REDUCING RACIAL AND ETHNIC HEALTH INEQUITIES CLOSING THE GAP GRANT PROGRAM (CTG)

RFA #20-0001

APPLICATION GUIDELINES

FY 2020-2021

Florida Department of Health

Office of Minority Health and Health Equity

Application Deadline:

April 16, 2020

Issuance Date: March 25, 2020

Please direct all questions about the online application process and related issues to:

Florida Department of Health
Office of Minority Health and Health Equity (OMHHE)
4052 Bald Cypress Way Bin A25
Tallahassee, Florida 32399-1744
Submit questions by email with the subject heading "RFA# 20-0001 Questions" to
RequestforApplication@flhealth.gov.

FUNDING ANNOUNCEMENT

The Florida Department of Health (Department), through its Office of Minority Health and Health Equity (OMHHE), announce the availability of funding for Fiscal Year (FY) 2020-2021 awards of the Minority Health Initiative: Closing the Gap (CTG) grant program to eliminate racial and ethnic health disparities and improve minority health outcomes.

Purpose: The CTG grant program seeks to promote the improvement of minority health outcomes and the elimination of health disparities through the development of closely coordinated community-based and neighborhood-based projects.

Eligibility: Any person, entity, or organization within a county may apply for a CTG grant and may serve as the lead agency to administer and coordinate project activities within the counties and develop community partnerships necessary to implement the grant, pursuant to section 381.7354 Florida Statutes.

Estimated Funds Available: Approximately $1.2 million, subject to the funding amount appropriated for FY2020-2021 by the Florida Legislature.

Anticipated Number of Awards: The number of awards is dependent upon the availability of funds, number of applications, and the amount of funding requested from each Applicant.

Range of Awards: The amount of award per applicant may vary. There are no minimum or maximum amounts for grant awards.

Type of Award: Grant

Budget Period: Eleven Months

Program Period: Estimated to be from August 01, 2020 – June 30, 2021

THIS IS NOT A COMPETITIVE PROCUREMENT SUBJECT TO THE REQUIREMENTS OF CHAPTER 120, FLORIDA STATUTES.

TIMELINE
RFA 20-0001

Applicants must adhere to the RFA timelines as identified below. It is the applicants' responsibility to regularly check the Vendor Bid System and the Department's website for updates.

Schedule	Due Date	Location/Notes
Request for Applications Released and Advertised	**03/25/2020**	Department of Health Grant Funding Opportunities Website: http://www.floridahealth.gov/about/administrative-functions/purchasing/grant-funding-opportunities/index.html Vendor Bid System: <<OPTIONAL>> http://vbs.dms.state.fl.us/vbs/main_menu
Submission of Questions	**03/31/2020**	Submit questions by email with the subject heading "RFA#_20-0001 Questions" to RequestforApplication@flhealth.gov.
Answers to Questions Posted on website	**04/03/2020**	Department of Health Grant Funding Opportunities Website: http://www.floridahealth.gov/about/administrative-functions/purchasing/grant-funding-opportunities/index.html Vendor Bid System: <<OPTIONAL>> http://vbs.dms.state.fl.us/vbs/main_menu
Applications due (no faxed or e-mailed applications)	**Must be received by 04/16/2020, 09:00PM** Eastern Standard Time	To upload your application, go to the Department of Health RFA Automated System https://requestforapplications.floridahealth.gov.
Anticipated evaluation of applications	**04/20/2020**	Review and Evaluation of Applications Begins
Award/Post Selected Providers Anticipated Date	**04/28/2020**	Department of Health Grant Funding Opportunities Website: http://www.floridahealth.gov/about/administrative-functions/purchasing/grant-funding-opportunities/index.html Vendor Bid System: <<OPTIONAL>> http://vbs.dms.state.fl.us/vbs/main_menu
Contract Negotiations Anticipated Date	**05/18/2020**	Contract negotiations with selected providers begins.
Anticipated Contract Execution Date	**08/01/2020**	Contracts established between the Department and CTG providers.

DEFINITIONS

1. **Applicant:** Any person, entity or organization that submits an application in response to this RFA.
2. **Community:** A body of people living in the same locality or having a common language or interest or populations living and interacting with one another in a particular environment.
3. **Contract:** A formal agreement or order that will be awarded to an applicant under this RFA, unless indicated otherwise.
4. **Contract Manager:** An individual designated by the Department to be responsible for the monitoring and management of the resulting Contract.
5. **Determinants of Health:** The range of personal, social, economic, and environmental factors that influence health status are known as determinants of health.
6. **Diversity:** The condition of having or being composed of differing elements, especially, the inclusion of different types of people (as people of different races or cultures) in a group or organization.
7. **Evidence-Based Intervention (EBI):** An intervention designed to implement one or more strategies linking public health or clinical practice recommendations to scientific evidence of the effectiveness and other characteristics of such practices recommended by the Community Preventative Service Task Force (CPSTF).
8. **Federally Qualified Health Centers (FQHCs):** All organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.
9. **Guide to Community Preventive Services:** A free resource of evidence-based recommendations and findings from the CPSTF (https://www.thecommunityguide.org/).
10. **Health Inequities:** Differences in health status or health resources between different populations resulting from social and/or economic disadvantage. Health inequities adversely affect groups of people who have systematically experienced greater social or economic barriers to health or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographical location; or other characteristics historically linked to discrimination or exclusion.
11. **Health Equity:** The attainment of the highest level of health for all people.
12. **Health in All Policies (HiAP):** Collaborative approach that integrates and articulates health considerations into policymaking across sectors, and all levels, to improve the health of all communities and people
13. **Health Outcomes:** Change in the health status of an individual, group, or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.
14. **Health System:** A group of independent, interrelated elements (i.e. individuals, institutions, and infrastructures) that form a unified whole to promote and protect the health of people through the implementation of essential public health services.
15. **Implementation Plan (IP):** A summary of the formalized strategy adopted by an applicant which outlines action steps that will be taken within the funding period and beyond to increase outreach, awareness, training, education, screening, and referrals.

16. **National Minority Health Month:** Led by the United States Department of Health and Human Services, health and health equity partners and stakeholders are encouraged to work across public and private sectors to collaborate on initiatives to reduce inequities, advance equity, and strengthen the health and well-being of all Americans in the month of April.
17. **Minority Racial and Ethnic Populations:** African Americans/Black, Hispanic/Latino Americans, Asian Americans, Native Hawaiian/Other Pacific Islanders, American Indians, and Alaska Natives.
18. **Partner Organizations:** Organizations the applicant will partner with to provide services related to the contract either directly or indirectly.
19. **Policies:** Laws, regulations, and formal rules that are adopted to guide individual and collective behavior within an organization.
20. **Priority Area:** The eleven health areas identified in the statute: adult and child immunization, Alzheimer's disease and related dementias, cancer, cardiovascular disease, diabetes, HIV/AIDS, lupus, maternal and infant mortality, oral health, sickle cell disease, and social determinants of health.
21. **Priority Population:** The racial/ethnic group identified by an applicant in its RFA application.
22. **Project:** The applicant's proposal intended for funding through this grant.
23. **Reducing Racial and Ethnic Health Inequities Closing the Gap (CTG) Grant Program**: Programs promoting coordinated efforts to reduce and eliminate racial and ethnic health inequities in Florida.
24. **Reducing Structural Barriers:** A process using interventions to decrease structural barriers, which are non-economic obstacles that make it difficult for people to access needed services (e.g., inconvenient hours or days of clinical service, transportation costs, unpaid sick leave).
25. **Service Area:** The geographic level to which program services will be directed (i.e. county, zip code, census tract, community, neighborhood).
26. **Social Determinants of Health (SDOH):** Conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.
27. **Socioeconomic Status:** A measure of the relative influence wielded by an individual, family, or group because of their income, education, and occupation. Socioeconomic status is linked to a wide range of health problems, including low birth weight, cardiovascular disease, hypertension, arthritis, diabetes, and cancer.
28. **Systems Change:** Occurs when one or several elements in a system are markedly improved, substantially altering the relationship of elements to one another and the overall structure of the system itself.
29. **"Tools for Putting Social Determinants of Health into Action":** A compilation of tools and resources from the Centers for Disease Control and Prevention (CDC) to help practitioners taking action to address SDOH which is available at: https://www.cdc.gov/socialdeterminants/tools/index.htm.
30. **Underinsured Populations:** Populations who have health insurance but face significant cost sharing or limits on benefits that may impact their ability to access or pay for needed health services.
30. **Vendor Bid System (VBS):** Refers to the state of Florida internet-based vendor information system, which is available at: http://www.myflorida.com/apps/vbs/vbs_www.main_menu
31. **Vulnerable Populations:** Populations who are at greater risk of experiencing poor health outcomes due to social and economic factors such as place of residence, income, current health status, age, race/ethnicity, persons with disability, sexual orientation and distribution of wealth and resources.

