization, institution, or system; they may include a policy or environmental change strategy. Examples include: • A local health department reviews all community development plans to make recommendations that improve the health impact of the plan (e.g. walkability, location of food resources, etc.) • A preschool chain establishes a minimum standard for how many minutes of physical activity will be offered at all sites each day

Appendix S

Attachment 1

Personnel/Position Form

Person/Position	% of Time on CHC	% of Time Paid by the Grant	Function

Attachment 2

Attach a CV/Resume for each existing staff person on this grant.
Attach a Position Description for proposed positions on the grant not currently filled.

Attachment 3

*A complete template of the workplan will be emailed to applicants after submission of NOIAF

2020 CREATING HEALTHY COMMUNITIES IMPLEMENTATION WORK PLAN

Agency:_____ Grant #:_____ Priority Community:_____ County Served: _____

Long Term Objective #1: By December 31, 2024, the (x county) CHC Coalition will be a high functioning coalition.					
Program Impact Objective #1:					
4th Quarter Only: Has this Impact Objective been met? (Please indicate Yes/No, if No explain):					
# of Process Objectives:	**# of Process Objectives Met:**				
Outcome Evaluation:					
Process Objectives	Related Activities	Agency or Person Responsible	Specific Dates for Each Activity		Evaluation Measures
			Start	End	
1.					
Q1:					
Q2:					
Q3:					
Q4:					

Attachment 4

Letters of Support

Provide three letters of support from community partners who will assist in completion of workplan activities. One letter must come from a community planner at the municipal, county or regional level. Applicants are encouraged, but not required, to seek the additional letters from partners from the following fields: disability inclusion, food access, community organizing, healthcare systems, and nonprofit organizations promoting healthy eating and/or active living.

Attachment 5

Coalition Member Form

All grantees are required to complete this form listing current or proposed coalition members along with their organizational affiliation. Coalition members should represent various sectors of the community such as schools, planning, transportation, healthcare, non-profits, community residents, the disability community, council members, and others that will provide insight on improvements that need made within the three priority communities.

Coalition Member	Organizational Affiliation	Proposed	Current	Priority Community Representation

Attachment 6

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 and submit a statement of support from the local health districts. See pages 5-6 of the RFP for more information.

References

Centers for Disease Control and Prevention – Division of Community Health. A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Atlanta, GA: US Department of Health and Human Services; 2013.

Guide to Community Preventive Services:. Atlanta: Community Guide Branch, National Center for Health Marketing, Centers for Disease Control and Prevention, February 2009.

Institute of Medicine. *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation.* Washington, DC: The National Academies Press, 2012.

Khan, L., Sobush, K., Keener D., Goodman, K., Lowry, A., Kakietek, J., Zaro, S. (2009). *Recommended Community Strategies and Measurements to Prevent Obesity in the United States*: Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Robert Wood Johnson Foundation. *Advancing Policies to Support Healthy Eating and Active Living Action Strategies Toolkit, A Guide for Local and State Leaders Working to Create Healthy Communities and Prevent Childhood Obesity:* Leadership for Healthy Communities. Updated February 2011.