

Michigan Department of Community Health

REQUEST FOR PROPOSALS (RFP)

FOR

**Implementing Public Health Prevention Strategies for Obesity,
Diabetes, and Heart Disease and Stroke through Chronic
Disease Coordinating Networks**

Issued: November 5, 2014

**Application Deadline:
January 6, 2015
3:00 pm**

Division of Chronic Disease and Injury Control
Michigan Department of Community Health
P.O. Box 30195
Lansing, MI 48909

Michigan Department of Community Health Part One: Overview Information

RFP Title: [Implementing Public Health Prevention Strategies for Obesity, Diabetes, Heart Disease and Stroke Through Chronic Disease Coordinating Networks](#)

Issue Date: November 5, 2014

Issuing Organization: Michigan Department of Community Health (MDCH) is the sole point of contact regarding all matters relating to this RFP selection process.

Technical assistance for the RFP: Interested parties may email questions regarding the RFP and its requirements to Annemarie Hodges, hodgesa5@michigan.gov.

Responses to all questions and will be posted at http://www.michigan.gov/mdch/0,1607,7-132-2946_43858---,00.html. All questions must be submitted in writing and received before December 12, 2014 at 12 noon to ensure a response.

Eligibility

Eligible entities include local public health departments, health systems, and community-based organizations. Organizations serving rural communities are encouraged to apply jointly with additional organizations serving other rural communities to maximize reach and impact.

Selection criteria will be based on the capacity of the defined community to:

- 1) Demonstrate high chronic disease burden among obesity, diabetes, hypertension, heart disease, and stroke and/or high prevalence of risk factors for chronic disease (i.e., low physical activity, limited access to fruits and vegetables), and Healthy MI Plan enrollment/prevalence of low income populations (see background for information on indicators).
- 2) Build partnerships and implement programs to address health inequities and reach priority-targeted populations sufficiently to impact outcomes.
- 3) Address all of the 15 strategies under Components 1 and 2 (see pg. 8-9).

Consideration will be given to provide geographical balance.

Grant Award Information

Number of Awards: 4-5

One Year Award Amount: Approximately \$440,000 (award range, \$350,000 - \$470,000)

Number of Years of Award: 4 years (Year 1=7 months)

Project and Budget Period: Year one anticipated start is March 1, 2015 and will continue through September 30, 2015 (7 months). Subsequent grant years will be October 1 through September 30 (12 months).

Announcement of Awards: Awards will be announced no later than January 16, 2015.

Grant award decisions will be final, made at the sole discretion of MDCH and not subject to protest or appeal. The award process is not completed until the grantee receives a properly executed agreement through MI E_Grants.

Funding Availability: Funding is from The Centers for Disease Control and Prevention (CDC). The ability to fund these proposals and the total number of grant agreements awarded will be based upon both the level of funding provided by the CDC and the quality of the applications received. Submission of a proposal does not guarantee funding. Throughout the project period, MDCH will continue the award based on the availability of funds and evidence of satisfactory progress by the awardee (as documented in required reports).

Funding Restrictions Funding may **not** be used for the following items:

- Research - If research is proposed the application will not be reviewed. For definition of research, please see the CDC web site: <http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf>.
- Clinical care, screening services, laboratory services, patient treatment/care or building projects
- Furniture or equipment exceeding \$500 without a detailed explanation in the application budget
- Pre-award costs
- To supplant state, local or organizational funding
- Lobbying, either to influence legislation or intervene in any political campaign
- Fund-raising activity for grantee agency
- Projects that include only health fairs or assemblies as their primary way of implementing strategies will **not** be considered. All strategies must be based on evidenced-based intervention(s).

Submittal Information

Letter of Intent Deadline: An email indicating your organization's intent to apply is due by November 19, 2014 to: Annemarie Hodges, hodgesa5@michigan.gov. A confirmation email will be sent upon receipt.

Application Deadline: **Submit completed application by January 6, 2015 at 3:00 pm** by email to Annemarie Hodges, hodgesa5@michigan.gov

Format: Page and margin sizes: 8.5" x 11" with 1-inch margins, single-spaced
Font size: 12-point un-reduced Calibri

Special Instructions

1. An electronic copy of the proposal is due via email by 3:00 pm on Tuesday, January 6, 2015. Proposals received after this date and time will not be scored or considered for funding.
2. Read the entire document. Notice important items such as application requirements, grantee requirements, proposal submittal date, and funding amount. Check the frequently

asked questions (FAQ) and responses on the website: http://www.michigan.gov/mdch/0,1607,7-132-2946_43858---,00.html

3. Follow the format required in the RFP when preparing a response. Respond to all sections in a clear and concise manner. Provide complete answers/descriptions. Do not assume MDCH or the review committee will know about your organization's capabilities. Do not leave any sections of the application blank. **Applications with missing sections will not be scored or considered for funding.**
4. Use the work plan template in Attachment D and budget forms provided in Attachments E and F.
5. Note all the dates and times in this document. Submit all required items by the deadline.

