

Child & Family Health Services Program  
Q & A Part 2, for FY 15 Grant  
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1. PHAB attachments—what does these mean? Where can we find them?  
This is a requirement for agencies that are not local health departments. This was previously known as the Local Health Districts Improvement Standards. Identify the PHAB standards that will be addressed by grant activities. Page 6 of the RFP has the attached link to the location of the PHAB standards. List the actual standard, not the domain.  
<http://www.phaboard.org/wp-content/uploads/PHAB-Standards-Overview-Version-1.0.pdf>
2. Should attachments be attached in the Application Section or Program Narrative?  
Attachments can be placed in either section with the attachment clearly labeled.
3. Are there any required measures or strategies (under measures) that you must complete? For example, in perinatal, is to reduce the rate of smoking section required (tobacco treatment specialists)? Under child & adolescent health, is the youth smoking cessation section required? Under child & adolescent health, is the breastfeeding section required.  
The Community Health Assessment and OIMRI components require all strategies and benchmarks are complete. You do not have to request funding for all strategies in the Community Health Assessment but must include how you are going to meet the benchmarks for these strategies.
4. For child & adolescent health, how are to track the number of visits for children under are age 1 and the number of visits ages 1-2. There is not currently a way to track this in MATCH. How do you run a report to get this information to meet the benchmark? Do you have a suggestion of the best way to clearly illustrate this benchmark?  
When you run the Child and Adolescent summary report on the very last screen before the report is an option to run the report by years of age or in months. You can select these options and delimit (determine the limits or boundaries) of the report respectively.
5. RFP Page 28 - Community Health Assessment and Planning - Specific strategies can be picked to address this grant cycle but do we need to list all 7 steps and strategies as written and state "not applicable" on those we will not be addressing for this cycle?  
All applicants are required to demonstrate the need for CFHS funds by reporting the results of their community health assessment (CHA). These results must include data about the target population, evidence of need of services and programs and how proposed strategies and interventions will address the need. Provide a brief (no more than three (3) pages) description of the process used to conduct the community health assessment for this FY2015 application. Applicants must clearly describe the community health assessment and planning process, including any in-kind and financial contributions of partners. Refer to the CFHS Program Standards for details on how to complete this portion of the narrative.  
All applications must include this description of the community health assessment process and results, even if the applicant is not seeking funds to support community health assessment activities.  
Since community health assessment and planning is an on-going process of identifying and analyzing a community's health problems, needs and assets, as well as its resources and capacity to address priority needs, a program plan (Attachment #3) including specific activities must be completed for all strategies listed in the Community Health Assessment and Planning Component Grid (Appendix C). If the agency is NOT applying for CFHS funds for community health assessment, each strategy must be addressed in the program plan so we can understand how the

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CHA is being implemented in the community. If the agency IS applying for CHA funds, it must include specific activities for each strategy for which funds are requested. If the agency is not applying for funding for all strategies, e.g. because it plans to address those strategies in subsequent years of the cycle, it must provide a timeline in the program plan for when those strategies will be addressed.

