Request for Applications

For

2017 - 2019

Minority Health Initiative Projects

Date of Issuance: February 14, 2017

Applications Due: March 14, 2017

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Office of Health Disparities & Health Equity

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Funding Opportunity Description

Grantor:	Nebraska Department of Health and Human Services
Office:	Office of Health Disparities and Health Equity (OHDHE)
Contact:	dhhs.minorityhealth@nebraska.gov
Updates to information contained in this document will be posted on our website: http://www.dhhs.ne.gov/healthdisparities	
Funds to Be Awarded:	Nebraska's Minority Health Initiative (MHI) grant funds will be $1,557,713 per year for a two year total of $3.1 million. Funding is contingent upon Legislative appropriations. Funds are allocated on a per capita basis according to the 2010 Census population figures for counties having 5% or greater minority population in Congressional Districts One and Three.
Project and Funding Period:	July 1, 2017 – June 30, 2019
Funding Purpose:	To address health disparities in minority populations, which include Black/African American, American Indian/Native American, Asian/Pacific Islander, Other (including refugee), Two or more Races, and Hispanic groups.
Reporting Requirements:	Quarterly: expenditures with narrative, project progress with narrative, and data Annually: project-to-date results, narrative
Description of Eligible Applicants:	Applicants must be entities registered with the Nebraska Secretary of State to do business in Nebraska, a government entity, or a federally recognized Native American Tribe.
Application Due Date:	March 14, 2017, 5:00 p.m. CT to be submitted via email to: dhhs.minorityhealth@nebraska.gov
Anticipated Date of Award Notification:	May 15, 2017

Purpose of Funding

The Nebraska Legislature appropriates funds for the purpose of implementing a minority health initiative in counties with minority populations of five percent or greater in the first and third Congressional Districts as determined by the most recent federal decennial census (Nebraska State Statute 71-1628.07). Per the United States Census, minority populations include Black/African American, American Indian/Native American, Asian/Pacific Islander, Other (including refugee), Two or more Races, and Hispanic populations. The Nebraska Department of Health and Human Services (DHHS) has tasked the Office of Health Disparities and Health Equity (OHDHE) with distribution and oversight of these funds.

The emphasis of this program is to enable organizations to better address the goal of health equity for minority populations. Partnerships are encouraged to gain the benefits of synergy. When a network of partners submits an application, each partner should submit a letter of commitment identifying the portion of the project for which they are responsible and their agreement to participate.

Project Priorities & Strategies

The legislation named five priority issues as targets for Minority Health Initiative funding. Based on this and current data, applications for the 2017-2019 awards must address at least one of the following priorities:

- Obesity
- Cardiovascular disease
- Diabetes (including pre-diabetes)

The other two priorities named in the legislation were infant mortality and asthma. If you wish to propose a project incorporating these or other health issues (e.g., unintentional injury), you must substantively justify their importance in the population you propose to serve.

Applicants must include efforts to address all minority (Black/African American, American Indian/Native American, Asian/Pacific Islander, Other, Two or more Races, and Hispanic) populations in the county, or provide rationale for prioritization of one or more such populations. While not named specifically in the Census data, please note that it is expected that refugees will be included in proposed projects, especially in counties with significant refugee populations.

The 2017-2019 Minority Health Initiative projects will use Results-based Accountability (RBA)[1] to achieve collective impact around diabetes, cardiovascular disease, obesity, and pre-diabetes for racial ethnic minority populations in Nebraska.

The collective impact model[2] consists of five elements:

[1] Friedman, M. (2015). *Trying hard is not good enough: How to produce measurable improvements for customers and communities*. Santa Fe, New Mexico: PARSE.

[2] Kania, J. & Kramer, M. (2011, Winter). Collective impact. *Stanford Social Innovation Review, 9*(1), pp 36-41.

1. **All participants have a common agenda for change including a shared understanding of the problem and approach to solving it through agreed-upon actions.**
   The common agenda for MHI is "Improved Health Outcomes for Culturally Diverse Populations in Nebraska."
2. **Collecting data and measuring results consistently across all the participants ensures shared measurement for alignment and accountability.**
   Indicators of importance to MHI are listed in Attachment 1. Using the RBA matrix, they have been sorted into three categories: *how much did you do?*, *how well did you do it?*, and *is anyone better off?* Project performance toward these indicators will be measured via common work plan elements and tools. All projects must choose from these indicators, and build those chosen into work and evaluation plans.

For projects requesting	Choose (at least) this many performance measures for each category			
	How much did you do? (a-r)	How well did you do it? (s-bb)	Is anyone better off?	
			Left side (cc-hh)	Right side (ii-ss)
$0 - $70,000	3	2	2	3
$70,001 - $200,000	5	2	2	4
$200,001 - $400,000	7	4	3	5
Over $400,000	9	4	3	7

3. **A plan of action that outlines and coordinates mutually reinforcing activities for each project.**
   - This does not mean every project must do the same activities, but that all activities must be aligned toward the common agenda and grounded on the shared measures of success. The OHDHE relies on local organizations – grantees – for their expertise in local issues, populations, and efforts. This expertise is essential to the application process and project implementation and evaluation.
4. **Open and continuous communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.**
   Efforts to ensure open and continuous communication may include:
   - Quarterly emails or newsletters
   - Quarterly technical assistance opportunities
   - Site visits
   - Communication with other grantees
   - Annual in-person meetings
   - Dashboard for MHI
   - Integrate feedback of participants – into individual projects and MHI processes
   - Reporting on integration of feedback
   - Common language – see Attachment 5: Glossary
5. **A backbone organization with staff and skills to serve the entire initiative and coordinate participating organizations and agencies.**
   The OHDHE will serve as the backbone organization, and will be responsible for:

- Providing strategic guidance
- Leading and/or facilitating communication efforts
- Creating a shared data system for reporting
- Utilizing data in a meaningful way

Minority Health Initiative projects must be data-driven and evidence-informed. Applications must include evidence-based or promising practices, and project narratives must include clear descriptions regarding how the applicant plans to amend the practice to fit the target population while maintaining and tracking fidelity to the extent possible.