INTRODUCTION

The Michigan Department of Community Health (MDCH) Diabetes, Obesity, Heart Disease and Stroke Prevention programs announce the availability of funds for *Implementing Public Health Prevention Strategies for Obesity, Diabetes, Heart Disease and Stroke Through Chronic Disease Coordinating Networks*. This RFP is funded through a grant from the Centers for Disease Control and Prevention (CDC) and financed by Prevention and Public Health Funds. The purpose of this funding is to support implementation of population-wide and priority population approaches to prevent obesity, diabetes, heart disease and stroke among adults and to reduce health disparities in these areas.

Priority populations are those population subgroups with uncontrolled hypertension, at high risk for type 2 diabetes, and/or at disproportionate risk of chronic diseases or conditions, and who experience racial/ethnic or socioeconomic disparities, including inadequate access to care, poor quality of care or low income. Applicants will be required to reduce risk and disparities by implementing each of 15 Strategies, organized within two Components as defined by the CDC (see pages 8-9 for the required Components and Strategies).

Component 1 supports environmental and system approaches to promote health, support and reinforce healthful behaviors, and build support for lifestyle improvements for the general population and particularly for the priority populations described above. Component 2 supports health system interventions and community-clinical linkages that focus on the general population and priority populations.

This RFP will support the establishment of community-based Chronic Disease Coordinating Networks (CDCNs) in a minimum of four high-burden chronic disease communities (a community may be defined as a county or contiguous counties, Metropolitan Statistical Areas or Zip Codes identified as high burden or high risk as described in the problem statement) to implement 15 required strategies as follows (see Attachment A for schematic of the CDCN).

Background

Despite continuous work in this area, chronic diseases still affect the quality of life for nearly 4 million Michiganders, kill more than 50,000 residents every year, and account for \$49.5 billion of the estimated \$66 billion in health care spending annually. Over 1 million adults have

diagnosed or undiagnosed diabetes. Diabetes causes over 286,000 hospitalizations, 8,741 stroke hospitalizations, 68,224 cardiovascular disease hospitalizations, and 8,584 deaths annually. In addition, over 35% of adults are estimated to have prediabetes, which equates to over 2.6 million people in MI; however, only an estimated 6.4% of adults with prediabetes are aware of it. Diabetes prevalence in MI increased 40% between 2001-2010; prevalence of diabetes among African American and Hispanic adults ages 18-44 is twice that of their White counterparts. Disparities by racial group are also seen within low income populations. Although prevalence of diabetes is similar by race among adults in MI Medicaid programs, indicators of more severe disease (such as hospitalizations and dialysis) are significantly higher among black than white adults. Among adults on Medicaid due to disability, hospitalization rates for diabetes are 30% higher among blacks than whites.

One out of three deaths in MI is due to cardiovascular disease (CVD) and CVD and stroke result in more than 160,000 hospitalizations annually. Controlling high blood pressure (HBP) in MI could reduce the risk of stroke by 40% and heart attacks by 27%. Although one third of adults have HBP, only 50% have it controlled. The extensive comorbidity of these chronic conditions is also noteworthy. Among MI adults with diabetes, HBP prevalence is significantly higher (78%) compared to those without diabetes (29%). Again, disparity persists by income and race/ethnicity. Among low income adults with disabilities enrolled in MI Medicaid programs, 45% have claims for diabetes, hypertension, CVD or asthma; nearly 20% have claims for 2 or more of these conditions. Hospitalization rates for congestive heart failure and hypertension in this population are 3 and 4 times higher among Black than White adults.

Overweight and obesity increase chronic disease risk in adults and children. In MI, 65% of adults are either overweight or obese. Obesity prevalence is higher among Black adults (41%) than White adults (30%) and among adults with disability (42%) than those without (27%). Compared to healthy weight adults (20%), more obese adults (56%) had comorbid diagnoses of diabetes, CVD, and/or HBP.

