AMERICAN PLANNING ASSOCIATION
IN PARTNERSHIP WITH
AMERICAN PUBLIC HEALTH ASSOCIATION

ANNOUNCE

REQUEST FOR PROPOSALS
REQUEST FOR PROPOSALS

The American Planning Association (APA) is an emerging leader in the field of healthy communities in partnership with the public health profession. As such, APA has received an award from the Centers of Disease Control and Prevention (CDC) as part of the National Dissemination and Implementation program within the Division of Community Health, Funding Opportunity Announcement #DP14-1418. These funds have allowed APA to bring support to local coalitions in efforts to reduce chronic disease in communities across the United States, and represent the first time APA has been able offer monetary resources to promote public health.

The purpose of this funding opportunity is to improve the capacity of planning and public health professionals to advance community-based strategies providing for equitable access to healthcare and nutritious foods, opportunities for physical activity, and less exposure to and consumption of tobacco. Through an overarching collaborative strategy that brings together members of APA and the American Public Health Association (APHA) working in communities, this project will address population health goals by promoting the inclusion of health in non-traditional sectors—specifically, urban and regional planning, but also transportation, recreation, real estate development, and others. Funds for this project will be competitively awarded to build local capacity in grantee communities across the U.S. and empower actors to continue such work beyond the funding cycle.

Each applicant’s proposal must address one or more of the following determinants of chronic disease:

- **Inactivity**: Increase opportunities for physical activity
- **Unhealthy diet**: Improve access to nutritious food
- **Tobacco**: Decrease exposure to and use of tobacco and nicotine products
- **Lack of access to preventive care**: Increase access to health care

In addition, **health equity** and improving opportunities for living a healthy life are central to the goals of this project. As the proposal takes shape, keep health equity in mind. Finally, health needs assessment and the use of built environment and health data will be key.

**Coalitions**

This funding opportunity will support existing and emerging coalitions anchored by members of APA chapters and APHA affiliates. For a definition of what makes up a coalition, please see the Eligibility Section of this RFP. Coalitions will be responsible for improving the capacity of planning and public health leaders to work with community members to advance health-promoting built environments. While APA and APHA members will serve as the core leaders of these coalitions, we strongly encourage participation from other sectors, such as:
- Parks and recreation: parks agencies, “friends of parks” groups, YMCA, etc.
- Transportation: transportation agencies, bicycle/pedestrian advocacy groups, etc.
- Social services: municipal agencies, social justice organizations, food banks, etc.
- Community development: city management, economic/community development corporations, community development financing institutions, socially responsible developers, neighborhood associations, faith-based organizations, etc.
- Schools: public and private schools, pre-school and head start, etc.
- Urban design: architecture, landscape architecture, etc.
- Real estate: residential and commercial developers, development organizations, etc.

By the end of the project period, APA chapters, APHA affiliates, and their coalition partners will have increased broad understanding among community leaders and residents in their communities about the importance of updating policies and systems to improve the environments in which people live, work, and play. Such improvements provide greater opportunity to make more healthful choices regarding food, physical activity, tobacco use, and/or preventive care. Evidence of such understanding will be measured through the establishment and growth of local level coalitions among public health, planning, other built environment fields, and community groups. In the slightly longer term, examples of intermediate outcomes will show the results of such coalition work, including updates to policies and procedures that impact environments.

Coalition Strategies

Coalition strategies must address at least one of the four key determinants of chronic disease through evidence-based policy, systems, and environment (PSE) changes. **PSE improvements are intended to have population level impact through interventions that address the determinants of chronic disease holistically.** In comparison, for example, educational programs or other kinds of individualized interventions do not have lasting population impacts. Chronic disease determinants include inactivity, unhealthy diet, tobacco use, and lack of access to preventive care. An applied example of PSE implementation for food and nutrition, including planning-related strategies, can be found in this recent CDC study: *An Approach to Assessing Multicity Implementation of Healthful Food Access Policy, Systems, and Environmental Changes*

[http://www.cdc.gov/pcd/issues/2014/13_0233.htm](http://www.cdc.gov/pcd/issues/2014/13_0233.htm)

Project “strategies” can be distinguished from project “activities” per the following:

- **Strategies** represent an overall approach to addressing an area of disease determinant, including the identified outcome. Examples are a change in institutional procurement to increase healthy food options; or the adoption/implementation of a joint use policy.