6. RFP Page 34 - Will there be trainings offered for Not On Tobacco (NOT) and if you have been trained previously many years ago, is there a refresher course?  
There is no refresher course available for the NOT program. There is a 1:1 webinar available through the American Lung Association that can be viewed at the time the 3 years certificate lapses. If it has been considerably longer than 3 years since the training, and the webinar wasn't viewed, the course should be repeated, as the curriculum may have changed or been updated.
7. RFP Page 35 - Can you briefly explain what OCCRRA is and how is it used to provide intervention to childcare facilities?  
Ohio Child Care Resource and Referral Association (OCCRRA) membership is comprised of eight regional nonprofit organizations (known as CCR&Rs). These CCR&Rs provide child care resource and referral services in 12 state-designated service delivery areas covering all 88 Ohio counties. OCCRRA and the network of CCR&Rs are the "go-to" resource for the implementation of quality early care and learning and afterschool support systems for providers (centers and family child care), parents, and communities. They implement statewide programs that improve service quality, including the Ohio Healthy Programs and Step up To Quality / Quality Achievement Awards. ODH is partnering with OCCRRA to implement the Ohio Healthy Programs.
8. Can you please offer some direction regarding the measure "Reduce the percentage of children who are overweight" – in the QA's it said the only program available for child care facilities is the OHP and I understand training with the curriculum will be offered. However, as an agency how are we to obtain letters from support from the day cares when we are have to present to them a curriculum we have not even seen ourselves?  
The Ohio Healthy Programs (OHP) uses the Healthy Children, Healthy Weight curriculum. The overall goal is to provide practical strategies to establish environments and policies that promote healthy weight in children, using modules focusing on Healthy Habits (healthy eating/feeding, physical activity, and parent engagement); Healthy Menus (for cooks and administrators) and Healthy Policies (for administrators and program leadership). More information regarding the curriculum can be viewed at <http://columbus.gov/healthy-children-healthy-weights.aspx>  
Again, please be sure to contact CFHS with all questions.
9. RFP Page 36 – What evidence based and best practices are there to choose from in the measure "Reduce the % of children who are overweight" work with schools?  
Let's Move, Nutrition Expedition and /or Fuel Up to Play 60, Choose My Plate, CATCH (K-8), CATCH Kid's Club After-School Program (K-8), SPARK and Veggie U.
10. For the CFHS Measure "Ensure that social/emotional and addiction needs of pregnant and postpartum women are met" - Would this include just our prenatal patients (of which we have a very small number) or can this also be our positive pregnancy tests. Or is this more focused on

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partnering with other outside clinics. Is there a minimum number of women that would be expected to screen and refer for this measure?

This strategy's aim is to build an infrastructure to make sure that women are screened and receive treatment for mental health and/or addiction. How you come up with the clients to screen would need to be established through meeting with stakeholders to find out how to best support this type of system in your community. There is no minimum, but again you would want to make sure that the infrastructure is/will be in place to properly complete these services being asked. It can be pregnant and/or post-partum women.

11. For the measure "Improve access to perinatal care" - This is under direct care this year whereas before it was under enabling. We do have a prenatal clinic that serves uninsured and underinsured clients as well as those with Medicaid. We meet or would be able to meet the required activities for this measure, but we do not meet the minimum of 25 un/underinsured clients? Would this be also those that receive Medicaid?

Only CFHS Direct Care funded clinics can apply for the Medicaid application funding. Clients who receive Medicaid do not qualify for the minimum of 25 un/underinsured clients. The 2 strategies for FY 2014: Conduct outreach for perinatal clients in high risk neighborhoods and Provide assistance for perinatal clients to gain access to Medicaid which were under the measure: Improve access to perinatal care are now incorporated under the strategy: Provide perinatal direct health care services.

12. When would the Tobacco Treatment Specialists (TTS) training be for this grant cycle? We have a LSW who has had 5A's training as well as a TTS, would the LSW be able to do the intervention program as well or would she need to complete the TTS class?

As of this time The Breathing Association is offering TTS training in November of 2014. CFHS is working on scheduling an earlier training date. The TTS training course awards a 2- year certification to provide smoking cessation services. The certificate must be maintained for the 2 years through continuing education. Recertification requires proof of continuing education from an accredited organization, with 18 hours training during the two year interval. A recertification fee of \$75 is subject to change. The LSW who is already a TTS specialist is not required to take the course.

13. It looks like our infant mortality rate has changed and is now only 7.5%. Does this mean I cannot apply for 'reduce infant mortality'?

If you have a rate that is lower than the state rate you can still apply for the strategy as long as you can justify the need using your community health assessment and any other data to support the need. We obviously want you to continue your efforts to continue to reduce the rate in your community, but we want you to support it using valid data. This eligibility and justification is not a new requirement. The requirements remain the same as SFY 2012

14. This question pertains to the Community Health Assessment (CHA) piece and the strategies. Do we need to address every strategy? We are just starting the planning for the 2014 CHA – developing the surveys with other community stakeholders, the survey will be ready for distribution in June and data collected and analyzed by October. So, my question would I address all the strategies, I know previously you needed to, but I wasn't sure if this had changed.

Please see response to Question #5.

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15. Is there a link to the Safe Sleep Campaign referenced in the RFP?

The following website will be finalized by April 1, 2014. This Safe Sleep website is for parents and the general public and will also provide links to the American Academy of Pediatrics. For communities implementing media messaging on their own, there will also be templates available. [www.safesleep.ohio.gov](http://www.safesleep.ohio.gov).