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NOTE: All awards in response to this Funding Opportunity are subject to the availability of funds and spending authority provided by the Florida Legislature. By submitting a grant application pursuant to this Funding Opportunity, all applicants acknowledge and consent to this condition.

Section 1.0 INTRODUCTION

1.1 Program Authority

The "Reducing Racial and Ethnic Health Inequities: Closing the Gap Act" is authorized by sections 20.43 (9) and 381.7351 - 381.7356, Florida Statutes.

1.2 Notice and Disclaimer

The CTG grant program is governed by sections 20.43 (9) and 381.7351 through 381.7356, Florida Statutes, "Reducing Racial and Ethnic Health Inequities: Closing the Gap Act." Pursuant to this Act, by this publication the Florida Department of Health (Department) gives notice of the expected availability of funds and its application process for submitting grant proposals.

Grant awards, if any, will be determined by the Department in accordance with the terms of this RFA. The Department reserves the right to offer multiple grant awards if it deems it is in the best interest of the State of Florida and the Department. Additionally, the Department reserves the right to negotiate with applicants prior to the offer of a grant award or execution of the contract. If during the grant funding period, the Department's authorized funds are reduced or eliminated, the Department may immediately reduce or terminate the grant award by written notice to the selected applicants. The termination or reduction will not apply to allowable costs already incurred by the selected applicants to the extent that funds are available for payment of such costs.

Materials submitted will become the property of the State of Florida. The Department reserves the right to use any concepts or ideas contained in the application.

Note: The receipt of applications in response to this publication does not imply or guarantee that any one or all qualified applicants will result in a contract with the Department.

1.3 Program Purpose

The Reducing Racial and Ethnic Health Inequities "Closing the Gap" grant program is seeking applications that employ evidence-based intervention (EBI) strategies to advance minority health outcomes, promote the reduction of health inequities, forge sustainable partnerships, and enhance prevention and health promotion efforts focused towards CTG priority areas through closely coordinated community-based projects in Florida. All activities and services proposed must be delivered in a culturally and linguistically appropriate manner, and include diverse populations, including persons with disabilities. Proposed strategies must address inequities in at lest one of the eleven priority areas, outlined in section 381.7355, Florida Statutes.

1.4 Available Funding

The total funding for this opportunity is based on the eleven priority areas outlined below and in section 381.7355, Florida Statutes:

Adult and Child Immunizations
Alzheimer's Disease and Related Dementias (ADRD)
Cancer
Cardiovascular Disease
Diabetes
HIV/AIDS
Lupus
Maternal and Infant Mortality
Oral Healthcare
Sickle Cell Disease
Social Determinant of Health (SDOH)

Proposals will be awarded to eligible applicants as funding allows. The amount of award per applicant may vary and is based on the merits of the application, size of the target population, scope of work, and geographic area of the proposal. Budgets must also be justified by proposal activities.

1.5 Matching Funds

In-kind matching of funds is encouraged in the form of free services and non-personnel resources. CTG program grants will be awarded on a matching basis. The funds must be matched at a ratio of one dollar in local (non-state) funds for every three dollars of grant funds provided by the CTG program grant except:

a) In counties with populations greater than 50,000, up to 50 percent of the local match may be in kind in the form of free services or human resources. Fifty percent of the local match must be in the form of cash.

b) In counties with populations of 50,000 or less, the required local matching funds may be provided entirely through in-kind contributions.

c) Grant awards to Front Porch Florida Communities shall not be required to have a matching requirement.

Within 10 days of notification of award, applicants must provide proof of an established account with funds specifically identified as match dollars for CTG program. Verification must be in the form of a certified bank statement, or other Department approved documentation, and submitted by an individual authorized to do so on behalf of the applicant. Funding acquired to provide other services may not be used as cash match.

Section 2.0 PROGRAM OVERVIEW

2.1 Background

Chronic diseases such as heart disease, cancer, stroke, and diabetes are the leading cause of death and disability in the United States. These conditions are often exacerbated by unhealthy behaviors tobacco use, poor nutrition, limited physical activity and/or inequitable access to healthcare services. Minority populations, particularly African Americans/Black, Hispanic/Latino Americans, Asian Americans, Native Hawaiian/Other Pacific Islanders, American Indians, and Alaska Natives are disproportionately impacted.

The SDOH are defined as the conditions in which people live, learn, work, play, and worship and can impact health and produce inequities. The determinants that negatively impact health and wellbeing include poverty; limited access to quality education or employment; inadequate housing; unfavorable work and neighborhood conditions; exposure to neighborhood violence; and the clustering of disadvantaged groups of people and places. Yet, current intervention strategies to reduce health inequities do not typically take a "life-course perspective" and tend to be disease-specific, often targeting individual and health systems factors without addressing SDOH.

Interventions targeting individual-level factors include improving health and lifestyle behaviors; reducing socio-contextual barriers, such as access to adequate food and employment resources or support for issues such as domestic violence; and delivering health programs that are culturally and linguistically tailored to specific individuals or groups. Health system interventions that address discrimination, access to care, and quality of care are also important. However, these approaches are not enough to address social determinants such as neighborhood conditions or poverty, which are also fundamental drivers of persistent health inequities. Policy, social norm and system change are the major components needed to achieve, support and sustain SDOH initiatives focused on improving health outcomes.

The CTG grant program works within the Department's mission to promote and protect the health and safety of all people in Florida by promoting holistic approaches to address the priority areas. This ideology is centered upon multilevel interventions that consider the complex interaction between individuals and their environments to better address the determinants of health and enhance priority area prevention and health promotion for local communities.

Over the years, the CTG grant program, through a competitive procurement process, has contracted with providers to stimulate the development of community-based and neighborhood-based projects that will improve the health outcomes of Florida's minority populations, including persons with disabilities within Florida counties. Further, the CTG grant program aims to foster the development of coordinated, collaborative, and broad-based participation by entities, either public and private, or faith-based organizations.

2.2 Program Expectations

The applicant will be responsible for establishing, expanding, or enhancing an infrastructure, partnerships, and agreements within their proposal and define how funding will facilitate the monitoring and adoption of EBIs that increase access to, and utilization of priority area services prioritized by this RFA. **Grants will be awarded to Applicants who identify and address the following:**

1. Identify Priority Area
Applicants must select one or more of the eleven priority areas as defined by 381.7355, Florida Statute:

1) Decreasing racial and ethnic inequities in maternal and infant mortality rates.
2) Decreasing racial and ethnic inequities in morbidity and mortality rates relating to cancer.
3) Decreasing racial and ethnic inequities in morbidity and mortality rates relating to HIV/AIDS.
4) Decreasing racial and ethnic inequities in morbidity and mortality rates relating to cardiovascular disease.
5) Decreasing racial and ethnic inequities in morbidity and mortality rates relating to diabetes.
6) Increasing adult and child immunization rates in certain racial and ethnic populations.
7) Decreasing racial and ethnic inequities in oral health care.
8) Decreasing racial and ethnic inequities in morbidity and mortality rates relating to sickle cell disease.
9) Decreasing racial and ethnic inequities in morbidity and mortality rates relating to lupus.
10) Decreasing racial and ethnic inequities in morbidity and mortality rates relating to Alzheimer's disease and dementia.
11) Improving neighborhood social determinants of health, such as transportation, safety, and food access, as outlined by the Centers for Disease Control and Prevention's "Tools for Putting Social Determinants of Health into Action."