Healthy lifestyle behaviors can prevent occurrence and progression of chronic disease. Unfortunately, only 20% of MI adults adhere to the 2008 Physical Activity Guidelines. Furthermore, adults with disability (15%) are much less likely to report adequate activity (vs. 22% in adults without disability). Consumption of fruit and vegetables is also low: only 18% of adults report eating fruit and vegetables 5+ times/day. As income declines, the proportion reporting inadequate physical activity and inadequate consumption of fruits and vegetables increases. For example, prevalence of no leisure time activity is twice as high among low income compared to the highest income adults in MI, with similar difference by education status. Disparities by race/ethnicity are particularly striking, with report of lack of physical activity being 50% higher among Black and Hispanic adults than White. The compounding of low income, racial and ethnic disparities, and comorbidities converges on people with disabilities and African American and Hispanic adults to create priority populations for prevention strategies. MDCH Division of Chronic Disease and Injury Control will work with state partners and support communities in reducing chronic disease burden specific to obesity, hypertension and diabetes at the state and local level.

In preparation for release of this RFP, MDCH staff compiled a list of indicators related to disease burden, healthy lifestyle choices, and economic stress to describe the disease burden. The following indicators align with the priority health outcomes of this RFP, and were analyzed

as they correspond to MI’s 45 local public health department (LHD) jurisdictions. MDCH staff explored racial and economic disparities within these indicators and ranked them.

Indicators		Data Source/s	Measure
Chronic disease	Diabetes Obesity	Michigan Behavior Risk Factor Survey (MiBRFS) 2011 -2013	% self-reporting yes that they had ever been told by health provider that they had one or more of these conditions
	Hypertension	MiBRFS 2011, 2013	hospitalization rate of each condition per 10,000 population
	Heart disease and stroke burden	Michigan Inpatient Database (MIDB)	hospitalization rate of each condition per 10,000 population
Lifestyle risk	Fruit and vegetable consumption	MiBRFS 2011, 2013	% self-reporting ‘no’ to consuming fruits and vegetable \geq 5 times/day
	Leisure time physical activity	MiBRFS 2011-2013	% self-reporting ‘no’ to a minimum level of leisure time physical activity
Economic	Low income (proxy measure)	Enrollment in Healthy MI Plan (Medicaid expansion)	rate per 1,000 eligible population

PLEASE NOTE: Chronic disease burden indicators, including rankings, are provided in Attachment B and may be used by applicants to help determine and describe the disease burden and risk in their communities. These rankings, in combination with additional racial/ethnic, economic, and health disparity data provided by applicants to describe their target communities, will be used to ensure that communities selected for funding have sufficient burden and can address health disparities faced by most vulnerable populations.

APPLICATION REQUIREMENTS

Applicants should organize their application narrative according to the main sections described in this section and outlined in the section ‘Submission Requirements and Review Criteria’ (pages 12-17). The description of your approach should include a brief Introduction, then move into Collaboration, Community & Target Populations, Components & Strategies, Organizational Capacity, and finally to Evaluation & Performance Measures. In addition to the application narrative, a work plan (Attachment D), budget (Attachments E & F), and supporting documents (i.e. letters of supports, position descriptions, etc.) are required.

Collaboration – Chronic Disease Coordinating Networks

Each applicant organization will establish a Chronic Disease Coordinating Network (CDCN) to foster innovative partnerships that will strengthen the prevention and detection of diabetes,

hypertension and obesity. In each community, the CDCN lead agency (applicant) will be a coordinating and unifying entity for the partnership.

The MDCH CDCN Coordinator will oversee state-level activities to coordinate efforts and communication among the selected applicants. A community/local CDCN coordinator will work with both state and community partners and serve as the liaison between MDCH and the CDCN partners, providing communication and technical assistance (TA) and ensuring that all Component 1 and 2 strategies and activities are implemented at the community level.

Each CDCN will designate a local coordinator to oversee partnerships, sub-contracts, local meetings, and coordinate all activities necessary to fulfill Component 1 and 2 strategies and activities in its defined community. The CDCN will also designate an evaluator to oversee data collection and evaluation processes and procedures.

