Preventive Health and Health Services (PHHS)
BLOCK GRANT WORK PLAN
GUIDANCE

Updated May 2018

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PHHS BLOCK GRANT
WORK PLAN

Introduction: This Work Plan guidance document is to help Grantee's develop their application for funding that provide details of how funds are expended through the Work Plan objectives and activities.

AT-A-GLANCE

The outline below gives an "At-A-Glance" summary of the structure of the PHHS Block Grant Work Plan in the Block Grant Management Information System (BGMIS).

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PHHS BLOCK GRANT WORK PLAN GUIDANCE

1. COVER PAGE

The cover page provides the grantee's administrative information, the executive summary of the application, and a funding rationale for the prioritization of Block Grant funds.

Grantee must verify the accuracy of information on this page in BGMIS before the Work Plan can be submitted. The link labeled "verify this Work Plan" located on the upper right hand corner, must be clicked to complete this task.

1.1. Administrative Information

The administrative information section under Cover Page collects the general information pertaining to the applicant, such as the DUNS#, the Block Grant Coordinator's contact information, Governor's name and email address, State Health Officer's name and email address, CDC Work Plan ID; and, date the Work Plan was created and submitted to CDC. Grantee should provide current information appropriate for each category in the fields provided.

2. EXECUTIVE SUMMARY

The executive summary allows grantees to provide readers, such as Advisory Committee members, the general public, and CDC, with a summary of the proposed activities for the upcoming fiscal year. It describes the background, funding assumptions, and proposed allocation and funding priority for the fiscal year. Below is the language that this section of the Work Plan must have to complete the Executive Summary. Please replace the bold underlined text with your own information that applies.

- On (**ENTER MEETING DATE HERE**), the Advisory Committee reviewed and recommended programs for funding, contingent upon the receipt of funding for FY 20xx.

- On (**ENTER MEETING DATE HERE**), the Public Hearing was convened.

- This work plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Year 20xx. It is submitted by the ***ENTER NAME OF GRANTEE HERE*** as the designated state agency for the allocation and administration of PHHSBG funds.

- Funding Assumptions: The total award for the FY 20xx Preventive Health and Health Services Block Grant is ***ENTER $ AMOUNT HERE***. This amount is based on an allocation table distributed by CDC.

- Funding for FY 20xx Sexual Assault-Rape Crisis (HO IPV 40) activities detailed in the Work Plan: ***ENTER $ AMOUNT HERE*** of this total is a mandatory allocation to the ***ENTER NAME OF GRANTEE HERE*** which provides this funding to ***BRIEFLY DESCRIBE ACTIVITIES HERE***.

- Program Title, Healthy People Objective (HO), and Activities, please repeat this section for all funded Programs/HO's:
  - Program Title:
  - ***ENTER NAME OF HEALTH OBJECTIVE***, ***ENTER $ AMOUNT HERE*** of this total will be utilized to ***DESCRIBE WHO IS THE RECIPIENT OF FUNDS AND ACTIVITIES HERE***.

If all or parts of the funds are going to a contractor/sub-recipient to support implementation of activities, please identify the contractor/sub-recipient and the allocated amount.

- Administrative costs: associated with the Preventive Health Block Grant total ***ENTER $ AMOUNT HERE*** which is less than ***ENTER PERCENT HERE*** of the grant. These costs include funding for ***DESCRIBE WHO IS THE RECIPIENT OF FUNDS AND ACTIVITIES HERE***.

- The grant application is prepared under federal guidelines, which require that states use funds for activities directed toward the achievement of the National Health Promotion and Disease Prevention Objectives in Healthy People 2020.