2. Identify Service Area
Applicants must determine a service area of interest, reach and need. All applicants must use and cite an accredited data source or report (e.g. community health needs assessment, FLHealthCHARTS, US Census, Community Commons, etc.) to substantiate the selection of their service area.

3. Identify and Define Target Population
Applicants must clearly define which persons are eligible for proposed priority area services using population data from the selected service area. Applicants should select one or more of the following five minority populations, listed below, as their target population(s) for their intended programmatic activities: African American/Black, Hispanic/Latino, Asian American, American Indian/Alaska Natives, Native Hawaiian/Other Pacific Islanders. Persons with disabilities should always be considered in the development and distribution of said priority area services. **Applicant must define and describe their target population by the following:**

1. Demographic breakdown
2. Relevance of the target population to the priority area(s)
3. Baseline health status data
4. Health inequities/health disparities

4. Identify EBIs related to the selected priority area

Applicants must utilize EBIs for each priority area of focus to help facilitate effective and efficient distribution and delivery of priority area services in said service area. Refer to Appendix A for a list of EBIs that may be used. **Please specify the selected EBI(s) in your application.**

All activities and services must be evidenced-based, delivered in a culturally and linguistically appropriate manner, and prioritize minority populations, including persons with disabilities

5. Address specific needs of target population
Applicants must explain how they will identify and address the specific needs of their target population that may fall outside the focus of their priority area(s). Without addressing the social determinants of health, particularly as it relates to evidence-based prevention, intervention, and local policy initiatives, it is difficult to adequately address the priority area(s).

2.3 Organizational Capacity

The Department is committed to continuity of the current state and community interventions and enhancements to meet the needs of all Floridians for the elimination of health inequities. The Department is seeking grantees with the capacity to deliver quality EBIs to Florida's residents.

The Department desires the successful grantees to have prior work experience working with racial and ethnic minority populations in a culturally competent manner as well as the following qualifications and demonstrated prior work experience:

1. Possess the organizational capacity required to make a change to a specific public health issue or community concern.
2. Mobilized or contributed to the mobilization of the community regarding a specific public health issue or community concern resulting in a policy change.
3. Maintained or participated in a community partnership implemented to promote for or change a specific public health issue or community concern.
4. Promoted for or changed a specific public health issue or community concern.
5. Used media to bring public awareness for a specific public health issue or community concern.

Applicants applying for funds to support implementation within their organization should demonstrate achievements from prior quality improvement efforts focused on one of the eleven priority areas, if applicable. Achievements highlighted should include how improvements in systems were measured, improvement efforts were monitored, how performance measures changed and improved, and how the changes made were sustained.

Section 3.0 TERMS AND CONDITIONS OF SUPPORT

3.1 Eligible Applicants

A CTG grant program may be awarded to any person, entity, or organization within a Florida county. This application does not exclude current or past CTG applicants. Persons, entities, or organizations within adjoining counties, with populations of less than 100,000 based on the annual estimates produced by the Population Program of the University of Florida Bureau of Economic and Business Research (https://www.bebr.ufl.edu/population) may submit multi-county proposals if the populations served are representative of those to benefit from the activities of the RFA. The proposal must clearly identify a single lead agency who will be responsible for overseeing and ensuring the completion of the approved project. The populations of a multi-county proposal will be combined for determining match obligations as indicated in Section 1.5 – Matching Funds.

3.2 Minority Participation

In keeping with the One Florida Initiative, the Department encourages minority business participation in all its procurements. Applicants are encouraged to contact the Office of Supplier Diversity at (850) 487-0915 or visit their website at http://osd.dms.state.fl.us for information on becoming a Florida Certified minority owned business enterprise (MBE) or for names of existing Florida Certified MBEs who may be available for subcontracting or supplier opportunities.

3.3 Corporate Status

For all corporate applicants, proof of corporate status must be provided with the application. Tax-exempt status is not required, except for applications applying as non-profit organizations. Tax-exempt status is determined by the Internal Revenue Service (IRS) Code, Section 501(c)(3). Any of the following is acceptable evidence:

a. A statement from a state taxing body, State Attorney General, or other appropriate state official, certifying that the applicant has a non-profit status and that none of the net earnings accrue to any

3.4 Non-Corporate Status

Documentation that verifies the official not-for-profit status of an organization in accordance with Chapter 617, Florida Statutes.

3.5 Period of Support

The term of any contract resulting from this RFA will be for a period of eleven months anticipated to begin August 01, 2020 and ending June 30, 2021.

3.6 Use of Grant Funds

Applicants must provide a detailed description of how the funds will be used. Costs not allowed for this program may be found at https://www.myfloridacfo.com/Division/AA/Manuals/documents/ReferenceGuideforStateExpenditures.pdf

Section 4.0 APPLICATION AND SUBMISSION INFORMATION

4.1 Application Forms

Applicants must use the official forms attached to this RFA. Alternate forms may not be used. All required forms and content should be submitted in one document in the order and formatting set forth in this RFA. Applications for funding must address all sections identified below in the order presented and in as much detail as requested. The provision of extraneous information should be avoided. Applicants must adhere to the page limits as identified below.

4.2 Application Format

1. Applicants are required to complete, sign, and return the "Cover Page" (See 8.1) with the application.
2. Applications should be single-spaced and written in Times New Roman or Arial 12-point font.
3. Applications pages should contain 1" margins and be numbered consecutively.
4. Applications Headers should identify each section and Footers should include the name of the organization and page number.

4.3 Order of Application Package

Provide the following items in the following order in the application package:

1. Cover Page – (One Page Limit)
2. Table of Contents – (Two Page Limit)
3. Project Abstract – (One Page Limit)
4. Project Narrative – (Eighteen Page Limit)
5. Project Evaluation – with logic model **– (**Six Page Limit**)**
6. Budget Summary – (One Page Limit)
7. Budget Narrative – (Three Page Limit)
8. Attachments

Note: Any application not meeting the specific requirements will be returned with notification of failure to comply with RFA guidelines.

4.4 Cover Page

One Page Limit

Each copy of the application must include a signed Cover Page (See 8.1) which contains the following:

1. RFA number
2. Title of the application
3. Legal name of the organization or individual (applicant's legal name)
4. Applicant's mailing address, including city, state and zip code
5. Telephone number, fax number and email address of the person who can respond to inquiries regarding the application
6. Federal Employer Identification Number (FEIN)
7. Total amount of grant funding requested
8. Contact person for negotiations
9. Name, title, and signature of the person authorized to submit the application on behalf of the applicant

11. County, or counties, to be served
12. Priority Area(s) covered

4.5 Table of Contents

Two Page Limit

The application must contain a table of contents with page numbers identifying major sections of the application. The table of contents is not included in the project narrative page limit.

4.6 Project Abstract

One Page Limit

A project abstract must identify the main purpose of the project, the priority population to be served, types of services offered, the area to be served, and expected outcomes. In addition, applicants should specify within their Project Abstract, how the EBI strategies supported through funding will demonstrate short term impact within the grant period as well as potential for long term sustained impact through specific, measurable, achievable, realistic, and time-bound (SMART) objectives.

4.7 Project Narrative

Eighteen Page Limit

The Project Narrative is limited to 18 singled spaced pages and shall not exceed the maximum number of pages for each section. If the narrative exceeds the page limit, only the first pages written within the page limit will be reviewed. Applicants should provide enough details for reviewers to be able to assess the project appropriateness and merit. Key components of the Project Narrative include:

1. Organizational Overview
2. Statement of Need
3. Project Description
4. Project Management Plan
5. Collaboration
6. Workplan
7. Implementation Plan

Note: The 18-page limit applies specifically to the Project Narrative. Page limits for other sections of the application are specified in the appropriate section. Required forms are not counted as part of the Project Narrative page limit (See Section 8.0 for the required forms).