- **Activities** represent the steps and actions to achieve a strategy. Examples are educating institutional procurement officers on importance of healthier food options; or
stakeholder meetings among coalition staff and school officials regarding specific steps necessary to remove barriers to joint use.

For additional information on PSE strategies, see “Project Strategies” in Appendix A.

Project Outcomes

Proposals will be assessed on their strategies and capacity to achieve the following (immediate or short-term) outcomes during the funding period:

Short-term Outcomes

- Stronger partnerships among APA state chapters and APHA state affiliate groups
- Increased knowledge of APA & APHA members and the sub-recipient coalitions on how to achieve public health goals through interventions in built and social environments
- Increased community capacity among sub-recipients to implement PSE improvements, including creation/improvement of cross-sectoral coalitions, efforts to collect community data, and development of community action plans (CAP)
- Increased stakeholder awareness of the health impacts of planning decisions, how planning decisions are made, and where to incorporate health issues into the process
- Increased messaging by APA, APHA, and sub-recipients on the importance of policy, systems, and environmental improvements specific to their initiatives
- Increased coalition building among local members of both APA & APHA
- Engagement of allied professionals (e.g., landscape architects, city managers) in partnerships to improve health
- Development of action plans to shape a built environment that better promotes physical activity, healthy eating, tobacco prevention/cessation, and access to preventive care

These outcomes are intended to lead to the following intermediate and longer term outcomes in the months and years following the funding period:

Intermediate Outcomes

- Increased access to physical activity opportunities
- Increased access to environments with healthy food or beverage options
- Increased access to smoke-free or tobacco-free environments
- Increased opportunities for chronic disease prevention, risk reduction, or management through clinical and community linkages
- Positive changes in attitudes, beliefs, knowledge, awareness, and behavioral intentions for strategies to improve built and social environments that promote healthy behaviors

Long-term Outcomes

- Institutionalize health in the planning field and broaden the definition of “healthy communities”
- Fully integrate the work of planners and public health professionals
- Reduce rates of smoking and exposure to secondhand smoke
- Increase daily consumption of fruit, vegetables, and healthy beverages such as water
- Increase physical activity
- Increase access to and use of preventive care services
- Reduce chronic disease burden among Americans of all ages, backgrounds, and locations

**Geographic Scale**

Applicants must define the geographic area or areas that will be served by the coalition and include a rationale for choosing those areas. Applicants must describe the chronic disease burden and related risk factors within the targeted area(s) and the total number of people that will be reached by proposed strategies, with the requirement to **reach at least 50% of the population within the targeted area(s)**.

*Reach* is defined as the number of people receiving messaging and/or being impacted by PSE improvements. While some of the population will be directly impacted by new policy, systems, or environmental improvements, other may receive broad level messages aimed at the general public. Together, these efforts must be designed to reach at least 50% of the population in the targeted area.

With the requirement to reach at least 50% of the population within the targeted area(s), health needs assessments and the use of data will be key for identifying and illustrating the geographic area(s) most in need of the interventions related to the chronic disease factor(s) selected. PSE strategies should be appropriate for both the chronic disease factor(s) selected and the needs identified in targeted geographic area(s), based upon existing evidence such as health/poverty data.

If the coalition does not have access to data on chronic disease or related social determinants of health (e.g. poverty, education attainment, etc.), APA recommends partnering with an organization that does – such as a state or local health department – or using a tool such as the Community Commons, CDC’s Behavioral Risk Factor Surveillance System (BRFSS), US Census, American Community Survey, etc. Please see APA website www.planning.org/nationalcenters/health/psecoalitions for additional resources.

**Award Information**

- **Project Timeline**
  
  a. Awards are expected to average between $100,000 and $150,000 depending on the number awarded
  b. Project period: 15 months
  c. Interested applicants **must** submit a Letter of Intent (LOI) if they wish to apply. Proposals sent by applicants who did not submit a LOI will not be considered.
The LOI is due on Tuesday, December 2 at 5pm EST. The LOI must include the following:

i. Organizational name of lead applicant or coalition name.
ii. Identification of which APA Chapter and APHA Affiliate will be involved.
iii. Point of contact – name, organization, phone number and email address.
iv. Approximate budget request. Applicants will not be held to this amount, but this information will assist APA in assessing available funds.
v. The LOI should be sent as an email attachment in MS Word or PDF format to Health@planning.org

d. Complete proposals, including all accompanying documents, are due on Monday, December 22, 2014 at 11:59 PM EST and should be sent to Health@planning.org

i. Documents should be submitted as attachments MS Word or PDF format.
ii. Each document should be named according to its contents and include the name of the lead applicant. For example: “Project Narrative_QRstatechapter” or “Budget_STstatechapter”.