Ohio Department of Health Safe Sleep Policy

[http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/cfhs/child%20and%20family%20health%20services/ODHPolicy\\_Safe%20SleepFINAL1213.ashx](http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/cfhs/child%20and%20family%20health%20services/ODHPolicy_Safe%20SleepFINAL1213.ashx)

Infant Safe Sleep Policy Fact Sheet

<http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/cfhs/child%20and%20family%20health%20services/Infant%20Safe%20Sleep%20Policy%20Fact%20Sheet.ashx>

Ohio Department of Health Safe Sleep Home Page

<http://www.odh.ohio.gov/features/odhfeatures/SafeSleep/Safe%20Sleep%20Home%20Page.aspx>

16. Is there a minimum or maximum amount that we should allot to Cribs for Kids?

No, there is not a minimum or maximum amount. It should be based on the needs of your community.

17. For the measure: Ensure the social/emotional health and addiction needs of pregnant and postpartum women are met" Can you provide some specific examples of what activities would meet the strategies for those clinics that do not do direct care? Do you see this as outreach or for serving current clients?

An example would be that there is a "map" of what happens/where women go when they have certain scores on the screening tool. The women would be screened; the screening would be sent to a central location if warranted by the score; and then depending on the resources in the community, the women would be linked to an appropriate provider. There would need to be a feedback loop so the information could be tracked such as the agency sends a form back once the client has attended their first appt. and then the outcome of the treatment. Again this could be done by the subgrantee agency or contract agencies. This is not an outreach strategy but rather a strategy to promote building an infrastructure in your community to screen and make sure prenatal and post-partum women are getting the treatment services that they need. So it is up to the applicant agency to form a system that will promote this type of activity. The outreach may come in the form of communicating with the stakeholders in your community about how to build this type of system of care.

18. For the measure "reduce the percentage of children who are overweight" Would we need to do both the childcare and school based programs? Or is it for one or the other?

No, you do not need to do both. You may do one or both depending on the data from your Community Health Assessment.

19. In reference to the CFHS 15 RFP, Child and Adolescent Component, page 36, I am interested in the school based nutrition education program to use. Currently, I am using the My Plate education program with third graders in the public school system. Is this same program allowable for the CFHS 15 grant?

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Refer to Question #9

20. My question is about how ODH wishes to see the CHA component planning. For FY15 specifically, I have plans for partnership-building, data collection, implementation & evaluation – then, subsequent year plans that follow those for additional interventions planning & continuation through the cycle with YRBS data. My question is, does ODH wish to see both next year’s plan AND a 5- year plan? Should we be breaking those out in the program plan & narrative into two distinct timelines? This is a really tricky thing to write correctly, given that we haven’t finished the 5 year cycle.

If the agency is applying for CHA funds, it must include specific activities for each strategy for which funds are requested. If the agency is not applying for funding for all strategies, (e.g. because it plans to address those strategies in subsequent years of the cycle), it must provide a timeline in the program plan for when those strategies will be addressed.

21. After checking the Health Status Profile for our County, we realized that our Infant Mortality rate is 2.3. According to the RFP, we cannot apply for the CFHS measure of reducing infant mortality without a 7.7% rate. Our county doesn’t have any hospital facilities, so few deaths are declared within the county. In addition, we have an exceptionally high rate of moms smoking in their last trimester of pregnancy, no OB/GYN’s in the county and there is very little support for breast feeding moms. No one in the county is providing adequate safe sleep education and we hate to lose our momentum. What are your thoughts for us?

Please see the answer to Question # 13.

22. Just a point of clarification-are we allowed administrative cost (historically was 10% of total award) in this application. Two of us listening to the bidder’s conference thought we were but as we move toward putting this together-I just want to assure we prepare our budget correctly.

Any personnel charges to the CFHS grant must be supported by a time study that reflects the hours charged. Provide a description of the job duties related to the amount of funds charged to the CFHS grant.

23. How do I know if a child care facility is already participating in the Ohio Healthy Program?

You need to check with the child care facility directly. The counties who receive funding from Creating Healthy Communities (CHC) will likely have facilities who are already participating. Those CHC counties are listed here

<http://www.healthy.ohio.gov/healthylife/createcomm/2014%20Creating%20Healthy%20Communities%20Projects.aspx>

Once funded, you will coordinate with ODH, CFHS, & CHC to avoid duplicate efforts.