4.7.1 Organizational Overview

Two Page Limit

The organizational overview should identify the overall mission and purpose of the project and how it relates to the purpose of this RFA. The organizational overview should also:

1. Identify the focal populations to be served, types of prevention and intervention activities offered, the area to be covered by the project, expected overall outcomes, and the applicant's experience related to preventing, addressing and eliminating health disparities.
2. Demonstrate the organization's capacity and ability to direct, perform, and complete the proposed activities including project management experience.
3. Demonstrate the organization's background or experience establishing partnerships and connections with other organizations and how those connections interface with the applicant's organization.
4. Indicate operating hours.
5. Indicate plans for sustainability.

4.7.2 Statement of Need

Two Page Limit

The Statement of Need will be used to describe the need for the proposed project. Applicants must include in narrative form all the following information:

1. Demographic information about the focal population to be served in the proposed target county (or counties) under this project.
2. Justification for the need of funding to address health inequities in the targeted area, including strengths and challenges.
3. Impact of the problem on the identified target population.
4. Prevalence of health inequities that exist within the county or areas proposed.
5. Risk factors and other health or social indicators that contribute to the problem.
6. Previous and current efforts and outcomes undertaken to address minority health and health inequities including any collaborations with health entities, local governmental agencies, civic associations, and others that show experience with the identified problem and target population.
7. The sources of all data and statistics used to validate the need.
8. A comparison of data for the proposed project geographic area with statewide averages to demonstrate relative need for the project.
9. Sources of other funds currently received by the applicant to support proposed activities. Explain how the funding requested under this program will be used differently than the funding already received for the proposed activities.
10. Identify other health inequities programs operating in the county serving the same population proposed to be served under this project. Applicant should explain how it proposes to avoid duplication of existing services or how the proposed program will enhance or differ from services provided by existing programs.

4.7.3 Project Description

Four Page Limit

In narrative format explain how the services will be provided to address the needs identified in the Statement of Need section (Section 4.7.2). Applicants must include all of the following information:

1. Activities to be conducted as a result of this funding including the timeframes for implementation. Describe all strategies to be used for policy initiatives, prevention, intervention, education and outreach.
2. An explanation of how and to whom activities will be implemented. Include the intended focal population, the total number of unduplicated individuals that will benefit from each activity, the area/s served and/or locations and settings in which activities will commence. Be as specific as possible including descriptions,

such as number and length of classes (e.g., ongoing or repeated, number of hours and sessions offered, number in each session or activity etc.).

3. Strategies to address potential barriers to the provision of the activities proposed.
4. A description of plans to collaborate with organizations and health care systems to conduct outreach, recruit for program activities and provide referrals for follow-up services.
5. Lists of intended outcomes or specific changes expected as a result of program activities.
6. A description of how the program will be staffed, (e.g., paid staff and/or volunteers, consultants and subcontracts). Identify the number and type of positions needed, which positions will be full-time, and which will be part-time, and qualifications proposed for each position, including type of experience and training required. Applicant must explain how staff and volunteers are recruited as well as how consultants and subcontractors are procured.

4.7.4 Project Management Plan

One Page Limit

1. Outline, in narrative form, a detailed project management plan that defines how the project is executed, monitored, and controlled by the applicant. The objective of the project management plan is to define the approach to be used by the applicant to deliver the intended activities of the project (**See Attachment 2).**

2. The Project Management Plan must outline how the applicant will handle any issues, including remedies, to be taken if project timeline changes occur. Describe the contingency plan if the targeted monthly totals will not be reached; how resources will be redirected to successfully carry-out the proposed project; and how the applicant plans to sustain the program once grant funding ends.

3. Administration and management strategies that will be used in the grant must include or indicate the following:
   a. Relevant qualifications of proposed key staff for the project. Provide a resume for each proposed staff.
   b. The level of effort for each proposed key staff position (e.g. 50%, 75%), including pertinent staff provided on an in-kind basis.
   c. Position or job descriptions related to the project for staff positions, including those to be filled.

4.7.5 Collaboration

Three Page Limit

A. This section must describe the planned efforts to partner with other organizations within the local community to deliver the proposed project as described in the Program Description (section 4.7.3) for the benefit of the identified focal population. Collaboration may also be considered as a means of ensuring program sustainability once grant funding ends. Applicants must identify the following information in narrative form:

1. The collaborative process used to plan and implement the proposed project. Describe who will be involved, how these relationships will be maintained, the expected roles and responsibilities of each organization, and assurances that there is no duplication or overlap of services.
2. For each collaborative partner, describe their role, activities, and expected outcomes as a result of their input.
3. Evidence of collaborative partnerships. Documentation may be provided in the Appendix section of application (See Appendices Section 4.10).

4.7.6 Workplan

Three Page Limit

This section must describe how the proposed project will be carried out and linked to the objectives and needs.

Applicants must submit a work plan using SMART objective for implementation of proposed activities, including activities which will be conducted to meet each objective each month, methods used to assess whether or not objectives are met, timeframe, and the individual responsible for carrying out each activity. All awardees will be expected to submit an updated work plan in the frequency specified in the resulting contract. **A sample work plan template is provided below (see Attachment 1).**

4.7.7 Implementation Plan

Three Page Limit

The following areas are required in the applicant's Implementation plan:

1. Description of current organizational structure including clinic sites, political climate, etc.
2. Description of required EBI strategies to increase screening rates and referrals;
3. Description of the possible barriers and challenges to implementation;
4. List of resources available for implementation;
5. List of program objectives for health system partnership;
6. Description of project monitoring and data review process; and,
7. Description of plans to retain partner organizations, collect screenings, referrals, and priority area services.

4.8 Project Evaluation

Applicants will provide their process for evaluating program activities within their proposed project. The preliminary evaluation plan should define key evaluation questions to be answered, how progress will be measured, how challenges will be identified and addressed and how progress measured through evaluation will be shared with partner organizations involved in the implementation of the project.

The submitted evaluation plan should describe:

- Key stakeholders and their role in the evaluation
- Program logic model
- Expected direct result of an activity (output or product)
- Short-term outcomes tied to each objective (achievable by the end of the funding period)
- Timeline for measuring project progress
- Methods for collecting and analyzing evaluation data
- Process for sharing evaluation results with partner organizations and stakeholders
- Process for using evaluation findings for continuous quality improvement
- Staff and their qualifications for conducting programmatic evaluation

Suggested Resource: CDC Evaluation Framework: (cdc.gov/eval/framework/index.htm).

Evaluation efforts are expected to be implemented to begin at the start of the project to capture and document actions contributing to program outcomes. The evaluation must be able to produce documented results that demonstrate whether and how the strategies and activities funded under the program made a difference in the improvement in access to care services and the elimination of health inequities. OMHHE will provide technical assistance as needed on evaluation during the first two months of the contract to assist with refining the evaluation approach and measurements, with the awardee finalizing the evaluation plan by September 30, 2020.

1. Awardees will evaluate the implementation and measure the outcomes of proposed activities, including quarterly reporting on the strategies and objectives identified in proposed work plans. Measurements may include quantitative and qualitative assessments of service participation; yield from promotional, outreach, and recruitment efforts; and, where possible, increases in knowledge, intended behavior modification, or noted improvements in quality of life measures as a result of participation in the activities provided.
   a. The quarters for reporting will be as follows: Q1. August-September; Q2. October-December; Q3. January-March and Q4. April-June.

2. The evaluation plan must clearly articulate how the applicant will assess program activities starting with assessment of program implementation. The evaluation must be able to produce results that demonstrate whether and how the strategies and activities funded under the program made a difference toward the improvement of minority health and the elimination of health inequities. The evaluation should identify the expected result (i.e., a particular impact or outcome) for each major objective and activity and discuss the potential for replication. The evaluation is an internal process and funds may not be authorized to secure an outside evaluator.