• APA will accept questions via email only.
  a. Interested Applicants can submit questions to Health@planning.org
  b. APA will post answers to Frequently Asked Questions at www.planning.org/nationalcenters/health/psecoalitions
  c. APA will only respond to questions sent to Health@planning.org
  d. Deadline for submitting questions: Sunday, December 7 at 11:59 PM EST

• Please join APA and APHA for an informational call on Tuesday, November 25 at 3-4PM EST.
  a. https://planning.adobeconnect.com/healthrfp1/event/event_info.html
  b. There will be limited time for questions during the call. Interested applicants are strongly encouraged to submit questions via email prior to the call: Health@planning.org

Applicant Eligibility
Coalitions are required to have members from both an APA Chapter and an APHA Affiliate located in the same geography (e.g., same state/region). Additional coalition members should represent different sectors and stakeholder groups, and include experts and/or practitioners in the subject area on which the coalition will focus PSE strategies. Coalitions will work in local communities of their choosing, based on criteria and merits listed below. Coalitions of Chapters, Affiliates, and others must propose focused, innovative work to address one or more of the four identified risk factors based upon the need within their local communities: (1) inactivity (2) unhealthy diet, (3) tobacco, and (4) lack of access to preventive care. The national organizations of APA and APHA and others will partner together to offer technical assistance and resources to assist Chapters/Affiliates in meeting the proposed objectives.
a. A cross-sectoral coalition – defined as a collective initiative that fosters collaboration and coordination across multiple sectors and stakeholders (e.g., parks and recreation, transportation, social services, community development, schools, urban design, real estate, healthcare).

b. Local Chapter of APA -- APA Chapters will manage the application process. APA chapters must work together with APHA affiliates to develop proposal content, including: selection of topic areas, selection of appropriate strategies/interventions, identifying short term outcomes, identifying roles and responsibilities, and drafting an outline for the community action plan. The APA chapter will serve as the application manager and accept and administer funds, it may be the case that the APHA affiliate will lead coalition activities and manage the community action plan for the project.

c. The targeted community is not currently receiving funding from CDC’s Division of Community Health (DCH), in particular the Partnerships to Improve Community Health (PICH – funding #DP14-1417) or Racial and Ethnic Approaches to Community Health (REACH – funding #DP14-1419PPHF14) programs. http://www.cdc.gov/chronicdisease/about/2014-foa-awards.htm

d. Administrative requirements of lead applicant
i. Complete a proposal that meets all of the application submission criteria.
ii. Possess 501(c)(3) tax status.
iii. Include Letters of Support from each organization involved as key partners in the coalition. Upon award, grantees will be required to develop a Memorandum of Understanding (MOU) among the organizations involved in the coalition.
iv. Agree to participate in and cooperate with the on-going grant evaluation
v. Adherence to federal guidelines in all fiscal matters.
vi. Ability to attend all required calls, trainings and meetings.
vii. Be willing to share lessons learned with CDC, national partners, and other local community organizations.

Application Review and Selection Process

Applications will be reviewed through a committee made up of APA, APHA, and outside reviewers. The committee will use an objective process for scoring proposals. Each application will be ranked according to numerical scores.

Final selection of awardees will be vetted by CDC, which will ensure equitable distribution and non-duplication of resources across geographies, including a consideration of current DCH funding.

Proposals will be evaluated using the following selection criteria:

1. Coalition capacity – 30 points
**Collaboration, partnerships, and responsiveness to application:** Applicant has expressed support for APA’s program, its goals, and program activities and has proposed actions in keeping with proposal requirements outlined in this RFP. Applicant has identified strategic priorities and a list of organizations or people that will support the program, including representation from an APA Chapter and an APHA affiliate.

**Capacity/readiness:** Applicant has included letters of support from key partners that demonstrate broader community commitments to program goals and activities.

2. **Demonstrated Need and Impact – 20 points**
   - **Demonstrated need:** Applicant has clearly identified health needs and program priorities of the targeted community OR presents a plan for doing so, with a focus on socioeconomic and racial diversity to address health disparities.
   - **Community impact:** Proposed strategies match the demonstrated need and are policy, systems, and environment based; they will impact at least 50% of the focus population.