24. Under the OIMRI eligibility and justification it states, “the program is focused on at risk African American...” under bullet 1 it says ‘An IMR is at least 2 times the state rate of infant mortality (15.4/1000 live birth)’. The rate referenced seems to be the overall IMR for the state of Ohio times 2 (7.7 times 2 = 15.4). Our question is.....Are we to only look at the IMR, LBW and VLBW for African American population or are we to look at the County’s total population?

The basis for the infant mortality rate is the overall State infant mortality rate of 7.7/1,000 live births, thus the 15.4 IMR. Since the rates for all counties are included in the state rate, the

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applicant's county eligibility and justification criteria for serving an at risk African American population the must be based State rate. The eligibility and justification is the State rate vs. the county's race rate. For example for, Infant Mortality rate is 20.2 vs. 7.7 OH; Low Birth Weight is 13.5 vs. 12.9 OH rate; Very Low Birth Weight of 4.6 vs. 2.4.

25. Once we choose to apply for funding for a specific measure are we correct in thinking that we can choose which strategies to implement. Meaning, we do not have to do every strategy within a measure?

The two components which require all strategies are the Community Health Assessment and OIMRI. In the Community Health Assessment, you do not have to request funding for all strategies but you must address all strategies. The perinatal and Child/Adolescent Health components you may choose which strategies to implement based on the needs of your community.

26. We have a quick question regarding the RFP for FY15 CFHS. On page 34 – Appendix C the measure is: Reduce the rate of smoking and increase smoking cessation among teenagers. We do have a high teen smoking issue that needs addressed. We are noticing that the Not on Tobacco (NOT) program is a treatment program (rather than prevention) and from what we can understand from our research will only target current teen smokers. We are wondering if there is any latitude in program choice or must it be the NOT program. It seem we would have more success in meeting more students in the classrooms if the program presented could be more of a prevention program which is reaching those who have not started smoking **and** those who have already begun.

The CFHS grant is using the NOT program. There is the Stop Tobacco and Nicotine Dependence (STAND) program which is a youth led advocacy and prevention program for junior high through high school age youth. For more information on the STAND program please contact Mandy Burkett (6614-644-7553) or Amy Gorenflo (614) 466-1717.

27. I have a brief question for you relating to the selection of each of the five components. If we choose to apply for one component, do we need to address all of the CFHS measures in that component or are we able to focus on one or two? For example, in the Child and Adolescent Health Component could the focus be on reducing smoking and obesity or must we provide for all of the CFHS measures including well child clinics?

Please see the answer to Question #3.

28. The Sliding Fee Scale 2014 is already out. Are we supposed to use the 2013 or the 2014 for this grant?

Please use 2014. Here is the link to the poverty guidelines:  
<http://aspe.hhs.gov/poverty/index.cfm>

29. In the working with Child Care facilities to increase nutrition education, access to healthy food choices and/or physical activities – strategy – are we to be providing training to the Child Care facilities or programing, like with the Let's move program but using the Ohio Healthy program?

Yes, you will be providing the Ohio Healthy Program training to the child care facilities.

30. If we are providing training in the Ohio Healthy program to Child Care facilities and providers only, how is the number of children reached determined?

The childcare facility and the CFHS sub grantee agency track the actual number of children served.

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31. I wasn't clear on the Public Health Impact statement; if we are a Health Department do we need to write this or is this only if the applying agency is not a Health Department?

If you are a Health Department you do not need to write the Public Health Impact Statement per the RFP page 6.

32. On Page 21 of the RFP can you clarify for me what the statement about funding cash needs that says: "Do not exceed 20% of the funds being provided by ODH" Does this mean that ODH funds should not exceed 20% of the agencies overall budget?

You must 20% budgeted in each quarter, leaving 20% remaining in the balance. Please contact Jennifer McCauley if you have further questions about this at (614) 728-7402 or [jennifer.mccauley@odh.ohio.gov](mailto:jennifer.mccauley@odh.ohio.gov).

33. Is OCCRRA implemented directly for the children, or is this a program that is more of a train the trainer for the staff?

In terms of providing training for Ohio Healthy Programs, OCCRRA's role is to train the CFHS subgrantee or subcontract staff. Once trained, the CFHS trainers deliver the training to childcare facility staff. CFHS trainers do not deliver the program to children or families, the childcare facility staff does.