3. The evaluation plan will be reviewed for the following criteria:
   1. Does the evaluation plan include a logic model that helps clearly depict the applicant's program activities and its intended effects?
   2. Does the evaluation plan include core evaluation questions for both process and outcome specific, time-phased, measurable objectives, and indicators of progress?
   3. Does the evaluation plan include detailed information about data collection, analysis, and reporting?
   4. Does the evaluation plan adequately speak to relevant standards for program evaluation planning, implementation, and the use of findings for program accountability and improvement?

Evaluation Resources:

American Evaluation Association. The Program Evaluation Standards. https://www.eval.org/p/cm/ld/fid=103

Centers for Disease Control and Prevention (CDC). (2017). A Framework for Program Evaluation in Public Health. Morbidity and Mortality Weekly Report (MMWR) 1999; Volume 48 (NO. RR-11). https://www.cdc.gov/mmwr/PDF/rr/rr4811.pdf

Lennie, J., Tacchi, J., Koirala, B., Wilmore, M., Skuse, A. (2011) *Equal Access Participatory Monitoring and Evaluation toolkit*.

W.K. Kellogg Foundation Evaluation Handbook

W.K. Kellogg Foundation Logic Model Development Guide

4.9 Budget Summary and Budget Narrative

In addition to filling out the budget summary form a separate budget justification narrative and computation of expenditures must be provided, as outlined below.

Applicants should recognize that the budget should reflect the various phases and activities of planning, organizing, implementation, evaluation, and dissemination.

Budget Summary– One Page Limit (See 8.2)

1. All costs contained in the Budget Summary must be directly related to the services and activities identified in the application. All costs must be presented in the format outlined in this RFA.
2. Indicate the amount of match an organization or a partner agency will be providing for each budget category if there is a match of cash or in-kind services being committed to the project.
3. The method of cost presentation will be a line item budget using the format found in in the document.
4. Administrative or Indirect costs should be directly related to project activities and may not exceed 10% of the salary and fringe benefits.

Budget Narrative – Three Page Limit (See 8.3)

1. Provide a brief justification for each budget line item. Applicants should demonstrate how the proposed expenditures relate to the activities in the work plan or how the proposed expenditures will improve progress towards project objectives in a narrative format.
2. Include only expenses directly related to the project and necessary for program implementation using only the standard heading listed on the budget summary. The budget narrative should match the budget summary.
3. Provide a narrative description of the amount and sources of cash match. Provide similar information on other budget items under the appropriate headings. Participation in an annual CTG workshop is mandatory and must be included in your budget.

4.10 Application Appendices

Applicants should provide the following appendices as applicable. All appendices must be clearly referenced and support elements of the Project Narrative:

Appendix A of the application must include:
1. An organizational table or chart is required for all applicants except individuals.
2. A current roster of the board of directors, including name, address and telephone numbers is required for all applicants except individuals (if applicable)

Appendix B of the application must include:
1. Proposed data collection instruments.

Appendix C of the application must include:
1. No more than a one-page verification of applicant's official status (e.g.., Community-Based Organization (CBO), 501(c)(3), etc.).

Appendix D of the application must include:

1. Letters from the County Health Departments (CHDs) of the counties in which services will be provided outlining any partnerships, referral agreements, and collaborations on the CHD's Community's Health Improvement Plan (CHIP). Letters should be signed by the CHD Administrator, CHD Director, or a designee.

Appendix E of the application must include:

1. Letters of agreement, support, or commitment from organizations where program activities will be implemented that details the collaborative partnerships. Letters with collaborative partners should identify their role and contribution to the project.

4.11 Authorized Signatory

The signature on the application must be that of an authorized official of the organization. An authorized official is an officer of the applicant's organization who has legal authority to bind the organization to the provisions of the RFA and the subsequent grant award. This person is usually the President, Chairman of the Board, Chief Executive Officer, or Executive Director. If a person other than the President, Chairman of the Board, Chief Executive Officer, or Executive Director signs the application, a document establishing delegated authority must be included with the application. The authorized signature certifies that all information, facts, and figures are true and correct and that if awarded a grant, the agency will comply with the RFA; the contract; all applicable state and federal laws; regulations; grant terms and conditions; action transmittals; review guides; and other instructions and procedures for program compliance and fiscal control. The signatory is certifying that these funds will not be used to supplant other resources nor for any other purposes other than the funded program. The organization also agrees to comply with the terms and conditions of the Department as it relates to criminal background screening of the Chief Executive Officer, Executive Director, program director, direct-service staff, volunteers, and others as necessary.

Section 5.0 SUBMISSION OF APPLICATION

5.1 Application Deadline

Applications must be received by the date and time indicated in the Timeline listed above.

5.2 Submission Methods

Electronic Submission of Applications

Applications may only be submitted by uploading to the Florida Department of Health RFA Automated System: https://requestforapplications.floridahealth.gov.

5.3 Instructions for Submission of Applications

Instructions for Electronic Submission of Applications

Applicants are required to submit the electronic application, via the Florida Department of Health RFA Automated System, as follows:

- The application must be signed by an individual authorized to act for the applicant agency or organization and to assume for the organization the obligations imposed by the terms and conditions of the grant.
- The naming convention of the application must follow this format: RFA#-Provider Name-Program Specific Information (Example: RFA20-001-Elimination Inc-Closing the Gap).
- The application must be uploaded into the system by the deadline stated in the Timeline.
- To upload the application, go to https://requestforapplications.floridahealth.gov/. Click the drop-down menu to select the applicable RFA.
- To upload a document for the first time, select Browse, click to choose file(s), then click Upload.
- One or more files may be uploaded at one time. Accepted file types are .pdf, .xls, .xlsx, .doc, and .docx only).
- To upload multiple files, click the keyboard's Ctrl key and select the files. Zero-byte files will be ignored. For the submitted document(s), maximum file size must not exceed 100 MB.
- To replace a previously uploaded document, select Overwrite from the Upload Type drop-down menu. You must enter the session key received with your initial submission confirmation. Click Browse to choose the updated file(s), then click Upload. **Note: In order to properly overwrite the previous upload, the updated file(s) must have the exact same file name as the document(s) being replaced.**

Applicants are encouraged to submit applications early. The applicant must click the Upload button prior to the deadline time in order to receive a successful confirmation. Once the deadline time has passed, the system will no longer offer an option to upload documents for the applicable RFA.

Applicants with inquiries regarding the electronic upload process via the automated system may contact RequestforApplication@flhealth.gov.

Section 6.0 EVALUATIONS OF APPLICATONS

6.1 Receipt of Applications

Applications will be screened upon receipt. Complete applications are those that include the required forms as stated in the Required Forms Section of this application (See 8.0). **Applications with incomplete or missing components will be considered not meeting the minimum requirements for review.** Incomplete applications will be returned with notification that they did not meet the submission requirements and will not be entered into the review process.
Notification of incomplete application will be sent via email from the Contract Manager within 10 business days following the close of the RFA.

6.2 How Applications are Scored

Applications will be scored by Evaluators. Evaluators are selected based on their expertise in priority area prevention strategies, minority health, social determinants of health (SDOH), cultural competency, and their impact on health outcomes, and related issues confronted by minority populations in the state of Florida.