Adaptations to evidence-based practices should be done carefully and with the guidance and oversight of local project evaluators[3]. Things that can probably be modified include:

- Names of health care centers or systems
- Pictures of people and places and quotes
- Hard-to-read words that affect reading level
- Wording to be appropriate to audience
- Ways to recruit your audience
- Incentives for participation
- Timeline (based on adaptation guides)
- Cultural preferences based on population

The following lists things that may be modified, but only with substantive justification.

- Substituting activities
- Adding activities to address other risk factors or behaviors
- Changing the order of the curriculum or steps (sequence)

These components of evidence-based practices may not be modified.

- The health communication model or theory
- The health topic/behavior
- Deleting core elements or whole sections of the program
    - Reduction of program: timeline or dosage (e.g., activities, time/session)
- Putting in strategies that detract from the core elements

Lists of evidence-based and promising practices can be found at the following. Minority Health Initiative applicants should use these databases in selection of practices.

- Centers for Disease Control and Prevention's (CDC) Task Force on Community Preventive Services, at http://www.thecommunityguide.org
- University of Chicago and Robert Woods Johnson Foundation, Finding Answers Intervention Research (FAIR) Database http://www.solvingdisparities.org/fair
- Results First Clearinghouse Database http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2014/09/results-first-clearinghouse-database
- Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices, at http://nrepp.samhsa.gov

[3] Brownson, R., Baker, E.A., Leet, T.L., Gillespie, K., True, W.R. (2011). *Evidence-based public health* (2nd ed.).New York: Oxford.

- University of Kansas, Community Toolbox, at http://ctb.ku.edu

Eligible Organizations

Applicants must meet the following qualifications to be eligible to respond to this Request for Application (RFA) and to receive funds:

a. Define a geographical service area composed of an eligible county or group of eligible counties where services will be provided to minority (Black/African American, American Indian/Native American, Asian/Pacific Islander, Other [including refugee], Two or more Races, and Hispanic) populations.
b. Be an entity that is registered with the Nebraska Secretary of State to do business in Nebraska and offer services in Nebraska, a government entity with a Nebraska service area, **or** a federally recognized Native American Tribe with a Nebraska service area. If an organization plans to serve a Native American population on Tribal land, a letter of support of the application from the Tribal Chairperson is required.
c. Have the infrastructure to provide services within the eligible county(ies).

Available Funding (Subject to funding appropriated by the Nebraska Unicameral)

It is anticipated that $1,557,713 will be available each year (a total of $3.1 million for the two-year project period) in grant funding for minority public health services in counties having a minority population equal to or exceeding five percent of the total population of the county in Congressional Districts One and Three as determined by the most recent (2010) federal decennial census. Funds available per county for the two-year period are listed below.

Information on county populations by race and ethnicity may be found at http://www.dhhs.ne.gov/healthdisparities.

County	Funds available
Adams	$69,750.21
Arthur	$482.10
Box Butte	$33,631.29
Buffalo	$95,918.60
Chase	$9,159.90
Cherry	$11,030.45
Cheyenne	$17,721.99
Clay	$11,589.68
Colfax	$86,469.44
Cuming	$16,738.51
Dakota	$181,462.40
Dawes	$21,675.21
Dawson	$170,894.77
Deuel	$1,966.97
Dixon	$13,633.79

County	Funds available
Dodge	$88,147.15
Dundy	$3,008.34
Garden	$2,217.66
Hall	$309,893.82
Johnson	$16,622.80
Kearney	$6,305.87
Keith	$12,341.76
Kimball	$6,942.24
Knox	$19,534.69
Lancaster	$862,091.05
Lincoln	$68,400.33
Madison	$112,117.15
Merrick	$8,484.96
Morrill	$15,157.22
Otoe	$23,931.44

County	Funds available
Phelps	$9,526.29
Platte	$97,769.86
Red Willow	$13,691.64
Richardson	$10,278.37
Saline	$65,237.76
Sarpy* CD1	$303,665.09
Scotts Bluff	$174,308.04
Sheridan	$17,548.44
Sioux	$1,369.16
Stanton	$7,713.60
Thurston	$81,012.07
Wayne	$13,537.37
Webster	$4,319.62
York	$18,126.96

* Sarpy County is divided between Congressional Districts One and Two. Only the District One portion is eligible for this funding. See http://www.dhhs.ne.gov/healthdisparities for a detailed map of Sarpy County.

NOTE: These figures are based on the 2010 U.S. Census and the most current Congressional District map, as required by the Nebraska State Statute § 71-1628.07.

DHHS reserves the right to award based on the combination of applications that best address the purpose of this RFA.

Project and Funding Period

The project and funding period for the grants awarded under this competitive RFA will begin July 1, 2017 and continue through June 30, 2019. Award notices will be sent no later than May 15, 2017. Between the date award notices are sent and June 30, grantees will work with DHHS and the local project evaluator to finalize work plans, evaluation plans, and itemized budgets.