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

Yes, it is allowable if it is identified as a necessary part of primary data collection for community health assessment; the additional funds would be allocated in the CHA strategy "Assess Data Needs/Capacity".

To be funded through CFHS, the agency would need to adhere to the ODH guidance which requires FIMR to be a multi-disciplinary, multi-agency, community based program that identifies local infant mortality issues through the review of fetal and infant deaths using the standard components of the FIMR model (e.g., case review team, maternal interviews and community action team) and develops recommendations and initiatives to reduce infant deaths.

35. A question about case management/care coordination. A CHA was conducted and it was found there are plenty of OB's but the patients do not keep their appointments. The county would like to perform case management/care coordination services.

The perinatal component has direct care (prenatal and post-partum visits); socio-emotional, and smoking. These case management/care coordination services could be considered part of the wrap around care for direct patient care. However, the county would need to meet all the benchmarks that are related to direct patient care.

The socio-emotional measure ensures women are screened for mental health and addiction needs using one of the suggested screening modalities and then appropriately linked to treatment.

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36. I have a question about one of the benchmarks within the OEI component. Within the FIMR benchmark it mentions reporting all FIMR cases to the National FIMR database. Is this required for communities who report FIMR cases into a local database? Will there be additional support from ODH to report cases into the NFIMR database? I did not attend the training last week- other individuals from my agency did, the additional support may have been discussed during that training.

At the FIMR training in March, each participating OEI county was given a copy of the NFIMR database on a CD. County FIMR programs are not required to use this database; it was provided as an option if counties choose to use it. ODH will request that FIMR programs submit a basic subset of data variables to the state on a regular basis; however this list has not yet been finalized. At this point there are no plans to share data with National FIMR.

37. On the CFHS component: Child and Adolescent:

- a. Reduce the rate of smoking and increase smoking cessation among teenagers: do we have to do this one if we do the direct care?

No, you do not.

- b. If we do the nutrition one, does it have to be to preschoolers?

No, you may choose childcare, schools or both

- c. The social emotional health care needs of children and adolescents: if we work with our counseling center by referring the child identified at the WCC appointment, after completing the social emotional checklist. Is there more we should be doing?

Please see question #10

38. Do you have an approximate amount that should be allocated for each measure? Several strategies would include training and materials for the required programs that are listed, but the websites for these programs are not clear as to what our exact costs might be.

NOT: \$200 per person (Please reference questions 8, 22a, and 38 in first round of questions)

TTS: \$500 and plus 5-day training in Columbus (Please reference question #23 in first round)

Baby and Me Tobacco Free: \$1200 and one day training in Columbus

(Please reference question 24 and 31 in first round of questions)

OHP: Budget for travel 2-day training in Columbus and for duplication of materials

39. I have contacted the NOT program, the lady I spoke with indicated that typically the program is led by someone in the school system (teachers, guidance counselors, etc) as opposed to an outside community educator. Just wondering how you would see our role in this program, actually leading it or providing the information and training to the school personnel?

The NOT program can be facilitated in schools and other community settings by teachers, school nurses, counselors and other staff and volunteers specially trained by the American Lung Association. The sub-grantee can implement the program by identifying and training a health department staff member, or sign a memorandum of understanding with the school(s) to send a school staff member to the training. In addition to the training dollars, the sub-grantee can provide monies to assist in implementation of the program. The sub-grantee will be responsible for the oversight of the program, whether it is a health department or school employee.