2.1. Funding Rationale

The funding rationale section helps identify the factors that helped the Grantee and the Advisory Committee decide on funding certain programs within the FY 20xx Block Grant Work Plan. For each Program funded, the grantee should consider the following four factors and rank them in the order of importance (1 to 4, 1 being the most important factor and 4 being the least important factor) in determining priority funding for a specific program, each Program in the Work Plan should be ranked:

- State strategic planning process
- Data trends from national, state, and local data collection systems
- Health need that was established by data trends but it is under or unfunded
- Other (for example a disaster or outbreak of infectious disease). Please explain if other is selected.

3. STATUTORY INFORMATION

Statutory information includes:

- the Advisory Committee member composition,
- the date and minutes of the Public Hearing,
- the dates and minutes/highlights of Advisory Committee meetings, and
- signed certification forms.

Copies of the minutes and signed certification forms must be uploaded in BGMIS in order to submit the Work Plan to CDC.

3.1. Advisory Committee Member Information/Composition

This section requires grantee to indicate the committee members' title and affiliation with organization, constituency, or perspective. It is required that the Advisory Committee be composed of such members of the general public, and such officials of the health departments of political subdivisions of the State, as may be necessary to provide adequate representation of the general public and of such health departments.

3.2. Advisory Committee Meetings

Grantees must hold a minimum of two Advisory Committee meetings each fiscal year, one of which must be prior to work plan submission. The second Advisory Committee meeting may be held at a future date, but that date must be prior to July 1st of the fiscal year. As per the legislation, the State Health Officer (SHO) must chair the meetings. The SHO may appoint a designee to chair the meetings. If a designee is appointed, the minutes must reflect the designated appointment by the SHO. BGMIS allows Advisory Committee

meetings to be entered with meeting dates up to 5 months prior to the start of the fiscal year (e.g. May 1, 2017 or later for FY 2018 work plans). Both required meetings must be held prior to July 1st of each fiscal year.

The minutes from all Advisory Committee meetings must clearly document discussions of each funded Health Objective (HO). The minutes should include:

- date of the meeting,
- a list of attendees' names, titles, affiliated organizations,
- name of the individual who chaired the meeting (noting if the chair was designated by the SHO),
- a recommendation on each funded HO by the Advisory Committee members, and
- all meeting minutes must be uploaded in BGMIS prior to July 1st of each fiscal year.

As per the legislation, the State agrees if any revisions are made in such plan during the fiscal year, the State will, with respect to the revisions, hold hearings and make proposals public and submit to the Secretary (CDC) a description of the revisions Consider discussing the revisions to the Work Plan with your CDC Project Officer to ensure requirements are being met.

3.3. Public Hearing

At least one Public Hearing is required per federal fiscal year. A Public Hearing must have occurred prior to application submission. Grantees must upload the invitation that went out to the public and identify how the Work Plan was made available for public view, (e.g. posted on the web).

After the Public Hearing is held, Grantees must prepare minutes that include:

- how the Work Plan was made available for public viewing,
- how the public was invited, the invitation
- the date the Hearing was held,
- who was in attendance, and
- any comments that were made by attendees,

Minutes and the invitation must be uploaded in BGMIS prior to July 1st.

As stated in the legislation, if there are revisions made to the Work Plan during the fiscal year, grantee must hold Hearings in addition to the initial required hearing. Please contact your CDC Project Officer prior to engaging in any revisions.

3.4. Certification and Assurances (Non-Construction Programs) Forms

A Certification form (PHS-5161-1) which states grantee requirements regarding Debarment and Suspension, a Drug free work place, Lobbying, Program Fraud Civil Remedies Act, and Environment tobacco smoke must be signed by an authorized agent (the Principal Investigator on the Notice of Grant Award) . Blank Certification forms are provided in the BGMIS for grantees to print and have signed and dated by the authorizing agent.

An Assurance Form (SF 424B) is also required and must be signed by an authorized agent (the Principle Investigator identified on the Notice of Grant Award) to ensure grantees are in compliance regarding Non-Construction Programs. Grantees are required to have the forms signed, and dated. Both the Certification and Assurance forms are required to be signed each fiscal year by an authorized agent (the Principle Investigator identified on the Notice of Grant Award) and must be uploaded into BGMIS upon submittal of the Work Plan.