Use of Funds

Minority Health Initiative grant funding may only be used for activities outlined in the approved Work & Evaluation Plan. Use of funds must be based on the approved budget.

Attachment 2 includes a list of costs disallowed under this funding. If a proposal is approved for funding but includes these costs, they will have to be removed from the MHI budget prior to project implementation.

Funds cannot be used to subsidize individuals for the cost of health care (e.g., pay for visits to physicians or medications) or for lobbying. Funds awarded may not be used for construction or renovation of real property (e.g., buildings, land, etc.).

Use of funds to lease/purchase health related equipment, software, and computers are allowable when the equipment is essential for the program. However, the Minority Health Initiative grants will not support projects that are solely or predominately designed for the purchase of health related equipment, software, and/or computers.

Funds may be used to pay for salaries for project staff, fringe benefits, travel, meeting expenses, postage, supplies, and other expenditures approved by DHHS.

All funded organizations must be good stewards of funds awarded.

Proposals may include indirect costs, if the application includes a copy of a current negotiated Indirect Cost Rate (ICR) agreement, approved by a Federal or State cognizant agency. Applicants that have never had a negotiated indirect cost rate agreement may elect to charge a *de minimis* rate of 10% of modified total direct costs. Said de minimus rate shall be calculated in the same manner which de minimus rates are calculated under federal

awards, per 2 CFR200If claiming a *de minimis* rate, show the calculation leading to the claimed indirect costs in the budget and budget justification.

Whether applying an Indirect Cost Rate agreement or claiming a *de minimis* rate, please specify in the budget justification the types of costs that are included in your indirect costs.

Evaluation and Quality Improvement

Evaluation includes the identification of performance measures, determination of the effectiveness of activities and outcomes, and quality improvement. Evaluation will help showcase the effectiveness of the MHI project and identify areas for enhancement.

Grantees shall work with an internal or external project evaluator and DHHS to finalize their project work plan, evaluation plan, and itemized budget to be completed by June 30, 2017.

Grantees are encouraged to prioritize and allocate staff time to evaluation activities for their projects. Although OHDHE will provide assistance with project evaluation, implementation of and reporting of evaluation activities is the responsibility of each grantee. Please see Attachment 3 for additional information about evaluator expectations and qualifications. Funding can be identified in the grantee's budget for evaluation costs.

If applicants intend to work with an external evaluator, it is strongly suggested that they begin discussions with that individual or organization early in development of their application and subsequently the project work and evaluation plan, data collection plan, and budget. It is also strongly suggested that evaluators, whether internal or external to the applicant organization, collaborate with the Project Director, project officer, and OHDHE statewide evaluator as appropriate throughout project implementation.

Reporting Requirements

Grantees will be required to report at the following intervals:

- Quarterly: expenditures with narrative, project progress with narrative, and data
- Annually: project-to-date results, narrative

Please see Attachment 4 for data reporting requirements.

2017-2019 Minority Health Initiative Reporting Schedule		
Report Title	**Period Covered**	**Due Date**
First quarter	July 1 – September 30, 2017	October 31, 2017
Second quarter	October 1 – December 31, 2017	January 31, 2018
Third quarter	January 1 – March 31, 2018	April 30, 2018
Fourth quarter	April 1 – June 30, 2018	July 31, 2018
Year One Annual Report	July 1, 2017 – June 30, 2018	July 31, 2018
Fifth quarter	July 1 – September 30, 2018	October 31, 2018
Sixth quarter	October 1 – December 31, 2018	January 31, 2019
Seventh quarter	January 1 – March 31, 2019	April 30, 2019
Eighth quarter	April 1 – June 30, 2019	July 31, 2019
Year Two Annual Report	July 1, 2018 – June 30, 2019	July 31, 2019

Application Deadline

A **complete, signed application** must be emailed to dhhs.minorityhealth@nebraska.gov by **March 14, 2017, 5:00 p.m. CT**. Narratives must be emailed as Microsoft Word documents, forms completed and emailed as Microsoft Excel files, and appendix items emailed as Adobe PDF files. All applications that fulfill all mandatory requirements will be reviewed and scored. DHHS reserves the right to waive any deviations or errors that it determines are not material, do not invalidate the legitimacy of the application, and do not improve the applicant's competitive position.

Applications received after **March 14, 2017, 5:00 p.m. CT** will be considered late, and will not be reviewed or scored. Additions or corrections will not be accepted after the closing date. DHHS is not responsible for applications that are late due to applicant email system inadequacies or any other reasons. All versions of the application, including attachments, become the property of the Nebraska Department of Health and Human Services upon receipt and will not be returned to the applicant.

Application Technical Assistance

During the period following release of this RFA and submission of applications, all questions should be submitted in writing to dhhs.minorityhealth@nebraska.gov. All questions and their respective answers will be posted in writing online at http://www.dhhs.ne.gov/healthdisparities within 2 business days of receipt. Applicants are strongly encouraged to check the website every 24-48 hours for updates. In no case shall verbal communications override written communications. **Only written communications will be binding.**

Any information provided by the applicant verbally shall not be considered part of its application. Only written communications from applicants received by DHHS within the required timeframe will be accepted.

There will be a Technical Assistance call for applicants at 12:00 pm CT on February 21, 2017. During this call, we will talk through key pieces of the RFA, but will not answer questions. Attendance is optional but encouraged for all applicants.