The CDCN applicant organization will be the lead agency and have the capability to act as the CDCN fiduciary and to establish and operate the CDCN. The lead agency will demonstrate organizational capacity to coordinate and carry out the required activities, including the ability to implement evidence-based programs, participate in evaluation activities, and work with community partners. Each CDCN will have the following responsibilities:

- 1) Maintain the public health mission of reaching as many people as possible in the defined community, with focus on eliminating health disparities,
- 2) Work with the CDCN-identified partners including health care providers, health care systems, employers, community organizations, citizens, community health workers and pharmacies, among others, to support all grant activities and strategies,
- 3) Work closely with the MDCH CDCN Coordinator and MDCH program staff to ensure compliance with the established grant work plan and timelines,
- 4) Collaborate with and provide MDCH with all required evaluation data and reports necessary to meet CDC grant requirements and
- 5) Participate in joint learning and sharing opportunities as arranged by the MDCH CDCN Coordinator.

CDCNs are expected to establish and/or build upon existing community partnerships to maximize resources, increase public health impact, minimize duplication, and complement current community, MDCH, and/or federally-funded efforts in their areas. Partners may include local public health departments, FQHCs, health systems, MSUE, transportation and community planning organizations, food systems or food access organizations, as well as food service or retail outlets. (See Attachment A for schematic of CDCN.) Letters of support for CDCN identified partners are required.

Defining Community & Identifying Target Populations

Applicants must define the community/communities that the CDCN will serve and identify the criteria for selection of those communities based on disease and risk-factor burden. CDCN communities may be defined as counties or contiguous counties, Metropolitan Statistical Areas or Zip Codes identified as high burden or high risk as described in the preceding problem statement.

The priority populations that will be the focus of the CDCN strategy implementation must be specified. When addressing health disparities, applicants must state their commitment to the elimination of health inequities and include a plan to address health disparities that

contains: 1) the extent to which the health disparities are manifested within the health indicators of the population; 2) the specific group/s that experience a disproportionate burden for the indicators in the defined community; 3) the social and environmental conditions in the community leading to the disparity; and 4) strategies/activities to address health disparities to maximize impact. These statements must be supported by data.

Chronic disease indicators are provided in Attachment B; applicants should provide additional community-level data supporting burden and risk. Priority populations are those affected disproportionately by uncontrolled high blood pressure or at risk for type-2 diabetes due to racial, ethnic, socioeconomic or other characteristics; e.g., inadequate access to care, poor quality of care, or low income.

Applicants will commit to inclusion of populations that can benefit from strategies: e.g., people with disabilities, people with limited health literacy, lesbian, gay, bisexual and transgender populations, or others, and include those populations in the CDCN.

Components & Strategies to Reduce Risk and Address Disparities

As noted in the introduction, the primary purpose of this project is to support implementation of population-wide and priority population approaches to prevent obesity, diabetes, heart disease and stroke among adults and to reduce health disparities related to those conditions. In order to do so, CDCNs must implement each of 15 strategies, organized within 2 components. Applicants must briefly address the components and strategies in the 'Approach' portion of the application narrative.

Component 1 strategies support environmental and system approaches to promoting health, supporting and reinforcing healthful behaviors, and building support for lifestyle improvements for the general population and particularly for the priority populations described above.

1A: Environmental strategies to promote health and support and reinforce healthful behaviors

- 1A-1. Implement nutrition and beverage standards including sodium standards (i.e., food service guidelines for cafeterias and vending) in public venues that may include worksites and other key locations such as hospitals.
- 1A-2. Strengthen healthier food access and sales in retail venues (e.g., grocery stores, supermarkets, and chain restaurants) and community venues (e.g. food banks) through increased availability (e.g. fruit and vegetables and more low/no sodium options), improved pricing, placement, and promotion.
- 1A-3. Strengthen community promotion of active modes of transportation and community venues for physical activity through signage, worksite policies and practices, social support, and joint use agreements for schools, community centers, parks, fitness facilities in communities and jurisdictions.
- 1A-4. Develop and/or implement transportation and community plans that promote walking.

1B: Strategies to build support for healthy lifestyles, particularly for those at high risk, to support diabetes and heart disease and stroke prevention efforts

- 1B-1. Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for lifestyle change. For example, create and implement a comprehensive plan to build support for evidence-based lifestyle change; i.e., the Diabetes Prevention Program (DPP) and coordinate with existing organizations and programs supporting evidence-based lifestyle change.
- 1B-2. Implement evidence-based engagement strategies (e.g. tailored communications, incentives, etc.) to build support for lifestyle change; e.g., the Diabetes Prevention Program.
- 1B-3. Increase coverage of evidence-based supports for lifestyle change by working with network partners (e.g., educate employers about the benefits and cost-savings of evidence-based lifestyle change programs such as the Diabetes Prevention Program as a covered health benefit).