3.5. Certification and Assurance Statement Form

A Certification and Assurances Statement form is required and must be signed and dated by the current Governor or delegated official (must be cabinet level within the jurisdiction such as the Commissioner). A new form must be signed by the Governor or designee at the start of each term and/or if the Governor vacates the position during the term. In subsequent years of the grant, a copy of that form can be submitted each year thereafter.

If a delegated official has been authorized to sign and date the form, the official's name and title must be indicated on the form. Please note if a delegated official is signing the form, it must be signed and dated each fiscal year. All forms must be uploaded into BGMIS upon submittal of the Work Plan.

4. TOTAL BUDGET

The Total Budget section provides a dollar breakdown of each Program by the amount allocated to the National Health Objective(s) that is associated with the Program. Important budget considerations include:

- The Annual Basic and Sex Offense amounts must match the current allocation table amounts.
- The Annual Basic administrative cost must not exceed 10% of the Annual Basic amount.
- The Sex Offense administrative cost must not exceed 10% of the Sex Offense amount.

Funds may be transferred to another Block Grant. The total transfer amount must not exceed 7% of the Annual Basic amount. At any time in the first three quarters of the fiscal year a Grantee may transfer not more than 3% of their Annual Basic allotment to another Block Grant. The remaining transfer amount can be transferred in the last quarter of a fiscal year. Grantee must document in BGMIS the name of the Block Grant that funds are being transferred to.

Direct Assistance (DA) is funding provided by the state to support a CDC employee to provide specialized expertise otherwise not found in the state health department. If Direct Assistance funds are being provided, grantee is required to indicate the name of the person(s) receiving the Direct Assistance, the person's CDC Center location, and the amount being provided.

NOTE: If you are requesting DA, please discuss the intention with your Project Officer (PO) at the earliest possible time. This will allow CDC to address internal accounting issues in a timely manner.

5. PROGRAM(s)

The Program section includes the Program's Strategy (title, goal, health priority, primary strategic partners, and evaluation methodology) information on the program setting, program Full Time Equivalents (FTE) allocation, and National Health Objective (which includes State Health Objective, Annual Impact Objectives and Annual Activities.

5.1. State Program Strategy

Under the State Program Strategy, the grantee must list and describe the following items in detail for each funded Program:

- Program's title: All programs described in the work plan must be identified by a Program Title that is descriptive of the State Health Department Program.
- Goal(s)/Program Strategy: Identify the plan or method the Program is attempting to achieve, specifically what outcomes are expected.
- Health Priority: Identify the primary health concerns the Program will target (e.g. smoking cessation, infant mortalities, access to prevention services, etc.)

- Primary Strategic Partners: Identify stakeholders within the health department (categorical programs), other agencies, state organizations, or community organizations who the Program will work with to achieve its goal.
- Evaluation Methodology: Identify the Program's plan to evaluate the progress of reaching the program's goal(s).

5.2. Program Setting or Site

Under the program setting or site section, grantee is required to indicate the settings or sites that most or all program activities take place (e.g. State Health Department, Community Health Center/Clinic, Schools, etc.).

5.3. Program FTE Allocation

The legislation for PHHS Block Grant requires that grantee identifies the number of FTE's allocated to each program. Grantee will identify the name (first and last) and position title of each FTE, this does not include contractors, sub-contractors, or consultants. In this section, the grantee enters the percent of time that FTE devotes to Block Grant activities. For example, an individual that is 50% funded by Block Grant dollars may be providing support to State activities, Local activities or Other activities. The 50% can be broken down to state at 16%, local at 17%, and other at 17%, equaling to a total of 50%. Please note that the BGMIS system does not allow for fractions.