RFA Timeline

Issuance of RFA	February 14, 2017
Technical Assistance call	12:00pm CT, February 21, 2017
Applications Due	5:00pm CT, March 14, 2017
Award notification	May 15, 2017
Final work plans, evaluation plans, itemized budgets due	June 30, 2017
Project and funding start date	July 1, 2017

DHHS reserves the right to amend the RFA at any time prior to the application deadline. In the event DHHS decides to amend, either to add to or delete any part of this RFA, a written amendment will be posted on the DHHS Web site. Potential applicants are advised to check the webpage http://www.dhhs.ne.gov/healthdisparities periodically for possible amendments to this RFA.

Funding Conditions

1. Applicants should plan to spend half of the awarded funds in each year of the two-year project and funding period, or provide justification regarding why this might not occur. If funds are not expended as planned, the remaining amount may not be carried over to the following calendar year.
2. The Department of Health and Human Services reserves the right to fund more than one project per county.
3. Expenses associated with preparing and submitting an application will not be reimbursed by DHHS.
4. The Department of Health and Human Services reserves the right to withdraw any award if agreement on details of the project is not reached to the satisfaction of DHHS by June 30, 2017.
5. DHHS reserves the right to withdraw an award, and/or renegotiate the work and evaluation plan, budget, or other component of a proposed project. If project deliverables including quarterly and annual reports are not completed satisfactorily and on time per the schedule provided by DHHS, DHHS has the authority to withhold and/or recover payment of funds.
6. Grantees are to expend funds in accordance with the approved line item budget. If cumulative changes exceed 10% of the total award or would add or eliminate a line item, the Grantee must request, in writing using the DHHS–provided form, a budget or a work plan revision, depending on what needs to be changed, prior to implementation of proposed changes. It is to the discretion of DHHS to approve the requested budget or work plan revisions. DHHS will provide written notice of approval or disapproval of the request within thirty (30) days of receipt. Budget and work plan revisions for the 2017-2019 MHI project period will not be approved if submitted after June 30, 2018.
7. Grantees must submit to DHHS timely, accurate, and complete reports per the schedule included in award letters using the forms, format, and time line provided by DHHS. This includes submission of all costs for which reimbursement is requested for a quarter.
8. Grantees will be reimbursed for actual and allowable expenses incurred and paid by the Grantee, in accordance with the State of Nebraska Prompt Payment Act. Grantees must submit reports to DHHS for expenses incurred and paid in the previous quarter. DHHS has up to 45 days from the Report Complete Date (see Attachment 5, Glossary) to pay Grantees after submission of a DHHS-approved request for reimbursement. Advance payments are not allowed by DHHS. Payments will not be made more frequently than quarterly. Grantees are encouraged to submit reports to DHHS in a timely manner to ensure prompt payment of expenses and cash flow maintenance. The costs reported under an award must be based on the approved budget. **Payments will not be made for quarters for which reports are received more than 180 days from the Report Due Date.**
9. Grantees are expected to contact DHHS if they or any community partner or collaborator

have difficulties implementing the work plan or need to make changes in the approved activities. DHHS will work with the Grantee to determine possible solutions or best outcomes. If changes need to be made in the work plan, the Grantee must contact DHHS in writing to request a revision or amendment, including changes in Project Director.

10. Grantees are to maintain accurate records regarding program implementation and evaluation which document the persons and organizations involved, activities carried out, and any materials or information developed. It is expected that these documentation records may include but will not be limited to logs, sign-in sheets, meeting minutes, survey and evaluation data, etc.
11. Grantees are expected to fulfill all program award related deliverables as well as to fulfill payroll, accounting, and administrative procedures.
12. DHHS may withhold payment of quarterly expenses for lack of documented and/or timely progress, as well as any non-compliance with grant requirements. Continued lack of documented and/or timely progress and/or noncompliance with grant requirements may result in award termination, and/or funds being redirected in the county or issuance of a new RFA for that county.
13. Grantees are required to provide source documentation of payments when requested by DHHS, at least one time per project year. The documentation requested can include payroll records, receipts, time studies, or other documents to fully justify the expenses claimed on the quarterly budget report. Submission of source documents may affect quarterly reimbursement, so grantees are advised to submit the documents in a timely manner.

Technical Assistance Meetings

The Project Director, Project Evaluator, and individual responsible for reporting on the project for each award are strongly encouraged to attend face-to-face technical assistance meetings, planned for July 2017 and July 2018. If such a meeting must be missed, Grantees are expected to notify the OHDHE administrator and their DHHS Project Officer in writing prior to the meeting, with justification for missing the meeting and a plan to get the information that will be missed. Funds allocated for attendance of such meetings will be forfeited and may not be reallocated to other or additional line items.

Just after the end of each quarter and before quarterly reports are due, technical assistance conference calls will be available. Attendance at these calls is optional for all grantees unless attendance is specifically requested by DHHS. The schedule of annual in-person and quarterly conference calls is below.

Project Officers may also schedule technical assistance calls or meetings, depending on needs of grantees and DHHS.

2017-2019 Minority Health Initiative Technical Assistance Meeting Schedule	
Annual technical assistance meeting (mandatory)	July 12, 2017
Technical assistance call (optional)	October 5, 2017
Technical assistance call (optional)	January 4, 2018
Technical assistance call (optional)	April 5, 2018
Annual technical assistance meeting (mandatory)	July 11, 2018
Technical assistance call (optional)	October 4, 2018
Technical assistance call (optional)	January 3, 2019
Technical assistance call (optional)	April 4, 2019

Application Review Process

Applications will be reviewed to ensure that all required documentation has been included. Applications that fulfill all mandatory requirements will be advanced for further evaluation. Applications will be judged non-responsive if they are incomplete, inadequately developed, or otherwise unsuitable for review and funding consideration. Non-responsive applications will not be reviewed further.