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40. Similar to the above question – the CATCH, SPARK, Play 60 programs, seem to be geared towards physical education teachers, if we decided to pursue these programs would we be visiting the schools on a regular basis actually doing the activities or providing the information to the schools and then doing follow-up type activities?  
**CFHS funded staff trains the staff at the facility (child care, schools) and may provide materials. The facility staff provides the program.**
41. Site and Service Form – if one person on the grant is housed at another location, do I complete (2) forms? That person is my supervisor who is listed on the grant.  
**Yes, if direct care or enabling are provided by the staff at that location.**
42. If we are not soliciting funds for the CHA component – do I still complete a Program Plan or simply address the component in the grant narrative?  
**Please see answer to Question #5.**
43. For the purposes of working with childcare agencies, can we provide a letter of support from our local OCRRA office to accompany our application and submit letters from specific childcare facilities during the first quarter?  
**You do not need to contact OCCRRA. You will contact childcare facilities as in the previous years to make sure you are able to work with them and submit the letters from the childcare facilities.**
44. Are we permitted to allocate additional funding to OEI for interventions beyond the \$50,000 that is currently allocated?  
**Local funds should support above the \$50,000 CFHS cap for the OEI interventions in the OEI component. You can use CFHS funds for other CFHS components/measures.**
45. Under OEI, can funding for the upstream interventions be awarded to FQHCs?  
**Funding is awarded to only those applicants eligible to apply for the OEI component, in other words, the 9 OEI cities/counties (Butler, Cincinnati, Columbus, Cuyahoga, Dayton, Lucas/Toledo, Mahoning/Youngstown, Summit, and Stark). It may be acceptable if an OEI team subcontracted with a FQHC to implement the upstream intervention.**
46. As instructed on the call, I looked at the CFHS 2014 Program Standards for the purposes of identifying the appropriate nutrition education curriculum for work with schools. I see that Let's Move is still listed, but only under the physical activity component. Does this mean that if we choose to work on access to healthy food choices that we cannot align our work to Let's Move and are limited only to Choose My Plate?  
**The programs listed in the standards are to serve as additional sources. The following are a list of programs for school age children: Let's Move, Nutrition Expedition and /or Fuel Up to Play 60, Choose My Plate, CATCH (K-8), CATCH Kid's Club After-School Program (K-8), SPARK and Veggie U.  
The only program for childcare centers is the Ohio Healthy Program.  
Programs listed on page 6 of Infrastructure, Population-Based and Enabling section of the CFHS standards: [http://www.odh.ohio.gov/odhprograms/cfhs/cf\\_hlth/standards/cfhs.aspx](http://www.odh.ohio.gov/odhprograms/cfhs/cf_hlth/standards/cfhs.aspx)**
47. Finally, with our current CFHS funding we added a strategy under Reduce the Rate of Infant Mortality addressing food access and pregnant women. We are piloting a program with our subgrantees and other community partners by which we work with pregnant women around goal

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setting and education related to fruit and vegetable consumption and provide them with a “prescription” to go to a local farmers market and buy fruits and vegetables using local food assistance benefits. Based on our pilot evaluation we have had good outcomes and would like to continue this program under our competitive application. Would this be permissible? If so, can it continue to fall under reduce the rate of infant mortality?

It is acknowledged your pilot program for pregnant women about educating and increasing fruit and vegetable consumption is excellent in concept and implementation. However, the strategy does not fit any FY15 Child and Family Health Services Request for Proposal measures or strategies.

48. If our Health District applies for funding in a particular measure and we are not awarded those dollars for that initiative, are we permitted to apply for funds for another measure? We realize the deadline for submission would have passed and this question is also assuming another entity has not successfully received funding. If not permitted to apply to work on toward another measure do those funds remain as non-awarded funds?

No, you are not permitted to apply for funds for another measure until the next competitive cycle. Based on you CHA data, you should select the measures that meet the eligibility and justification requirements.

49. Has Ohio begun a partnership with the Baby & Me Tobacco Free smoking cessation program at the state level? If we are interested in applying for funds for this strategy are we to research it and attempt to come up with costs estimates etc. independently? Are there any providers of this program in Ohio that can be contacted for information? We understand from the previous Q&A that there will be a training provided in the future for which we need to budget \$1200.00 but it is difficult to estimate what staff time will need to be allotted to run this program and how much time is needed to follow each participant etc. Additionally, how much supplies will costs.

Ohio has started a partnership with the Baby & Me-Tobacco Free smoking cessation program. There are no providers in Ohio to contact, because Baby & Me-Tobacco Free program is new to Ohio. Participants who quit smoking, complete the 4 prenatal cessation sessions, and stay tobacco-free after the baby is born, are eligible for a free \$25.00 diaper voucher, each month, for up to 12 months. Support for 50 women enrolled in the program, receiving 12 months post-partum diaper vouchers would equal \$16, 200.00. Items that would need to be budgeted for in addition to the vouchers would be CO Monitor, supplies, calibration kit (\$835.00), printed brochures (\$94.00 per 100 brochures), Saliva tests (optional, \$9.80 each), Program Manuals (\$49.50 each), monthly technical support for 12 hours per month not required, but recommended (\$480.00 per month). Each session is approximately 10 minutes of staff time.