An individual person may work in several Programs being supported by Block Grant dollars include those as well, and ensure the total FTE count for one individual does not exceed 100%. (i.e. Jane Doe works 50% on the Diabetes Program and 50% on the Rape Program, totaling 100% of funds being paid by the Block). If a position is vacant, please identify in the Program Strategy section the anticipated date it will be filled.

6. Program National Health Objective(s)

A Program includes three levels of objectives for reporting and tracking purposes. First is the National Health Objective (selected from HP2020); second is the State Health Objectives; and third is the annual Impact Objectives. Annual Impact Objectives are tied to the State Health Objective.

State and Impact Objectives reflect the SMART Objectives principles-- Specific, Measurable, Achievable, Relevant, and Time Based.

Specific	Describe the specific behavior or outcome you wish to achieve. This outcome should be related to a number, rate, percentage or frequency.
Measurable	Determine the system by which you plan to measure your progress towards the achievement of the objective.
Achievable	Ensure that the objective can be achieved with a reasonable amount of effort and the time projected.
Relevant	Ensure that the people with whom the objective is set have the necessary knowledge, skills, and abilities to make an impact on the situation.

Time Based	Include a time period or a start and finish date during which activity working toward the objective will take place.

For additional information on writing SMART objective, here are suggested Web links.

http://www.cdc.gov/nccdphp/dnpa/physical/handbook/pdf/handbook.pdf
http://www.cdc.gov/dhdSP/programs/nhdsp_program/evaluation_guides/docs/smart_objectives.pdf
http://www.cdc.gov/HealthyYouth/evaluation/

Under the National Health Objective section, you will select the National Health Objective from a drop down list in BGMIS. National Health Objectives are used as the basis for the PHHS Block Grant work plan, and are derived from the HP2020 Health Objectives document.

HP2020 objectives are considered long term and strategic in the planning process. Chapters which are health problem specific will have one or more health objective(s) that correspond to a specific health problem. For example: the Diabetes chapter has 16 health objectives which correspond to reducing Diabetes. If a state is using PHHS Block Grant funds to reduce Diabetes deaths, then select HO D-5 Diabetes Deaths.

Please note as you enter information into BGMIS, keep in mind that all Programs, State Health Objectives, annual Impact Objectives, Annual Activities, and Funding is tied to one or more National Health Objective.

6.1. State Health Objective(s)

6.1.1. Objective Description

In this section, the grantee provides information on the state health objective that includes the objective's SMART description, its baseline information and data source. Grantee is required to provide a specific, measurable, achievable, and realistic description of the objective including entering a start and end date for the performance period of the state health objective. The performance period can have an end date through year 2020.

6.1.2. Baseline Data

Baseline data applies both to health objectives that measure change in health status as well as health objectives that establish infrastructure or focus on health education. Each State Health Objective should have a baseline, a starting point.

For example, if you plan to provide training to local health departments, the baseline would be the number of trainings that you provide at beginning of reporting period compared to the number of trainings that you intend to provide at the end of the reporting period. The baseline data should reflect the status of the health problem within your state.

6.1.3. Data Source

In order to track the change or progress of your set objective, grantee is required to provide a data source that will be utilized to compare the baseline to the actual outcome during the reporting period. For example, will change be measured by data derived from standard surveys such as BRFSS or YRBS, data from the Medicare Medicaid database, Vital Statistics data, Hospital Discharge data, or others.

6.2. State Health Problem

The state health problem includes the: 1) health burden; 2) target population, population with disparate need within the target population; and, 3) data sources used to describe the state health problem. More information for each subsection of the state health problem is provided below.

6.2.1 Health Burden

The health burden is a description of the scope and magnitude of the burden as it applies to the state using current or trend data such as morbidity/mortality, incidence/prevalence by race, ethnicity, age, gender for the health problem related to the state and jurisdictions or regions. The grantee should include similar data on risk /contributing factors; disproportionately burdened groups; and other data that contributes to the picture of the health problem. Grantee may also include historical information on disease burden faced in the State.