3. **Proposed activities – 40 points**
   - **Strength of proposed activities and work plan:** Applicant has proposed program activities that appear to be effective and realistic, and demonstrates commitment to develop a plan for maintaining coalition work beyond the funding period.

4. **Budget – 10 points**
   - **Realistic and appropriate budget:** Applicant has proposed activities that are a match with proposed budget and budget justification.

**Submission Instructions**

Complete proposals, including all accompanying documents, are due on **Monday, December 22, 2014 at 11:59PM EST** and should be emailed to **Health@planning.org**. Only electronic submissions in MS Word or PDF format will be accepted.

Each proposal will include the following sections:

1. **Applicant Contact Information**
   1.1 Organizational Name of Lead Applicant or Coalition Name
   1.2 Coalition Members
   1.3 Contact Person
   1.4 Mailing Address
   1.5 Phone Numbers (e.g., office and mobile)
   1.6 Fax Number
1.7 Email Address

2. **Narrative** (maximum 12 pages single spaced, in Calibri 12 point font)

2.1 **Coalition capacity** – 30 points

- **Description of Coalition**: describe the proposed cross-sectoral coalition, including any history of its members working individually and/or collectively on planning and public health initiatives. Address plans for maintaining the coalition through the project period. The coalition must name a three person leadership team, including at least one representative from both an APA Chapter and an APHA Affiliate.

- **Statement of Purpose**: identify one or more of the determinants of chronic disease to be addressed. Describe the chronic disease burden within the geographic area of focus and the populations to be reached.

2.2 **Demonstrated Need and Impact** – 20 points

- **Geographic Area of Focus**: define the geographic area or areas that will be served by the coalition and include a rationale for choosing those areas.

2.3 **Proposed activities** – 40 points

- **Strategies and activities**: identify PSE strategies to address selected determinant(s) of chronic disease and outline specific activities that will be undertaken to achieve strategy outcomes. Proposed activities must address at least one of the following: 1) inactivity, 2) unhealthy diet, 3) tobacco, 4) lack of access to preventative care.

- **Project Management**: describe how the coalition plans to complete the activities at the funding level requested. Describe and outline the coalition’s capacity and timeline to successfully achieve the selected strategies and the coalition’s approach to project management, including proposed staffing. Include draft outline only of the coalition’s Community Action Plan (CAP). Successful applicants will need to prepare a final CAP within the first 60 days of the project period (see Additional information on CAP components below).

3. **Accompanying documents** – do not count within 12 page limit

1.1 **Budget narrative** – 10 points – see Budget outline in Appendix B for instructions

1.2 **Evidence of non-profit status**

1.3 **Relevant qualifications on key coalition personnel and organizations** (e.g., resumes or CVs, organization mission statements)
Additional Information
As stated above, funds will be awarded through a competitive grant process. Awardees will be required to work with APA and APHA to refine project scope and Community Action Plan, and both APA and APHA will be involved in monitoring, evaluating, and supporting awardees’ activities.

Community Action Plan
Based upon the choice of one or more chronic disease factors and appropriate PSE approaches, each coalition will be required to prepare a Community Action Plan (CAP) within 60 days of award. The CAP will identify implementation activities, timelines, and steps for achieving proposed project goals.
The draft CAP should outline and acknowledge activities based upon the categories below:
- Staffing
- Administrative Setup
- Strategic Planning and Program Development
- Training and Technical Assistance
- Outreach & Communications
- Travel

Upon award, APA and APHA will work with grantees to detail and finalize their CAP within the first 60 days of the project period.

Support for Grantees
APA, APHA and other collaborating national organizations will support grantees through technical assistance and training. Grantees will be required to receive training in coalition building and maintenance, relevant to their developmental stage as a coalition, as well as technical assistance on preparing and building capacity to educate policy makers, officials, community leaders/members, and others on PSE strategies and the determinants of chronic disease.

Grantees will be required to attend two in-person meetings. The first trip will require at least two (2) representatives from the coalition to travel to a kick-off meeting. Each participant must represent a different sector, at least one of whom must represent planning OR public health (an APA or APHA representative). The kickoff trip should be included in the proposed budget. A second required trip will take place at the conclusion of the entire project. This trip will likely take place in 2017, and costs for the wrap-up trip will be covered by APA.

APA advises that additional funds be budgeted for potential travel to trainings, regional conferences, etc.