Component 2 strategies support health system interventions and community-clinical linkages that focus on the general population and priority populations.

2A: Health system interventions to improve the quality of health care delivery to populations with the highest hypertension and prediabetes disparities

- 2A-1. Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance (e.g., work with health system partners to implement advanced Meaningful Use data strategies to identify patient populations who experience CVD-related health disparities).
- 2A-2. Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider level (e.g., use dashboard measures to monitor healthcare disparities and implement activities to eliminate healthcare disparities).
- 2A-3. Increase engagement of non-physician team members (i.e., nurses, pharmacists, and nutritionists, physical therapists, and patient navigators/community health workers) in hypertension management in health care systems including FQHCs, local public health in communities.
- 2A-4. Increase use of self-measured blood pressure monitoring tied with clinical support.
- 2A-5. Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes.

2B. Community clinical linkage strategies to support heart disease and stroke and diabetes prevention effort

- 2B-1. Increase engagement of CHWs to promote linkages between health systems and community resources for adults with high blood pressure and adults with prediabetes or at high risk for type 2 diabetes.
- 2B-2. Increase engagement of community pharmacists in the provision of medication/self- management for adults with high blood pressure.
- 2B-3. Implement systems and increase partnerships (e.g., EHRs, 800 numbers, 211 referral systems) to facilitate bi-directional referral between community resources and health systems including lifestyle change programs (i.e., DPP).

Organizational Capacity

Applicants must describe their organizational capacity to establish a CDCN, to coordinate activities to carry out the required strategies, to collect data and report outcomes, and to manage the financial requirements of the CDCN. MDCH anticipates that all applicants will be able to demonstrate sufficient capacity and readiness to implement the required strategies and demonstrate impact on the project period performance measures over the 4-year project period.

General readiness Applicants' general readiness to implement the evidence-based strategies in both components includes the ability of applicants to describe/demonstrate the following:

- 1) Ability to convene and coordinate community partners to effectively implement programs
- 2) Established partnerships with groups/organizations relevant to the strategies
- 3) Prior experience working and providing technical assistance on and demonstrating outcomes for priority populations
- 4) Ability to conduct program evaluation and monitor performance, including the ability to collect and use population-level data to demonstrate impact on priority populations

Readiness to implement component strategies Applicants' readiness to work on component-specific strategies includes the ability of applicants to describe/demonstrate the following:

- 1) Experience in policy/environmental change leading to health improvements
- 2) Success building support for lifestyle change for those at high risk for diabetes
- 3) Established partnerships with key stakeholders for:
 - a. nutrition and physical activity, policy/environmental improvement initiatives (e.g., state/local department of transportation, employers, retailers, food and farming groups, emergency food providers, parks and recreation departments, and others)
 - b. building support for lifestyle change (e.g., employers, insurers, state Medicaid agencies, health systems, representatives of CDC recognized lifestyle change programs, and others)
 - c. health system interventions to improve the quality of health care delivery to populations with the highest hypertension and prediabetes disparities (e.g., Quality Improvement Organization, Regional Extension Center, state Medicaid, other insurers, Primary Care Organization, state chapters of National Medical or Nurses Associations, faith-based and community-based organizations, Historically Black Colleges)
 - d. promoting community-clinical linkages (e.g., CHW Associations, Community Pharmacists, community organizations offering the CDC recognized lifestyle change program, Department of Housing and Urban/Community Development)
- 4) Experience in health systems quality improvement processes

- 5) Experience engaging health care extenders to promote linkages between health systems and community resources
- 6) Experience in developing systems to facilitate referral and promotion between health systems and community resources

Readiness to manage the project Applicants' capacity for project management – includes ability of applicants to describe/demonstrate the following:

- 1) Presence of core project management to execute strategies in both components including the roles and responsibilities of project staff
- 2) Staff assigned to day-to-day responsibility for key tasks such as: leadership of the project; monitoring of the project's on-going progress; preparation of reports; program evaluation; and communication with partners
- 3) Proposed contractual organization(s), consultants, and/or partner organizations that will have a significant role(s) in implementing program strategies and achieving project outcomes
- 4) An efficient and effective financial management system capable of making sub-awards to communities, jurisdictions, and other local organizations and for ensuring accountability of sub-awardees to demonstrate impact on the project outcomes

Evaluation, Performance Measures & Reporting Requirements

A table of the CDC/MDCH required performance measures appears in Attachment C. Applicants are expected to demonstrate capacity to evaluate progress within their communities and to identify at least one staff member to complete evaluation-related activities. CDCNs will be required to collect both process and outcome evaluation data for reporting on required performance measures. Awardees will work with the MDCH CDCN coordinator and the MDCH evaluation consultant to develop CDCN-specific evaluation plans, implement common data collection instruments and submit required evaluation reports.