6.2.2 Target Population

A Target Population is defined as the population for which the intervention is planned. Below are population demographics for Healthy People 2020 chapters that relate to health problems.

- Race and Ethnicity –The options for race and ethnicity reflect OMB minimum requirements for combined Race/Ethnicity reporting. Select "Other" when none of the items in the list identify the population served, or when the populations served includes additional items not included in the list. In the second instance, grantee would check "Other" in addition to the items in the list.

- Age – States vary widely in the age ranges that are used to define populations. Subsequently, an attempt was made to identify ranges that are consistent with ranges for CDC's National Center for Chronic Disease Prevention and Health Promotion. This will insure that the data that is submitted by the state can be used center (and hopefully) CDC wide. Choose the range that closely approximates the population age range(s) served. Use US and/or state census data.

The population demographics for the Healthy People 2020 Objectives that relate to Public Health Infrastructure generally differs significantly from the population demographics for Healthy People 2020 chapters that relate to health problems. For Public Health Infrastructure objectives, a target population is still defined as the population for which the intervention is planned; however due to the demographic differences, a special set of population demographics has been created for Healthy People 2020 public health infrastructure objectives and are located in BGMIS.

6.2.3. Population with Disparate Need

Based on the population being targeted, identify any sub-populations that bear a disproportionate burden from the health problem. In some instances, the Disparate Population will be identical to the Target Population.

- Race and Ethnicity –The options for race and ethnicity reflect OMB minimum requirements for combined Race/Ethnicity reporting. Select "Other" when none of the items in the list identify the population served, or when the populations served includes additional items not included in the list. In the second instance, you would check "Other" in addition to the items in the list.

- Age – States vary widely in the age ranges that are used to define populations. Subsequently, an attempt was made to identify ranges that are consistent with ranges for

CDC's National Center for Chronic Disease Prevention and Health Promotion. This will insure that the data that is submitted by your state can be used by the Center (and hopefully) CDC wide. Choose the range that most closely approximates the population age range(s) served. Use US and/or state census data.

- Gender- Identify target focus as male and/or female.

- Income – "Poverty thresholds are the statistical version of the poverty measure and are issued by the Census Bureau. They are used for calculating the number of persons in poverty in the United States or in states and regions." Refer to: How the Census Bureau Measures Poverty, http://www.census.gov/hhes/www/poverty/about/overview/measure.html.
  **Many states develop their own thresholds for poverty/low income. Use your states' definition if it exists. Otherwise, use US Census data.

- Geography – When possible, use the US Census Bureaus classifications for defining rural vs. urban populations. The following website provides helpful information. Census 2010 Urban and Rural Classification: http://www.census.gov/geo/reference/urban-rural.html
  **Use your state guidelines if they exist.

6.2.4. Data Source

Describe which data sources were used to determine the population statistics. In many cases, the US Census Data is used.

6.3. Evidence Based and Promising Practice

The PHHS Block Grant captures information about the public health science that is the basis of interventions carried out by Block Grant dollars. This section requires grantee to select from a list of established evidence based and promising practices or add their own if none apply, the Grantee would select "Other" to indicate what evidence based or promising practice on which the state based their program (e.g. Statewide Assessment of Emergency Medical Care, Interventions to Prevent Sexual Violence, National Healthcare Safety Network, etc.). CDC strongly encourages states to only use the most current evidence based or promising practice when using Block Grant funds to meet their state health objectives.

6.4. Block Grant Role Under the National Health Objective

The Block Grant's role under the National Health Objective helps define how funds are being utilized, particularly to indicate if the funds are for state rapid response activities such as listeria outbreaks, for startup of new activities, supplementing other existing state funds, or no other funds exist from the federal or state government to support the National Health Objective.

6.5. Block Grant Funds for the National Health Objective

Under this section, the grantee is required to allocate funds to the National Health Objective under each Program for annual basic funds, sex offense, and other budget line items provided in this section.