The scoring of proposals establishes a reference point from which to make negotiation decisions. It in no way implies that a contract will be awarded. The maximum points possible 390. Scoring will be in the following categories up to the maximum points indicated for each category:

Reducing Racial and Ethnic Health Inequities "Closing the Gap" (CTG) Grant Program: **Proposal Evaluation Scoring Rubric** ***RFA# 20-0001***		
Prospective Applicant's Name: _____ **Annual Amount Requested:**		
Scoring Criteria		
Staffing and Organizational Capacity: Provides information on staffing levels and organizational capacity that indicates a comprehensive understanding of requirements to complete the local project activities. Criteria to be considered are listed below. **Maximum Possible Score for the Section is 40.**	**Maximum Points Possible**	**Points Awarded**
1. To what extent does the applicant sufficiently demonstrate and clearly identify how the administrative structure of the organization, its mission, services provided, and the overall infrastructure will meet the activities?	10	
2. To what extent does the applicant sufficiently demonstrate and clearly identify the background of the organization and previous related experience, including a brief description of similar projects (if any) that will advance the activities?	10	
3. To what extent does the applicant sufficiently demonstrate and clearly identify the positions, roles, capabilities, and experience of program staff as well the percent of time each is committed to the project activities?	10	
4. To what extent does the applicant sufficiently demonstrate and clearly identify the continuation plan if key staff leave the project	10	

or how new staff will be integrated into the project activities; how volunteers will be recruited, if used; and if subcontractors are used, their role in implementation of the project and experience with similar projects		
	40	
Total Score for Staffing and Organizational Capacity		
Statement of Need and Focal Population: Provides information for each proposed project that indicates a comprehensive understanding of the need for and purpose of the local project activities. Criteria to be considered are listed below. **Maximum Possible Score for the Section is 50.**	**Maximum Points Possible**	**Points Awarded**
1. To what extent does the applicant sufficiently demonstrate and clearly identify the priority population and geographic area proposed to be served by the activities, including age, gender, racial and ethnic background, health inequities, underserved populations, and risk factors?	10	
2. To what extent does the applicant sufficiently demonstrate and clearly identify the need for the activities for the priority focus area in the local community, including any gaps (unmet needs)?	10	
3. To what extent does the applicant sufficiently demonstrate and clearly identify data related to the priority focus area in the community, statewide averages, the population data of the community to be served, and other relevant data?	10	
4. To what extent does the applicant sufficiently demonstrate and clearly identify how the funding, through activities, will impact the problem on the identified priority population?	10	
5. To what extent does the applicant sufficiently demonstrate and clearly identify whether there are any other state or federally funded programs operating in the same county or local community that the project will serve, and if there are other programs, how the applicant plans to ensure that services are not duplicated or funds supplanted and how the proposed project activities will enhance or differ from existing projects?	10	
6. To what extent does the applicant sufficiently demonstrate an understanding of the challenges with community program participation in the priority area?	10	
	60	
Total Score for Statement of Need		
Workplan: Provides a coherent and understandable description of the proposed project that will meet the allowable activities under Section 2.2 of the RFA. Criteria to be considered are listed below. **Maximum Possible Score for the Section is 100.**	**Maximum Points Possible**	**Points Awarded**
1. To what extent does the applicant sufficiently demonstrate and clearly identify how the activities will be implemented?	20	
2. To what extent does the applicant sufficiently demonstrate and clearly identify the anticipated number of individuals that will be served, how this will be accomplished, and how the individuals will benefit from the proposed activities to meet the allowable project activities for the applicable priority focus area in?	20	
3. To what extent does the applicant sufficiently demonstrate and clearly	20	

identify how the proposed activities will meet the outcomes?		
4. To what extent does the applicant sufficiently demonstrate and clearly identify how evidence-based approaches will be integrated in the proposed activities to meet the allowable project activities for the applicable priority focus area will be? If applicable, the applicant identified proposed list of curricula that may be used.	20	
5. To what extent does the applicant sufficiently demonstrate and clearly identify how the roles and responsibilities of collaborative partners will support the proposed activities? To what extent does the applicant sufficiently demonstrate and clearly identify how partners will be recruited and how collaboration may be a means to create sustainability if project funding ends?	20	
	100	
Total Score for Program Description		
Evaluation: Provides evaluation plan for the project activities. Criteria to be considered are listed below. **Maximum Possible Score for the Section is 60.**	**Maximum Points Possible**	**Points Awarded**
1. To what extent has the applicant sufficiently demonstrated the use of a logic model to depict the relationship between program activities and its intended effects.	10	
2. To what extent does the applicant sufficiently demonstrate and clearly identify the project outputs and short-term outcomes?	10	
3. To what extent does the applicant sufficiently demonstrate and clearly identify which staff, including their qualifications, will be evaluating the project activities?	10	
4. To what extent does the applicant sufficiently demonstrate and clearly identify how the success of the activities will be measured?	15	
5. To what extent does the applicant sufficiently demonstrate and clearly identify how the impact of the activities on participants' knowledge, skills, and/or physical capabilities will be measured?	10	
6. To what extent does the applicant sufficiently demonstrate and clearly identify plans to analyze, disseminate, and use evaluation findings to improve quality of program activities?	15	
	70	
Total Score for Evaluation		
Timeline: Provides a timeline that is comprehensive, clear and concise for the project activities. Criteria to be considered are listed below. **Maximum Possible Score for the Section is 40.**	**Maximum Points Possible**	**Points Awarded**
1. To what extent does the applicant sufficiently demonstrate and clearly identify the activities?	10	
2. To what extent does the applicant sufficiently demonstrate and clearly identify the start and end date for each activity?	10	
3. To what extent does the applicant sufficiently demonstrate and clearly identify the person responsible for each activity?	10	
4. To what extent does the applicant sufficiently demonstrate and clearly identify the measures of success for each activity?	10	
	40	
Total Score for Timeline		

Budget: Provides a budget for the proposed project which provides a detailed line item breakdown for all cost items that will be incurred by the proposed project activities. Criteria to be considered are listed below. **Maximum Possible Score for the Section is 50.**	**Maximum Points Possible**	**Points Awarded**
To what extent does the applicant sufficiently demonstrate and clearly identify budget costs that are reasonable and consistent with the purpose, outcomes, and program strategy of the project activities?	20	
To what extent does the applicant sufficiently demonstrate and clearly identify the line item, number of units, the cost per unit, and the total costs?	10	
To what extent does the applicant sufficiently demonstrate and clearly identify that the budget is added correctly?	10	
To what extent does the applicant sufficiently demonstrate and clearly identify that there are no unallowable costs included?	10	
	50	
Total Score for Budget		
Budget Narrative: Provides a budget narrative that corresponds to budget and directly related to the success of the project activities. Criteria to be considered are listed below. **Maximum Possible Score for the Section is 30.**	**Maximum Points Possible**	**Points Awarded**
To what extent does the applicant sufficiently demonstrate and clearly identify the purpose of each line item in the budget and how that item will be implemented to support the project activities?	30	
	30	
Total Score for Budget Narrative		

_____ _____

Review Committee Member's Signature Date

_____

Print Name

Reducing Racial and Ethnic Health Inequities "Closing the Gap" (CTG) Grant Program:

Proposal Evaluation Scoring Rubric

Scoring Criteria	Maximum Points	Score
Staffing and Organizational Capacity	40	
Statement of Need	60	
Project Description	100	
Evaluation	70	
Timeline	40	
Budget	50	
Budget Narrative	30	
Total Possible Score	**390**	

NOTES:

_____ _____

Review Committee Member's Signature Date

_____

Print Name

6.3 Grant Awards

A grant may be awarded in a county, or in a group of adjoining counties from which a multi-county application is submitted. Front Porch Florida Communities grants may also be awarded in a county or group of adjoining counties that are also receiving a grant award.

The amount of the grant award shall be based on the county or neighborhood's population, or on the combined population in a group of adjoining counties from which a multicounty application is submitted, and on other factors, as determined by the Department. The Department may not establish a minimum amount or a maximum amount for grants and shall determine the amount of each award based on the merits of the application. The Department shall ensure that grants are awarded to applicants in various regions of the state, pursuant to section **381.7356** , Florida Statute.

6.4 Award Criteria

Funding decisions will be determined by the OMHHE who will take into consideration the recommendations and ratings determined by the evaluator committee. Funding an award determination is completely at the discretion of the Department not withstanding evaluation point totals, the Department will fund projects throughout communities statewide.