50. If the eligibility and justification for the CFHS measure: reduce infant mortality indicates that the county must have a rate of 7.7 or higher is it accurate that we should **not** consider applying for those funds since the CFHS&RHWP Health Status Profile indicates that the rate in this county is 7.6. This measurement is not presented in the most recent CHA done in our county.

Please refer to Question #13.

51. Under the Baby and Me Tobacco free program, the information we got says they recommend us to budget \$480 per month for technical assistance and data for 12 hours per month. Is that necessary for this program? Seems a bit high for 50 moms.

The guidelines state that monthly technical support (which includes data collection, and voucher redemption) is recommended, not required.

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52. Does the Breathing Association have a shorter recertification program for a CTTS that certification has lapsed or will they need to attend the 5 day session? **No, there is not a shorter version of the Breathing Association TTS training. It is recommended that the course be repeated and certification maintained through continuing education for the duration of the certification (2 years).**
53. Do the trainings have overnight stays or just one day, and for the quarterly meetings, are they in Columbus, per phone or regionally?  
**We meet once per year for the project directors' meeting (one-day). We will aim to host 2-3 conference calls. However, I would recommend budgeting for two one day trips in case something arises during the course of the year.**
54. Under the Baby and Me Tobacco free program, the information we got says they recommend us to budget \$480 per month for technical assistance and data for 12 hours per month. Is that necessary for this program? Seems a bit high for 50 moms.  
**Although the guidelines state that monthly technical support is recommended, not required, it is strongly advised that sub-grantees budget for TA due to the vast amount of benefits to the program's start-up and success. The \$480.00 includes data collection, technical assistance, management of vouchers at the local level and the store level, monthly conference calls, quarterly webinars and the latest updates. The states who are having the highest success and satisfaction with the implementation of the Baby & Me-Tobacco Free program are budgeting for technical assistance.**
55. Can I find out if anyone else in the county is implementing the Ohio Healthy Program?  
**At this time, you would need to ask the center directly.**
56. Can we work with Headstart programs in our county with the OHP program?  
**Yes**
57. Is the expectation that the number of children served are an *extension* of providing the training to the child care providers.  
**The program is an infrastructure program that facilitates systems level changes. The program is designed to target all children at the childcare center. Reporting the number of children served is one benchmark.**
58. Are both strategies: Work with Childcare facilities and work with schools required for the measure Reduce the percentage of children who are overweight?  
**No, you may choose one or both of the strategies based on the needs of your community.**
59. Do you know if OCCRA keeps a listing by county of those facilities who are already enrolled in the program? We know the potential number of total child care facilities, but have at this point no way of knowing which ones are already working through OCCRA?  
**At this time, you would need to ask the center directly. Please refer to question #23.**

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60. For the Ohio Equity Institute (OEI) funding, since our project hasn't yet selected the upstream and downstream interventions (and won't until June 2014) how does ODH recommend we account for the \$50,000 budget in GMIS? Also, for the FIMR we are allocated \$28,000. If we plan to hire a part-time staff person and it will cost more than \$28,000, should we put the entire cost on Attachment #5 OEI tab for FIMR implementation, or only put \$28,000 there and put the rest under the Child & Adolescent Health tab for reducing infant mortality?

For now, create a line item in Other Direct Costs in GMIS and your budget narrative; do not put the funding in contracts unless a contractor has been identified. Most OEI projects will need to submit a budget revision when plans have been approved by ODH and City MatCH. The remaining funds should be included in the Community Health Assessment component not Child and Adolescent Health. Refer to question #34.

61. Can you clarify the Health Equity component of the narrative and the Health Equity component of the application on GMIS. Does the information have to align with the GMIS categories or the format presented on page, Section M under Roman Numeral "I". Do both have to be completed or is the portion presented in the project narrative sufficient?

Write your program narrative following the RFP guidance. The narrative and program will assist you in completing the GMIS Health Equity module (helps you decide which boxes apply for your narrative/plan--which boxes to check).

Currently, the Health Equity component is having issues. A bulletin board message was posted on GMIS 3/24/2014. Please continue to check the GMIS bulletin board for updates.