Communications/Media
Awardees will be required to develop and maintain communications via media channels, including the broadcast of public service announcements developed by CDC.
Planning in the United States originated with a public health purpose. Rapid urbanization resulted in overcrowded and poorly constructed housing, noxious industrial and manufacturing uses, and increased levels of human and animal waste. The planning and public health professions were joined by a shared focus on urban reform and a common goal to prevent outbreaks of infectious disease. To address issues that resulted from rapid urbanization, federal, state, and local governments created a series of policies related to zoning, housing, and transportation. Today, we know that these policies have had lasting impacts on the ways we develop the built environment often resulting in unanticipated, detrimental health effects.

Furthermore, we know that health outcomes are shaped by more than individual behaviors and clinical care. In fact, the major contributing risk factors to disease are influenced by factors outside of the healthcare system, such as education, income, and the infrastructure and environments that exist within workplaces, schools, neighborhoods and communities (RADM Lushniak 2014). Yet, throughout the course of the 20th century and into the 21st, public health professionals have largely acted alone to promote health and prevent disease and injury. As planning diverged from its common roots with public health, the profession’s attention focused on managing land use, physical development, and supporting infrastructure. In contrast, public health professionals took the lead on addressing individual health and safety concerns. These diverging missions have led to a siloed approach to influence the social and environmental determinants that significantly impact individual and population health. Addressing the nation’s most challenging population health issues (e.g. chronic diseases, obesity, and widening health inequities) requires collaborations with multiple groups to integrate all components of the public health system and the built environment (HHS 2011).

The National Prevention Strategy, which serves as a comprehensive plan for health, calls for a collaborative, multi-sector approach across diverse settings. Its first Strategic Direction, to promote Healthy and Safe Community Environments, encompasses goals for the planning and built environment fields: to create, sustain, and grow communities that promote health and wellness through prevention.

The World Health Organization defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” To achieve the vision of a society in which all people live long and healthy lives, we must work collaboratively to create social and physical environments that promote health for all; reduce chronic disease risk through population-based strategies that reduce the burden of obesity; improve access to health care services; and reduce preventable illness, disability and death related to tobacco use and exposure. In this modern world of complex, interconnected and inter-dependent challenges, the fields of planning, public health, and allied professions are faced with the need to look for new ways to incorporate health-oriented goals into the planning process and promote potential for greater community equity.
Chronic diseases account for more than two-thirds of deaths in the United States and prior to death, have a significant negative impact on quality of life and productivity for sufferers. Furthermore, people of color, lower socioeconomic status, and those with other social disadvantages have a disproportionately higher rate of chronic diseases, adding yet another challenge to their lives (CDC 2013). By increasing opportunities for people to engage in healthy behaviors—getting physical activity, eating healthy foods, avoiding tobacco, and seeking regular medical care—chronic diseases and their impacts can be diminished. True systems transformation will be required to address public health challenges with greater efficiency, more balanced investment in health, and the use of population-level interventions (Lushniak, 2014).

Public health has been identified as a core element of vibrant places leading communities to integrate health into their planning processes and implementation actions. Decisions that leaders make regarding land use, urban design, and transportation impact local air quality, water quality and supply, traffic safety, physical activity, and other unhealthy exposures. These decisions are linked to some of the most intractable public health problems, including adult and childhood obesity, cancer, respiratory problems, and environmental justice. By addressing the determinants of chronic disease (inactivity, unhealthy eating, tobacco use, and limited access to preventive care) more holistically through built environment and policy, systems, and environment solutions, it is possible to reduce illness and promote quality of life for the long term.

Project Strategies

Coalition work must address at least one of the four key determinants of chronic disease through evidence-based PSE changes.

Project “strategies” can be distinguished from project “activities” per the following:

- **Strategies** represent an overall approach to addressing an area of disease determinant, including the identified outcome. Examples are a change in institutional procurement to increase healthy food options; or the adoption/implementation of a joint use policy.
- **Activities** represent the steps and actions to achieve a strategy. Examples are educating institutional procurement officers on importance of healthier food options; or stakeholder meetings among coalition staff and school officials regarding specific steps necessary to remove barriers to joint use.
- Activities may be focused (such as the examples above) or broad, such as communication activities to broadcast public service announcements or developing a long term plan for sustaining PSE improvements beyond the project period.