Evaluation activities in years 1-4 will focus on monitoring short-term and intermediate performance measures to meet project outcomes of increasing consumption of nutritious food and beverages, increased physical activity, increased engagement in lifestyle change, improved medication adherence for adults with high blood pressure, increased self-monitoring of high blood pressure, and increased referrals to and enrollments in lifestyle change programs; i.e., DPP. Ultimately, MDCH aims to improve chronic disease outcomes such as reducing death and disability due to diabetes, heart disease and stroke by 3% and reducing the prevalence of obesity by 3% in selected high-burden communities.

Awardees will submit quarterly evaluation reports to MDCH reflecting progress on short-term performance measures (planning, but not yet started, ongoing, completed), and will also submit a year-end evaluation report that will provide progress on these performance measures over the course of the project period (i.e., March-September for year one).

Outcomes

MDCH and CDCNs in high-burden communities will be responsible for addressing all strategies to achieve the following short-term and intermediate outcomes at the community level:

The expected short-term outcomes for each high-burden community include: 1) increased use and reach of strategies to build support for lifestyle change, 2) increased community clinical linkages that support self-management to control hypertension and prevent type 2 diabetes, 3) improved quality and delivery of clinical and preventive services to manage hypertension and prevent diabetes, and 4) increased number of community environments that promote physical activity and healthy eating.

The expected intermediate outcomes include: 1) increased referrals to and enrollments in lifestyle change programs, e.g. the Diabetes Prevention Program, 2) increased consumption of nutritious food and beverages, 3) increased physical activity, 4) improved medication adherence for adults with high blood pressure and 5) increased self-monitoring of high blood pressure tied to clinical support.

In the long term, the expected outcomes of the project include: 1) reducing occurrences of diabetes, heart disease and stroke by 3% as measured by MIDB and Medicaid data; 2) improving glucose control as measured by clinical data; and 3) reducing prevalence of obesity by 3% as measured by MiBRFS. CDCNs are not responsible for long-term outcomes.

Work Plan

Applicants must provide a detailed seven-month work plan for year one; a separate 12-month work plan for year two (October 1, 2015-September 30, 2016); and a succinct narrative summary of major activities for years three and four project (use the work plan template in Attachment D for each work plan). The work plans should include:

- 1) A SMART objective for each component category as indicated in the work plan template
- 2) Activities and milestones associated with the establishment of the CDCN and required strategies
- 3) Staff and administrative roles and functions to support implementation of the award
- 4) Administration and assessment processes to ensure successful implementation and quality assurance

SUBMISSION INSTRUCTIONS AND REVIEW CRITERIA

All applications will be screened initially for completeness by MDCH staff. Incomplete applications and applications that do not meet the eligibility criteria will not advance to full review. Applicants will be notified that their applications did not meet eligibility or published submission requirements. Each section of the application has an assigned point value for scoring. Reviewers will score the applications based on compliance with the application guidelines and capacity of the organization to achieve the proposed activity goals and objectives. The budget is not scored, but must be included and calculations accurate. Applications advancing to full review will be evaluated by an objective review panel according to the criteria listed in the submission requirements section that follows. Applications are required to include *all* of the following documents and contents within:

I. Cover sheet (not scored) The cover sheet must include:

- A. A descriptive title of proposed project

- B. The name, address, telephone number, and email address of the Project Director
- C. The name, address, telephone number, and email address of the primary contact for writing and submitting this application (if different from above)

II. Table of Contents (not scored) Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the Project Narrative section.

III. Project Abstract Summary (not scored) (Maximum 1 page) A project abstract must be submitted that is suitable for the general public. The project abstract must be a stand-alone, brief summary of the proposed project including the purpose and outcomes.

IV. Project Narrative (85 points possible) Maximum of 20 pages, single spaced, Calibri 12 point, 1-inch margins, number all pages. Content beyond 20 pages will not be considered. The twenty page limit is for the narrative only and does not include the work plan. The Project Narrative must include sections indicated. The Project Narrative must be succinct, self-explanatory, and in the order given in this section. It must address activities to be conducted over the entire project period as identified in this document. Please use the 'Application Requirements' (pages 6-12) as well as the following scoring descriptions for guidance when writing the application.