During the comprehensive evaluation phase critique will include the following areas:

1. Organizational Capacity
    a. The ability, capacity, and skill of the applicant and significant partners to deliver and implement the project that meets the requirements of this Request for Applications;
    b. Whether the applicant and any significant partners can perform the work within the specified time frame;
    c. The quality of applicant and significant partner(s) performance on prior projects with DHHS Division of Public Health;
    d. Other information that may be secured that has a bearing on the decision to award funding;
2. Project Narrative;
3. Project Work & Evaluation Plan;
4. Project Data Collection Plan; and
5. Appropriateness of the budget and justification.

DHHS reserves the right to reject any or all applications, wholly or in part. All awards will be made in a manner deemed by DHHS to meet the goals of the Minority Health Initiative.

Awards resulting from this RFA shall incorporate the following documents:

- Amendment to the Award with the most recent amendment having the highest priority;
- Award and any attached addenda;
- The signed application;
- Amendments to the RFA and any questions and answers; and
- The original RFA document and any addenda.

Unless otherwise specifically stated in an award amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the Award with the most recent dated amendment having the highest priority, 2) Award and any attached addenda, 3) the signed application, 4) Amendments to the RFA and any questions and answers; 5) the original RFA document and any addenda.

DHHS reserves the right to check any reference(s), regardless of the source of the reference information, including but not limited to, those that are identified by the Applicant in the application, those indicated through the explicitly-specified contacts, those that are identified during the evaluation of the application, or those that result from communication with other entities.

Information to be requested and evaluated from references may include, but is not limited to, some or all of the following: project description and background, job performed, functional and technical abilities, communication skills and timeliness, accuracy, and overall performance.

Application Instructions

Applications should be typed or word-processed, single-spaced, in 12-point typeface, with one-inch margins, and pages numbered. A complete version of the entire application must be submitted to dhhs.minorityhealth@nebraska.gov, the narrative as a Microsoft Word document and the forms as Microsoft Excel files. Appendices may be submitted as Adobe PDF documents. The email with which the application is submitted serves as the applicant's signature.

All applications must use the following format in describing the proposed project. Blank forms have been provided, and should be downloaded in Excel at http://www.dhhs.ne.gov/healthdisparities. The forms contain links to other sheets in the workbook, which are designed to save time by preventing typing the same information multiple times. For this reason, some of the cells are locked. Adherence to this format will help ensure that all required elements are included in the application and will greatly assist in review. ***Limit your application narrative to no more than 20 pages***. Lengthy applications and unnecessary attachments or supporting materials are strongly discouraged.

Application Format

I. Cover page (FORM A)

Complete all sections of the cover page (FORM A). See the Instructions tab of the 2017-2019 MHI RFA Forms files for assistance with completing the form.

II. Application Budget (FORM B) and Justification (FORM C)

Complete all sections of the budget (FORM B) and justification (FORM C). See the Instructions tab of the 2017-2019 MHI RFA Forms files for assistance with completing the forms.

Please note the following:

- **Disallowed costs**: some costs are disallowed under MHI funding. Please see Attachment 2 for this list.
- **Personnel**: Projects are required to have a named evaluator. This person may be internal or external to the applicant organization, but shall not be the Project Director, Community Health Worker, or other staff key to project implementation.
- **Indirect costs**: If indirect costs will be included, specify the costs included in your indirect cost rate agreement (IDC) or what is used to compute Modified Total Direct Costs (MTDC) for a 10% *de minimis* rate.
- **Incentives, food, and educational tools:** If used, incentives must be linked directly to the work & evaluation plan, and a description of the purpose of their use must be included. All incentives must serve an educational purpose related to the health topic being addressed. All incentives (including food) must be pre-approved by DHHS. Food may only be included if it is to be used as part of an educational event (e.g., healthy cooking classes).
- **Supportive services**: The budget for supportive services such as interpretation, translation, or transportation may be no larger than 10% of the total budget or $10,000, whichever is smaller. Clients should be assessed by project staff for resources to meet needs for supportive services (e.g., Medicaid).
- **Annual in-person Technical Assistance meetings:** For the purposes of your budget and justification, plan for these meetings to held in Lincoln, and require a full day of attendance by the Project Director, Evaluator, and person responsible for reporting. Please note that if a grantee does not attend one of the in-person technical assistance meetings, costs allocated to support the activity will be forfeited and may not be reallocated to another or additional line item.
- **Program income:** If program income is to be collected and applied to the project, it must be included in the budget and justification. Program income collected under Minority Health Initiative funding shall be used to defray project costs, and any outstanding balance of program income will be deducted from the final reimbursement.

III. Narrative & Work Plan

The narrative shall include responses to each of the RBA performance accountability *Turn the Curve* questions:

1. **Who are our customers?**
   - Define who you intend to serve and how the population(s) was selection, including demographics.
2. **What are our most important measures of quality and effectiveness?**
   - Using the table on page 4, select the appropriate number of each type of indicator from Attachment 1
   - In the narrative, describe how the indicators were chosen
3. **How are we doing on these measures?**

- Describe how the targeted priority health issue(s) were selected. This funding is intended to address health disparities among minority (Black/African American, American Indian/Native American, Asian/Pacific Islander, Other [including refugee], Two or more Races, and Hispanic) populations, so be sure to support your choice of priorities with data and other justification, as specific to the targeted population(s) as possible. Include information about the process used to select the priority health issue(s). This should be based on a formal needs assessment process such as Mobilizing Action through Planning and Partnerships (MAPP), the Community Health Improvement Plan (CHIP), or other community needs assessment.
- Clearly describe the process for utilizing the community-level needs assessment to identify the target population(s) for the application. Include a description of organizations or individuals involved in this process, the deliberation methods used, and any special considerations of relevance.