6.5 Funding

The Department reserves the right to revise proposed plans and negotiate final funding prior to execution of contracts.

6.6 Posting of Awards

1. www.floridahealth.gov/about/administrative-functions/purchasing/grant-funding-opportunities/index.html
2. http://www.myflorida.com/apps/vbs/vbs_www.main_menu
3. http://www.floridahealth.gov/programs-and-services/minority-health/closing-the-gap.html

Section 7.0 REPORTING AND OTHER REQUIREMENTS

7.1 Post Award Requirements

Funded applicants will be required to negotiate with the OMHHE contract managers to create and finalize the Work Plan.

Funded applicants will also be required to submit:

- Progress reports in accordance with the Attachment I of the contract.
- Quarterly/Annual Financial Status Reports.
- Quarterly evaluation reports.

The Department reserves the right to evaluate the organization administrative structure, economic viability, and ability to deliver services prior to final award and execution of the contract.

Section 8.0 REQUIRED FORMS

8.1 Cover Page

8.2 Budget Summary

8.3 Budget Narrative

8.4 Personnel Form

8.5 Certification of Drug Free Work Place

8.6 IRS Non-Profit Status 501 (c) (3)

8.7 Florida Department of Health Standard Contract

8.8 Financial Compliance Audit

Appendix A
Evidence-Based Intervention Repository

Priority 1: Alzheimer's

Goal: Identify a statewide system of resources and support to formalize the Alzheimer's disease and related dementias (ADRD) network (Florida State Health Improvement Plan (SHIP)).

Goal: Strengthen the capacity of care organizations to assess, diagnose and treat individuals with ADRD and expand support of their caregivers (SHIP).

Goal: Protect Individuals with ADRD from further vulnerability (SHIP).

- Best Practices:
  - Healthy Brain Initiative – CDC
    - https://www.cdc.gov/aging/pdf/2018-2023-Road-Map-508.pdf

Priority 2: Cancer

Goal: Reduce inequities in diagnosis of prostate, breast, colorectal and cervical cancer in minority populations by encouraging and providing regular screenings.

- Best Practices:
  - American Cancer Society Screening Guidelines (Colorectal) – American Cancer Society
    - https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html
  - American Cancer Society Screening Guidelines (Breast) – American Cancer Society
    - https://www.cancer.org/content/dam/cancer-org/online-documents/en/pdf/infographics/breast-cancer-screening-guideline-infographic.pdf
  - Against Colorectal Cancer in Our Neighborhoods (ACCION) – National Cancer Institute
    - https://rtips.cancer.gov/rtips/programDetails.do?programId=26767808

Goal: Increase awareness and education concerning prostate, breast colorectal and cervical cancer in minority populations.

- Best Practices
  - Cancer Screening: Group Education for Clients (Breast) – CPSTF
    - https://www.thecommunityguide.org/findings/cancer-screening-group-education-clients-breast-cancer
  - Cancer Screening: One-on-One Education for Clients (Cervical) – CPSTF
    - https://www.thecommunityguide.org/search/cervical%20cancer

Priority 3: Cardiovascular Disease

Goal: Improve overall heart health and decrease instances of cardiovascular disease among minority populations

- Best Practices:
  - Cardiovascular Disease Prevention and Control: Evidence-Based Interventions for Your Community – CDC
    - https://www.cdc.gov/dhdsp/pubs/docs/cpstf-what-works-factsheet.pdf
  - Cardiovascular Disease: Interactive Digital Interventions for Blood Pressure Self-Management – CPSTF
    - https://www.thecommunityguide.org/findings/cardiovascular-disease-interactive-digital-interventions-blood-pressure-self-management
  - Stay In Circulation: Take Steps to Learn About P.A.D – NIH Heart, Lung and Blood Institute
    - https://www.nhlbi.nih.gov/health/educational/pad/stay/

Goal: Reduce risk factors among those at a higher risk of developing cardiovascular disease

- Best Practices:
  - Cardiovascular Disease: Interventions Engaging Community Health Workers – CPSTF
    - https://www.thecommunityguide.org/findings/cardiovascular-disease-prevention-and-control-interventions-engaging-community-health
  - Health Information Technology: Comprehensive Telehealth Interventions to Improve Diet Among Patients with Chronic Diseases – CPSTF
    - https://www.thecommunityguide.org/findings/health-it-comprehensive-telehealth-interventions-improve-diet-among-patients-chronic-diseases
  - The Heart Truth- NIH National Heart, Lung, and Blood Institute
    - https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources?field_health_education_initiativ_target_id%5B224%5D=224&page=1

Goal: Improve medication adherence among patients with CVD

- Best Practices:
  - Cardiovascular Disease: Mobile Health (mHealth) Interventions for Treatment Adherence Among Newly Diagnosed Patients – CPSTF
    - https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/cardiovascular-disease-mobile-health-mhealth
  - Health Information Technology: Text Messaging Interventions for Medication Adherence Among Patients with Chronic Diseases – CPSTF
    - https://www.thecommunityguide.org/findings/health-information-technology-text-messaging-medication-adherence-chronic-disease
  - Cardiovascular Disease: Tailored Pharmacy-based Interventions to Improve Medication Adherence – CPSTF
    - https://www.thecommunityguide.org/findings/cardiovascular-disease-tailored-pharmacy-based-interventions-improve-medication-adherence

Priority 4: Diabetes

Goal: Promote early detection and screening for diabetes

- Best Practices:
  - Diabetes Self-Management Education and Support (DSMES) Toolkit – CDC
    - https://www.cdc.gov/diabetes/dsmes-toolkit/index.html
  - Diabetes Empowerment Education Program (DEEP) – UIC Midwest
    - https://mwlatino.uic.edu/deep-program/
  - Chronic Disease Self-Management Program (CDSMP) – Stanford
    - https://www.chronicdisease.org/mpage/domain4_selfm_diabet
    - https://www.cdc.gov/arthritis/interventions/self_manage.htm

Goal: Increase access to resources that promote healthy behaviors to prevent diabetes

- Best Practices:
  - National Diabetes Prevention Program (NDPP) – CDC
    - https://www.cdc.gov/diabetes/prevention/people-at-risk.html
  - Get Into Fitness Today (GIFT) Baycare
    - https://baycare.org/services/diabetes/get-healthy
  - Get Your Fit On (GYFO) – Baycare
  - Diabetes Education Empowerment Program (DEEP) – UIC Midwest
    - https://mwlatino.uic.edu/deep-program/
  - USDA based nutrition education for individuals and groups

Goal: Increase the percentage of minority children and adults who are at a healthy weight

- Best Practices:
  - Obesity Prevention and Control: Meal or Fruit and Vegetable Snack Interventions Combined with Physical Activity Interventions in Schools – CPSTF
    - https://www.thecommunityguide.org/findings/obesity-prevention-control-meal-fruit-vegetable-snack-interventions-combined-physical-activity-interventions-schools
  - Diabetes: Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among People at Increased Risk – CPSTF
    - https://www.thecommunityguide.org/findings/diabetes-combined-diet-and-physical-activity-promotion-programs-prevent-type-2-diabetes
  - Physical Activity: Social Support Interventions in Community Settings – CPSTF
    - https://www.thecommunityguide.org/findings/physical-activity-social-support-interventions-community-settings

Priority 5: HIV/AIDS

Goal: Engage with priority populations for the purposes of education and awareness

Goal: Increase the proportion of persons who are aware of their HIV status

Goal: Prevent new HIV transmissions from occurring

Goal Improve health outcomes for persons living with HIV (PLWH)