6.6. Annual Impact Objective(s)

Each federal fiscal year grantees will submit a work plan application for funding. The Annual Impact Objectives and Annual Activities timeframe must be within the two-year project period for the federal fiscal

year the grantee is applying for funding. (i.e. FY18 Work Plan Impact Objectives and Activities project period 10/1/2017-9/30/2019). Grantees could enter objective and activity dates based on when you plan to start working on an objective and/or activity (estimated start date) and dates you plan to complete the objective and/or activity (estimated end date). Dates for objectives and activities must be within the project period (two years) and cannot exceed 12 months.

Annual Impact Objectives identify what the grantee expects to happen as a result of the activities that are carried out. They are completed within a one-year timeframe and are considered strategic for planning purposes. The Annual Impact Objective should be concise and is guided by the SMART principles (see SMART Objective Principles above in section 6. Program National Objectives). Annual Impact Objectives must identify the purpose and/or the expected outcome. Grantee should include at least one annual Impact Objective, but no more than five per HO. For example:

- FFP Site Maintenance, Between 10/2018 and 09/2019, Fit and Fall Proof coordinators will maintain 100 Fit and Fall Proof exercise class sites in Idaho to ensure the program is accessible to community-dwelling older adults).
- Fund 5 School Districts, Between 10/2018 and 09/2019, KDHE will provide funds to 5 school districts serving a disproportionate number of high need students to revise local wellness policies that have been adopted by the state school board to address physical education, physical activity, nutrition, nutrition education and nutrition promotion.
- Foodborne Disease Infections, Between 10/2018 and 09/2019, reduce the number of foodborne disease outbreaks that are attributable to infected person by 10% from the 2005-2009 baseline of 37.

6.6.1. Annual Activities

Activities are short term and are carried out in order to obtain the desired annual Impact Objective. They must be very detailed and specific on how they will accomplish the annual Impact Objective; should include information on the what, when, who, and how implemented activities will meet the objectives.

Each Activity must have an Activity title reflective of what will take place. Activities are considered tactical and must include a beginning and an end date. Annual activities cannot exceed 12 months. They do not need to include a baseline or a data source. For example:

- Maintain/Recruit Class Sites, Between 10/2018 and 01/2019 Fit and Fall Proof coordinators will maintain the number of class sites listed in their respective contracts with the Department. A minimum number of six sites and a maximum of 25 sites will be maintained by each local public health district. New site shall be recruited in the event of a site ending classes as an effort to maintain the contracted number of sites. Class sites must offer low-cost or no charge FFP classes, held for a minimum of 45 to 60 minutes, two to three times per week for at least ten (10) consecutive weeks. At least three class sessions will be offered throughout the year at each established site. Pairs of volunteer class leaders will be recruited for each site.
- Promote Increased Physical Activity Before, During and After School, Between 10/2018 and 06/2019 KDHE will coordinate training for school staff on the comprehensive school physical activity program to further support implementation of model school wellness policies in the area of physical activity).
- Conduct Outbreak Investigations, Between 12/2018 and 09/2019, Central Office and field staff will ensure that all foodborne illness outbreaks are investigated. The Central Office staff will analyze data received and make information available on the health department website.

For the **Sex Offense Program**, annual Impact Objectives and annual Activities should be written so the reader clearly understands that the sex offense dollars are being expended as per legislation Section 300w-3 under "Use of allotments" which states funds are to be used in "Providing services to victims of sex offenses and for prevention of sex offenses" only.

PAGE LIMITS

CDC recommends the following page limits for the entire work plan:

1) For grantees with a PHHS Block Grant budget up to $1 Million the page limit is **up to 50 pages;**
2) For grantees with a PHHS Block Grant budget between $1 Million and $3.99 Million the page limit is **up to 85 pages**;
3) And for grantees with a PHHS Block Grant budget higher than $4 Million the page limit is **up to 125 pages**.