More examples of PSE strategies, including cross-cutting strategies that support health equity, are listed below. **This is not an exhaustive list, nor is it intended to prescribe coalition actions.**
The list is provided as guidance and with suggestions to help define and provide examples of PSE interventions. See additional resources in next section.

**Active Living**  Equitable access to resources and opportunities for physical activity are critical to ensuring that all citizens can live an active life. The uneven distribution of such resources reinforces health inequities, whereas safe streets, parks and recreation facilities, and multi-modal infrastructure promote equity. The following strategies are aimed at promoting equitable access to physical activity:

- Utilize Joint Use Agreements to combine existing resources and increase access to existing facilities, establish or enhance community partnerships, and reduce barriers to physical activity. These agreements may necessitate Crime Prevention Through Environmental Design (CPTED) strategies to address safety concerns, as well as education initiatives and outreach to promote use of improved facilities
- Adapt or create amenities on streets, trails, and pathways to promote safety and security for pedestrians and bicyclists
  - Engage residents to gain understanding of community needs and ensure inclusive decision-making and design that accommodates all users
  - Prioritize investments in planning, staffing, and capital projects
  - Leverage partnerships with businesses and surrounding landowners
- Develop partnerships that promote use of safe streets, trails, and pathways to increase walking and biking as means of both transportation and recreation; engage physicians for referrals such as “Rx for Walking”, as well as social groups to help promote active living
- Use health or health equity impact assessments to consider the effects of gentrification caused by infrastructure improvements, transit-oriented developments, and mixed-use zoning policies

**Food and Nutrition**  Low-income communities and rural areas are more likely to be food insecure, meaning that populations have limited or inconsistent access to sufficient food, in particular enough healthy, nutritious food. Strategies to improve access can address the community food retail environment, healthy restaurants, and land use planning and policies. The following are strategies to effectively implement these strategies:

- Community Awareness and Involvement: Conduct community food assessments that incorporate citizen input; promote engagement in the planning and policy process
- Affordability: Increase and promote food assistance programs and incentives for purchasing healthy foods including access to and opportunities to utilize SNAP benefits
- Economic Development: Implement policies designed to support businesses that promote local economic development through healthy retail
- Transportation: Promote connectivity between transportation modes that considers access to food for all segments of the population
- Safety: Gain an understanding of violence (actual vs. perceived), which can be a barrier to healthy food retail and access to that retail
• Lack of Exposure: Create or expand programs, such as Farm to Institution, that increase exposure to healthy food, particularly in schools (CDC, 2013)

**Tobacco Reduction Approaches** Collaborative strategies are required for reducing tobacco use, especially amongst those with a higher likelihood of exposure to tobacco advertising and secondhand smoke. Together, planning and public health officials and their partners can promote and implement PSE approaches to improve the built and social environments to reduce tobacco use and exposure. Examples of those approaches include:

• Enact smoke-free policies for multi-unit housing, parks and recreation facilities, and public buildings
• Limit advertising placement for tobacco and other nicotine products such as billboards and other signage, particularly near schools
• Utilize point of sale strategies to reduce access to tobacco and other nicotine products
• Leverage stakeholder support to address smoking and other tobacco related behaviors: address concerns and build support amongst housing providers, property managers, and developers; among business owners and operators; educators and parents
• Develop tools and capacity to gather feedback, incorporate resident input, and guide the implementation and monitoring process (CDC, 2013)

**Access to Preventive Care** It is essential that community residents have access to preventive care, which is a critical intervention to help prevent and arrest the development of chronic disease conditions. PSE strategies that improve access to care include:

• Conduct regular community assessments to understand who needs greater access to care and how to target inventions effectively
• Improve connectivity between transportation modes, especially public transit, that considers access to health clinics for all segments of the population, especially the disabled, the elderly, and those from low-income areas
• Institute policies and procedures allowing clinics to be co-located with public housing, low income housing, or in other high need areas

**Other Strategies**

In addition to addressing at least one of the four strategic areas above, health equity and improving opportunities and choices overall as they relate to health are central to the goals of this project. Applicants should keep health equity in mind for each PSE strategy employed, and address health equity directly in proposals. Examples of health equity approaches include, but are not limited to, the following:

**Health Equity Approaches** “Health equity means that every person has an opportunity to achieve optimal health regardless of: the color of their skin, level of education, gender identity,
sexual orientation, the job they have, the neighborhood they live in, and whether or not they have a disability” (CDC Health Equity Guide, p2)