4. **What is the story behind our data?**
   - Provide a description of the context in which the project is based – the why behind the what, so to speak. Why are the targeted health issues important to the target population? What are the causes and forces at work behind these conditions? What is happening to worsen things? What is happening to make things better? What barriers exist? What gaps are present? Include considerations such as the social determinants of health, and be specific (e.g., if the built environment is not sufficient to support walking trails, state so).
5. **Who are our partners with a role to play to help us do better?**
   - Describe your intended project partners, their expertise in the kind of project proposed, and the role(s) they will play in the project.
6. **What works to do better?**
   - Describe the process you used to select the key activities in the work plan.
   - Describe how the applicant organization assesses and addresses the CLAS Standards. Include information about how the organization addresses the Principal Standard; Governance, Leadership, and Workforce; Communication and Language Assistance; and Engagement, Continuous Improvement, and Accountability.
   - <u>If you received funding under the 2015-2017 Minority Health Initiative grants</u>: provide information on short-term, intermediate, and long-term outcomes of the project. List the goals and objectives of the current project and your progress toward achieving each. If you did not achieve planned outcomes, describe why and what was done or will be done to overcome those challenges. If you plan to continue the work of the previous project, include a description of how you will expand the reach to new clients and how you will take the project to the next level.
7. **What do we propose to do?**
   - Complete the Work & Evaluation Plan (FORM D)
   - If your project includes contributions by partners, note in the Outputs column of the Work & Evaluation plan outputs per partner organization.
   - Copy the indicators chosen from Attachment 1 to the Indicators column of the Work & Evaluation Plan
   - For each evidence-based or promising practice you plan to implement, complete the Evidence-based or Promising Practice Selection Worksheet (FORM E).

- Include in the narrative a description of how you will adapt the evidence-based or promising practice and how you will maintain fidelity to the practice. It is strongly recommended that applicants enlist the assistance of local project evaluators for this piece.
- Health education may only be included in work plans as supplements to community chronic disease prevention or management classes (e.g., healthy grocery shopping, mapping of walking trails).
- Case management is allowed under MHI funding, but only if it is focused on helping clients to overcome personal barriers to attending community classes or completing chronic disease self-management plans.
- Case management may include additional services (e.g., helping clients to complete applications for assistance), but must be more than just provision of additional services.

Please note: A work plan, evaluation plan, and two-year itemized budget and justification for each project will be finalized by the project director, local project evaluator, DHHS project officer, and OHDHE statewide evaluator.

IV. Data Collection Plan (FORM E)

Using the Indicators included in the Work & Evaluation Plan, complete the Data Collection Plan. Each Indicator should be assigned a row, and each column completed for each measure.

V. Organizational Capacity (FORM F)

Complete all sections of the organizational capacity form (FORM F). See the Instructions tab of the 2017-2019 MHI RFA Forms files for assistance with completing the form.

VI. Appendix (*will **not** count toward the page limit*)

Appendix items may be submitted in Adobe PDF format and shall include:

- Letters of Commitment (if applicable)
- Indirect Cost Rate (IDC) agreements or Indirect Cost Rate Allocation plan or De Minimis Indirect Cost computations (if applicable)
- Résumés for Project Director, Evaluator, Fiscal staff, and other key staff
- A copy of the applicant's latest audit report or financial statement
- The applicant's organizational chart

2017-2019 Minority Health Initiative Indicators

How Much Did You Do? (Quantity of Effort)	How Well Did You Do It? (Quality of Effort)
a. # of people served (***required for all projects***) b. # of health education sessions c. # of screenings for hypertension, diabetes, obesity, or pre-diabetes d. # newly diagnosed with diabetes or high BP e. # of interpretation sessions f. # transported g. # of transportation events (trips) h. # of people who receive health education i. # of people who receive interpretation services j. # of people who receive referrals to additional services k. # of people in case management for diabetes l. # of people in case management for hypertension m. # of people enrolled in Diabetes Prevention Program (DPP), Diabetes Empowerment and Education (DEEP), Road to Health (RTH), Chronic Disease Self-Management program (CDSM), or diabetes self-management education program (DSME) n. # of people who complete DPP, DEEP, RTH, CDSM, or DSME o. # of weeks of events (DPP, DEEP, RTH, CDSM, or DSME) p. # of visits with case manager/Community Health Worker (CHW) q. # of clients referred to MHI program by healthcare providers r. # of clients who received follow-up from CHW	s. CHW : participant ratio t. % satisfied with interpretation services u. % satisfied with health education v. % satisfied with transportation services w. % satisfied with program services x. % of diabetics with chronic disease self-management plan y. % linked to medical homes z. % served in primary language aa. % of hypertensives with chronic disease self-management plan bb. % linked to other resources (e.g., medication assistance)