A. Approach (25 points)

1. Introduction (5 points): Applicants must provide a brief introductory paragraph that includes a description of the problem in their community. Who is at risk? What is the burden? Applicants must also describe in 2-3 sentences specifically how their application will address the problem as described in the RFP 'Application Requirements.'

2. Strategy and Activities (20 points): Applicants must provide a clear and concise description of the approach and activities they will use to establish the CDCN and implement the required component strategies.

Collaborations: Applicants must describe how they will collaborate with other programs and organizations. Letters of support should demonstrate commitment of partners for the CDCN and the required strategies outlined in this RFP.

Community, Target Populations & Inclusion: Applicants must describe the specific geographic community and target population(s) selected and the criteria used in selection. Selection criteria must be based on disease and risk factor burden data and the potential to impact large numbers of adults. Applicants must also identify specific *priority* populations of focus. These priority populations are affected disproportionately by heart disease and stroke and prediabetes. Supporting data from the burden indicator table (Attachment B) or

local data should demonstrate increased health risk, including non-health data on factors that influence health (e.g., poverty, education, or housing). Applicants must address how they will include specific populations who can benefit from the program. CDC requires that women, ethnic minorities and other disadvantaged groups be included in public health programs that receive its funding.

Implementation of Components and Strategies: Briefly describe how the CDCN will approach implementation of the fifteen required component strategies. What opportunities exist for reducing risk, addressing disparities and working with health systems to improve the health of target and priority populations? You will have an opportunity to address your readiness to implement the component strategies in the section on organizational capacity as well.

Collaboration, and target populations and inclusion are also described on page 6-8.

Review criteria for Approach:

- Does the applicant include the relevant background information that describes the context of the problem?
- Does the applicant describe how the problem statement will be addressed and how the applicant will work with partners to implement targeted, population-level evidence-based interventions to address the prevention of obesity, diabetes, and heart disease and stroke among adults? Has the applicant demonstrated readiness to work on all required component-specific strategies?
- Has the applicant provided a thorough description of the CDCN?
- Are collaborations with programs and organizations explained in detail?
- Has the applicant selected specific target population(s) and described the criteria used in selection? Criteria must be based on disease and risk factor burden data.
- Has the applicant met health equity and inclusion criteria described on pages 6-8?

B. Organizational Capacity of Applicants to Implement the Approach (50 points):

1. Organizational Capacity Statement (20 points): Applicants must address the organizational capacity requirements as described in the RFP Project Description and include appropriate CVs/Resumes or position descriptions of key staff; e.g., CDCN coordinator, evaluation coordinator, and financial officer with this application. Applicants must also address the capacity to carry out the required strategies, including coordination with other federally and privately funded programs within the state to minimize duplication, leverage resources, address health equity, and maximize reach and impact.

2. Demonstrate readiness to work on component-specific strategies (20): *As described on pages 10 and 11.*

3. Project Management (10 points): Applicants must describe their capacity for project management to execute strategies in both components including the roles and responsibilities of project staff.

Review criteria for organizational capacity:

- Is leadership identified for program planning and development including the staffing and supervision of staff, contractors, and/or consultants? Are staffing levels and expertise related to successful strategy implementation? Does the applicant describe who will have day-to-day responsibility for key tasks such as: leadership of the project; monitoring of the project's on-going progress; preparation of reports; program evaluation; and communication with partners?
- Has the applicant demonstrated readiness to work on all required component-specific strategies? Has the applicant described contractual organization(s), consultants, and/or partner organizations that will have a significant role(s) in implementing program strategies and achieving project outcomes (Letters of Support)?
- Does the applicant describe financial capacity for executing and monitoring sub-awards to communities, jurisdictions, and/or local organizations and for ensuring accountability of sub-awardees?
- Has the applicant explained prior experience working and providing technical assistance on and demonstrating outcomes for priority populations?

C. Evaluation and Performance Measurement Plan (10 points)

Applicants must provide an overall description that is consistent with the Performance Measures (Attachment C) indicating capacity to participate in performance/project monitoring and data collection to evaluate effectiveness and to ensure continuous program improvement. This section should describe previous experience in process and outcome evaluation and describe how key program partners will be engaged in the evaluation process.