Achieving health equity starts with building a solid foundation. A multitude of strategies aimed at supporting cohesive coalitions and increasing organizational capacity have been identified:

- Write health equity into organizations’ strategic plans (CDC, 2013)
- Hire staff or create interdepartmental/inter-organizational work groups with a focus on diversity, non-traditional partners, and professional development
- Develop multi-sector issues-based collaborations, non-traditional partnerships for health, and incorporate health-related criteria into all decisions (Lushniak, 2014)
  - Involve officials from planning and public health departments and allied organizations
  - Involve professionals and community experts from: architecture, city managers, landscape architects, real estate/development, parks and recreation, land trusts, sustainability and environmental groups, schools and education, and transportation
  - Build dynamic partnerships built on trust, and develop a common language to improve health equity in communities
- Use the best available data in identifying existing conditions and conducting needs assessments. Recommended tools include: CDC Community Guide, Community Commons, GIS mapping, Health Impact Assessments, Health Equity Impact Assessment, the Bay Area Regional Healthy Inequities Initiative Organizational Self-Assessment Toolkit, as well as other tools to assess the built environment including Walk Audits, Windshield Surveys, Charettes, the Healthy Development Measurement Tool, and the Healthy Economic Assessment Tool. Such tools:
  - Are critical to understanding and targeting specific community health issues
  - Enable identification of populations and geographic areas with health, economic, and other social inequalities
  - Assist with determining current accessibility and barriers to services
  - Evaluate existing plans and conditions, identify areas for improvement, and help structure new plans around health goals and policies
  - Assist with prioritizing implementation goals for faster impact
- Develop a strategic communications plan that leverages opportunities to efficiently promote efforts, increase engagement, and improve dialogue amongst stakeholders
- Include robust evaluation: Evaluation tools are necessary for reinforcing the commitment to health equity
  - Develop and apply logic models that include processes and outcomes to guide implementation of comprehensive plans, strategic plans, and community health improvement plans (CDC, 2013)
  - Incorporate plan implementation metrics into staff and program performance evaluations to effectively implement and evaluate strategies

Resources
Together, APA, APHA and CDC recommend that applicants look to tools such as the Community Commons, CDC Community Guide, and CDC Health Equity Guide to find further examples of PSE improvements that will work in your states and local communities. These resources can accessed via the following links:

- [www.communitycommons.org](http://www.communitycommons.org)
- [http://thecommunityguide.org/](http://thecommunityguide.org/)

Other resources include:

2. APA: [www.planning.org](http://www.planning.org)
3. APHA: [www.apha.org](http://www.apha.org)

Additional resources can be found on [www.planning.org/nationalcenters/health/psecoalitions](http://www.planning.org/nationalcenters/health/psecoalitions)
Budget Justification Outline – Appendix B

Please submit a budget justification describing costs for the main categories for expenditure listed below. Additional cost categories may be added per specific coalition structure. Justification statements should be brief.

**Staffing**: This section should identify who will be doing the work of the coalition, what percentage of their time will be dedicated to the project, and total costs for staffing.

**Fringe**: List fringe benefit amount.

**Administrative Setup**: Describe any setup in addition to staffing that needs to take place, e.g. establishing workspace, electronic and telecommunications, scheduling and holding regular coalition meetings, hiring contractors/consultants for specific services outside of general staffing, and total costs for such actions.

**Strategic Planning and Program Development**: Identify and describe costs, if any, that will be associated with strategic planning and development, outside of other cost categories, e.g. consulting costs.

**Training and Technical Assistance (TA)**: Identify and describe technical assistance costs that the coalition plans undertake. Awardees will be required, at minimum, to receive training in coalition building and maintenance, relevant to their developmental stage as a coalition. Awardees may also include costs for doing trainings themselves, e.g. workshops.

**Outreach and Communications**: Identify and describe costs for broadcasting messages and other types of communications, including media format, and platforms (electronic, classroom) will be used to reach different groups.

**Travel**: Some travel will be required for the project. The first trip will require 2 representatives from the coalition to travel to a kick-off meeting. Each participant must represent a different sector, at least one of whom must represent planning OR public health (an APA or APHA member). The 3-day, 2-night kickoff trip should be included in the proposed budget. A second required trip will take place at the conclusion of the entire project. This trip will likely take place in 2017. Costs for the Wrap-up trip will be covered by APA and do not need to be included in the budget. Depending on coalition activities, additional travel may be advised to participate in regional meetings, conferences, or other educational/training events.