Is Anyone Better Off? (Quality & Quantity of Effect)	
cc. #/% of participants with improved nutrition dd. #/% of participants with increased physical activity ee. #/% of participants who achieve lifestyle change goals ff. #/% of participants who demonstrate knowledge increase as a result of health education gg. #/% of participants who indicate improvements in attitudes resulting from health education hh. #/% of participants who successfully complete a self-management plan	ii. #/% of participants with improved blood pressure jj. #/% of participants with improved HbA1c kk. #/% of participants with reduced weight ll. #/% of participants with reduced BMI mm. #/% of pre-diabetic participants who reduce their risk and are no longer considered pre-diabetic nn. #/% of participants who maintain weight loss oo. #/% of participants who maintain reduced BMI pp. #/% of participants who maintain improved blood pressure at 6 or 12 months qq. #/% of patients who maintain improved HbA1c at 6 or 12 months rr. #/% of participants who maintain lifestyle changes at 6 or 12 months ss. #/% of participants who are adherent to medication regimens

Minority Health Initiative 2017-2019
Disallowed Costs

PLEASE NOTE: The following items are not allowed under Minority Health Initiative funding, and should not be included in application budgets or budget justifications. This is not intended to be a complete list of every expense which would not be allowed. Federal regulations require that expenses must be reasonable and necessary to accomplish the purpose of the grant or contract. The allowability of a specific expense will be determined on that basis and by comparison to this list as well as the intent and purpose of the funding.

1. Advertising other than for recruitment of project personnel or volunteers or project events of the approved work plan
2. Bad debts
3. Cash incentives, gift cards, or vouchers
4. Conferences except for minority health conference
5. Entertainment, meals, diversions and ceremonials
6. Incentives and food that do not serve an educational purpose specific to the project and approved Work & Evaluation Plan
7. Furniture; including chairs, filing cabinets, and desks
8. Interest expense
9. Lease or purchase of motor vehicles
10. Legal and audit expenses not directly benefiting the MHI program
11. Screenings or assessments, to include costs for program staff time, that are not specific to the project priorities and included in the approved work plan
12. Stipends paid to employees or clients for attending classes or other project events
13. Supportive services (interpretation, translation, or transportation) that exceed 10% of the total award amount or $10,000, whichever is less. For clients requesting supportive services and who are Medicaid recipients, supportive services are not allowed in any amount.
14. Training not directly related to the work plan
15. YMCA, gymnasium, or similar memberships for project staff or clients

Minority Health Initiative
Evaluator Expectations

The local evaluator will have several important roles in the Minority Health Initiative project. The evaluator will be responsible for assisting sub-grantee staff in completing the program planning (e.g., needs assessment, strategy session, and/or implementation plan).

Evaluators will work with grantee project directors and DHHS to:

a. Implement evaluation components of MHI project work and evaluation
b. Monitor data collection plan
c. Ensure appropriate implementation or adaptation of evidence-based or promising practices
d. Design/develop project-specific performance measures
e. Report quarterly and annual evaluation results via Microsoft Excel
f. Develop project pre/post-tests, surveys, data collection forms, or other tools to evaluate project
g. Coordinate Minority Health Initiative data collection activities at the local level
h. Develop a reporting mechanism for collecting community- and program-level data
i. Analyze community- and program-level data and present findings (to sub-grantees, others as appropriate)
j. Participate in at least one initial grant meeting and subsequent meetings as necessary and appropriate
k. Participate in at least one initial meeting with the MHI overall evaluators
l. Track progress toward performance measures
m. Track indicators, progress toward overall planned result
n. Track fidelity to evidence-based or promising practices

It is strongly recommended that local project evaluators meet the following qualifications:

1. 3 to 5 years of experience as an evaluator of community-based programs
2. Good interpersonal, oral, and written communication skills
3. Experience with SPSS, SAS, or other statistical software and have basic to mid-level statistical analytical skills
4. Ability to travel
5. Master's degree preferred
6. Experience as a public health program evaluator and/or other community-based programs preferred

2017-2019 Minority Health Initiative
Data Requirements

Successful applicants will need to submit the following data for each client served under Minority Health Initiative funding, each quarter. Data collection forms are available for this purpose, but data may also be exported into Microsoft Excel from electronic health record (EHR) or other electronic systems. As long as the following data points are available in Excel format, grantees will not be required to use the DHHS Data Report Form.

a. Project-specific pieces – based on indicators and performance measures selected for the project
b. Date first served by the MHI project
c. Refugee status
d. Medicaid status
e. Private insurance status
f. Preferred/primary language
g. Age
h. Gender
i. County of residence
j. Race – self-identified
k. Ethnicity – self-identified

Minority Health Initiative 2017-2019
Glossary

Body mass index (BMI): measure of body fat based on height and weight

Capacity building: methods for sharing knowledge, developing skills, and creating institutional systems and capacity; these methods may include training, technical consultation and services, information packaging and dissemination, and technology transfer activities

Cardiovascular disease (CVD): health problems related to a process called atherosclerosis. Atherosclerosis is a condition that develops when a substance called plaque builds up in the walls of the arteries. This buildup narrows the arteries, making it harder for blood to flow through. If a blood clot forms, it can stop the blood flow. This can cause a heart attack or stroke.