Review criteria for evaluation plan:

- Has the applicant demonstrated the capacity to conduct program evaluation and monitor performance, including examples of past projects for which the applicant collected required data?
- Does the applicant describe how key program partners will be engaged in the evaluation process?
- Did the applicant commit to full participation in and compliance with the MDCH/CDC project evaluation, including compliance with reporting requirements included in the Project Description?

V. Work plan (15 points): Applicants submit a 7-month work plan for the first funding period beginning March 1, 2015 through September 30, 2015 and a separate 12-month work plan for year 2 (October 1, 2015 through September 30, 2016).

Review criteria for the work plans:

- Does the applicant include activities to establish and maintain partnerships of the CDCN?
- Does the applicant identify a SMART objective for each component category in the year 1 and 2 work plans?
- Are the listed activities appropriate to accomplish the work and achieve the performance measures for each strategy?
- Has the applicant provided a general summary of activities for years 3-4?

VI. Budget and Budget Narrative (not scored): Applicants must submit an itemized budget which clearly addresses Components 1 and 2. Using the templates provided (Attachments E & F), applicants should include sufficient description in each category to make clear that the proposed budget is reasonable and consistent with the purpose, outcomes, and program strategy outlined in the project narrative.

The budget must be allocated specifically to components and strategies with a minimum of 0.50 FTE devoted to network coordination and 0.10 FTE directed to project evaluation.

The FTEs and activities for overall coordination, evaluation and any administrative support should be distributed proportionately across the components and strategies as shown below.	
15%	Strategy 1A-1
35%	Strategies: 1A-2, 1A-3, 1A-4; 1B-1, 1B-2, 1B-3
35%	Strategies 2A-1, 1A-2, 2A-3, 2A-4, 2A-5 (hypertension); 2B-2
15%	Strategies 2B-1, 2B-3; 2A-5 (prediabetes)

See Attachments E & F for budget templates. The budget categories include:

- Salaries and wages
- Fringe benefits
- Travel
- Supplies
- Contractual costs
- Other categories
- Total Direct costs
- Total Indirect costs
- Total Costs

Applicants are required to include the following information with the submitted budget. See budget cover form—Attachment E:

DUNS #: _____ Employer ID #: _____

Type of Agency: Governmental Non-Profit For-Profit

Date Agency was established: _____

Period of most recent Single Audit: _____ No Single Audit

VII. Supporting Documents (not scored): Applicants must submit letters of support from prospective CDCN organizations/community partners, as well as resumes for key personnel and position descriptions for staff who will be hired to work on the project.

Please note: Additional information may be required before funding decisions are made; e.g., information regarding experience managing other significant federal and state awards, previous audit results, and/or agency financial management staffing.

RFP Checklist

_____ Letter of Intent due November 19, 2014

Complete all forms provided. Submit information for the sections listed below by January 6, 2015:

_____ Cover Sheet/Title page (not counted in page limit)

_____ Abstract –summary (not counted in page limit)

_____ Project Narrative (20 pages)

_____ Work Plan Year One (7 months)

_____ Work Plan Year Two (12 months)

_____ Budget – Completed budget templates; DUNS and EIN, and information regarding agency type and single audit.

_____ Letter(s) of Support

_____ CVs/Resumes/Position Descriptions

RFP Attachments (Attachments D, E, F are templates for required elements of the application)

- A. CDCN schematic
- B. Chronic Disease Burden Indicators
- C. Performance measures
- D. Work plan template
- E. Budget cover sheet
- F. Budget form templates

Resources

- Asset Limited, Income Constrained, Employed Report: www.uwmich.org/alice
- Obesity: www.cdc.gov/obesity/resources/recommendations.html
- Effective community interventions and policies: <http://www.thecommunityguide.org>
- Diabetes: <http://www.cdc.gov/diabetes/>
- DPP Program: <http://www.cdc.gov/diabetes/prevention/index.htm>
- Awareness of Prediabetes--US 2005-2010: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6211a4.htm?s_cid=mm6211a4_w
- CDC Diabetes Prevention Recognition Program Standards: <http://www.cdc.gov/diabetes/prevention/recognition/standards.htm>
- Michigan Department of Community Health Sample Grant Agreement Language: [https://www.michigan.gov/documents/mdch/Sample MDCH Grant Agreement Language 438325 7.pdf](https://www.michigan.gov/documents/mdch/Sample_MDCH_Grant_Agreement_Language_438325_7.pdf)