Case management: advocacy and guidance activities that help patients understand their current health status, what they can do about it, and why those treatments are important; and guide patients and provide cohesion to other health care professionals, enabling individuals to achieve health goals effectively and efficiently

Chronic diseases: illness that lasts three months or longer, generally cannot be prevented by vaccines or cured by medications, and do not disappear over time

Chronic disease self-management plan: structures that address problems from the patient perspective, and encompass traditional knowledge-based patient education; processes that develop patient problem-solving skills, improve self-efficacy, and support application of knowledge in real-life situations that matter to patients; and incorporate community self-management resources; the Stanford Chronic Disease Self-Management Program (CDSMP) is one example

Collective impact: structured process for cross-sector leaders to address a specific social problem, deploying a disciplined approach; includes 5 key elements: common agenda, shared measurement, reinforcing activities, continuous communication, backbone support

Community health worker/community health representative/promotora: an umbrella term used to define other professional titles; an individual who serves as a liaison/link between public health, health care, behavioral health services, social services, and the community to assist individuals and communities in adopting healthy behaviors; conducts outreach that promotes and improves individual and community health; facilitates access to services, decreases health disparities, and improves the quality and cultural competence of service delivery in Nebraska; a trusted member of, or has a good understanding of, the community they serve; able to build trusting relationships and link individuals with the systems of care in the communities they serve; builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

De minimis rate: defined here as defined in 2 CFR § 200, an alternative to an indirect cost rate, available only to entities that have never received a negotiated indirect cost rate; these entities may use 10% of modified total direct costs

Diabetes self-management education (DSME): ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care; process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards; supports informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life

Direct costs: Any cost that can be identified specifically with a particular project or program. Must be supported with source documentation (e.g., payroll time sheets, general ledger tracking of benefits, and receipts for line items purchased); direct costs cannot be included in an indirect cost rate, if an indirect cost rate is proposed

Disallowed costs: costs not allowed under Minority Health Initiative 2017-2019 funding. See Attachment B: Disallowed Costs

Equipment: tangible personal property having a useful life of more than one year and a per-unit acquisition cost of more than $5,000

Evaluation: systematic study conducted to assess how a program/intervention is working, typically examines achievement of objectives in the context of other aspects of program performance or in the context in which it occurs

Evaluator: someone whose job is to judge the quality, importance, amount, or value of something

Evidence-based: a policy, program or service that has been evaluated and demonstrated to be effective in preventing health problems based upon the best-available research evidence, rather than upon personal belief or anecdotal evidence

Fringe benefits: allowance and services provided by employers to their employees as compensation in addition to regular salaries and wages; including but not limited to costs of leave (vacation, family-related, sick, or military), employee insurance, pensions, and unemployment benefit plans

HbA1c: (also known as A1c, glycated hemoglobin, or glycosylated hemoglobin) a blood test that correlates with a person's average blood glucose level over a span of a few months. It is used as a screening and diagnostic test for pre-diabetes and diabetes. A healthy A1C target is <9.

Health system: the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations

Hypertension: condition in which the long-term force of the blood against your artery walls is high enough that it may eventually cause health problems, such as heart disease. Blood pressure is determined both by the amount of blood your heart pumps and the amount of resistance to blood flow in your arteries. The more blood your heart pumps and the narrower your arteries, the higher your blood pressure.

Incentives: something that motivates or encourages someone to do something; a payment or concession used to stimulate greater investment or output

Indicator: a measure which helps to quantify the achievement of a result

Indirect costs: costs incurred for common or joint purposes, and are usually allocated among an entity's programs in proportion to each program's share of direct costs

Interpretation: rendering of oral messages from one language to another

May: denotes discretion

Medical home: team-based health care delivery that is led by a healthcare provider and intended to provide comprehensive and continuous medical care to patients, with the goal of obtaining maximized health outcomes

Modified total direct costs: all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel, and subawards and subcontracts up to the first $25,000 of each subaward or subcontract; excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs and the portion of each subaward and subcontract in excess of $25,000

Must: Denotes the imperative, required, compulsory or obligatory

National Diabetes Prevention Program (NDPP): A CDC-recognized lifestyle change program is a proven way to prevent or delay type 2 diabetes

Objective: a change that is desired, is measurable over a period of time and for a specific target group; the basis of program activities

Output: activities undertaken in implementation of a work plan

Outcome: statement of an intended result

Performance accountability: focuses on the well-being of client/customer populations and how well programs, agencies, and service systems implement programs

Performance measure: measure of how well a program, agency, or service system is working

Program income: income generated by or resulting from an activity or program supported by grant funding, collected from a program for donations, class fees, or third-party payments; should be used to defray costs of service delivery

Result: a condition of well-being for children, youth, families, or communities; stated in plain language

Results-based accountability: data-driven, decision-making process to help communities and organizations get beyond talking about problems to taking action to solve problems

Social determinants of health: conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks

Report complete date: date report has been assessed by Project Officer and found to be free of missing or inaccurate information and in the correct forms and formats; this date marks the beginning of the 45-days DHHS has to make a payment

Report due date: deadline for submission of reports to the approved reporting system, per the schedule on page 9 of the RFA

Report submission date: date grantee indicates report is ready for assessment by Project Officer

Shall: Denotes the imperative, required, compulsory or obligatory.

Should: Indicates an expectation.

Story Behind the Data: an analysis of the conditions, causes and forces at work that helps explain why a baseline of an indicator looks the way it does

Strategy: a coherent collection of actions that has a reasoned chance of improving results and indicators

Supplies: tangible personal property having a useful life of less than one year and a per-unit acquisition cost of less than $5,000

Supportive services: interpretation, translation, childcare, and transportation
Taxes: Social Security and Medicare contributions made by employers; the amounts match what is withheld from employee paychecks, and both amounts are remitted to the federal government
Translation: rendering of written information from one language to another
Will: Denotes the imperative, required, compulsory or obligatory