- Tier 1: Community Outreach, Engagement, and Education
  - Community-Level Prevention
    - Activities:
      - Condom distribution
      - Community outreach, mobilization, engagement, and education
      - Social media and marketing
      - Referral to prevention and essential support services
- Tier 2: HIV Testing and Linkage to Prevention and Care Services
  - HIV Testing
    - Activities:
      - Routine, opt-out HIV testing in health care settings
      - Targeted HIV testing in non-health care settings
      - Integrated screening activities
  - Prevention for HIV-Negative Persons at Increased Risk for HIV
    - Activities:
      - PrEP Screening, Referrals, and/or Provision
      - nPEP Screening, Referrals and/or Provision
  - Prevention for PLWH
    - Activities
      - Linkage to and re-engagement in HIV medical care
      - Medication and treatment adherence services
      - Risk Reduction Interventions for PLWH
  - Referral and Navigation to Prevention and Essential Support Services
    - Activities
      - Referral and navigation to screening and treatment for STIs
      - Referrals and navigation to essential support services (e.g., housing, food assistance, transportation, employment)
- Tier 3: Comprehensive HIV Prevention Services
  - Combination of strategies from tiers 1 and 2
    - HIV Testing
    - Prevention for PLWH
    - Community Level Prevention
    - Referral and Navigation to Prevention and Essential Support Services

Evidence-Based Effective HIV Interventions

- Diagnose: Diagnose all people with HIV as soon as possible after infection
  - Routine HIV testing in Clinical Settings
  - HIV Testing in Non-Clinical Settings
  - HIV Testing in Retail Pharmacies
  - Social Network Strategy for HIV Testing Recruitment
  - Personalize Cognitive Counseling
  - Mobile Testing Services
  - Venue-based HIV Testing
  - HIV Self-Testing Kits
  - Integrated Screening (incorporating HIV screening with other health and wellness screenings to reduce stigma and normalize HIV testing)

- Treat: Treat persons diagnosed with HIV rapidly and effectively to achieve and maintain viral suppression; all of these activities can be used for *Prevention for PLWH* strategy
  - Access to telehealth visits to reduce barriers to treatment adherence
  - Choosing Life! Empowerment, Action, Results (CLEAR)
  - Community PROMISE
  - Healthy Relationships
  - Helping Enhance Adherence to Antiretroviral Therapy (HEART)
  - HIV Navigation Services
  - Partnership for Health – Medication Adherence
  - Partnership for Health – Safer Sex
  - Peer Support
  - Project START +
  - Stay Connected
  - Taking Care of Me
  - Transgender Women Involved in Strategies for Transformation (TWIST)
  - Women Involved in Life Learning from Other Women (WILLOW)

- Prevent: Protect people at risk for HIV using potent and proven prevention interventions, including PrEP and syringe services programs (SSPs); all of these activities can be used for *Prevention for HIV-negative persons* strategy
  - Pre-exposure prophylaxis (PrEP)
  - Condom Distribution Programs
  - D – Up: Defend Yourself!
  - Mpowerment
  - Popular Opinion Leader (POL)
  - Risk Reduction Counseling
  - Safe in the City
  - Sin Buscar Excusas/No Excuses
  - Sister to Sister
  - Syringe Services Programs
  - Video Opportunities for Innovative Condom Education & Safer Sex (VOICES/VOCES) for Men who have Sex with Men (MSM)

- Social Media and Marketing, Targeted Outreach, Mobilization, Public/Private Partnerships, Stigma Reduction, HIV Education and Awareness
  - HIV/STI Prevention Education
  - Business Responds to AIDS (BRTA)

- Faith Responds to AIDS (FRTA)
- Let's Stop HIV Together (CDC Campaign Resources)
  - For Consumers
    - Stop HIV Stigma (Anti-Stigma)
    - Doing It (Testing)
    - Start Talking. Stop HIV (Prevention)
    - HIV Treatment Works (Care and Treatment)
  - For Health Care Providers:
    - HIV Screening; Standard Care
    - Prescribe HIV Prevention
    - Transforming Health
    - Prevention is Care
- Social Marketing
- Targeted Outreach for Priority Populations (face-to-face, Internet-based)

Priority 6: Immunization

Goal – Increase access to immunizations for infants, children and teens

- Best Practices:
  - Vaccination Programs: Schools and Organized Child Care Centers – CPSTF
    - https://www.thecommunityguide.org/findings/vaccination-programs-schools-and-organized-child-care-centers
  - Vaccination Programs: Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Settings – CPSTF
    - https://www.thecommunityguide.org/findings/vaccination-programs-special-supplemental-nutrition-program-women-infants-children-wic
  - Vaccination Programs: Home Visits to Increase Vaccination Rates – CPSTF
    - https://www.thecommunityguide.org/findings/vaccination-programs-home-visits-increase-vaccination-rates

Goal – Maintain adequate follow ups for vaccinations and immunizations

- Best Practices:
  - Vaccination Programs: Client or Family Incentive Rewards – CPSTF
    - https://www.thecommunityguide.org/findings/vaccination-programs-client-or-family-incentive-rewards
  - Vaccination Programs: Health Care System-Based Interventions Implemented in Combination –CPSTF
    - https://www.thecommunityguide.org/findings/vaccination-programs-health-care-system-based-interventions-implemented-combination
  - Vaccination Programs: Client Reminder and Recall Systems – CPSTF
    - https://www.thecommunityguide.org/findings/vaccination-programs-client-reminder-and-recall-systems

Priority 7: Lupus

Goal: Epidemiology and surveillance to develop data collection systems to accurately determine the burden of lupus in Florida.

Goal: Environmental approaches to develop a sustainable funding agenda.

Goal: Health care system interventions to improve the education and training of healthcare providers about the symptoms and treatment of lupus

- Best Practices:
  - Florida Public Health Plan for Addressing Lupus
    - 2019 Statewide Lupus Stakeholders Summit – (See OMHHE homepage: http://www.floridahealth.gov/programs-and-services/minority-health/index.html)

Priority 8: Maternal/Infant Mortality

Goal: Reduce sexually transmitted infection (STI) incidence; reduce sexual risk behavior; reduce repeat pregnancy; reduce psychosocial risk factors

- Best Practices:
  - Centering Pregnancy Plus (CPP)
    - Score: Best
    - Target Population: Young pregnant women receiving prenatal care
    - https://cdn.ymaws.com/www.chronicdisease.org/resource/resmgr/lupus/lupus_tools/Florida_Lupus_PlanFinal.pdf

Goal: Reduce infant mortality and related inequities in minority populations

- Best Practices:
  - Pregnancy Health: Community-Wide Campaigns to Promote the Use of Folic Acid Supplements
    - https://www.thecommunityguide.org/findings/pregnancy-health-community-wide-campaigns-promote-use-folic-acid-supplements

Goal: Reduce risk of maternal mortality and pregnancy related deaths in minority populations

- Best Practices:
  - Association of Maternal Child Health Programs
    - Association of Maternal Child Health Programs
  - Pregnancy Health: Exercise Programs to Prevent Gestational Hypertension – CPSTF
    - https://www.thecommunityguide.org/findings/pregnancy-health-exercise-programs-prevent-gestational-hypertension
  - Pregnancy Health: Lifestyle Interventions to Reduce the risk of Gestational Diabetes – CPSTF
    - https://www.thecommunityguide.org/findings/pregnancy-health-lifestyle-interventions-reduce-risk-gestational-diabetes

Priority 9: Oral Health

Goal: Reduce the incidence of tooth decay among children

- Best Practice:
  - School-Based Dental Sealant Delivery Programs – CPSTF
    - https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/dental-caries-cavities-school-based-dental-sealant

Goal: Reduce the incidence of tooth decay among minority communities

- Best Practice:
  - Dental Caries (Cavities): Community Water Fluoridation – CPSTF
    - https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/dental-caries-cavities-community-water-fluoridation

Priority 10: Sickle Cell Disease (SCD)

Goal: Improve health outcomes for patients living with sickle cell disease and sickle cell trait.

- Best Practice:
  - Educational Intervention to Improve the Health Outcomes of Children with Sickle Cell Disease
    - https://doi.org/10.1016/j.pedhc.2014.06.007
  - iCanCope with Sickle Cell Pain: Design of a Randomized Controlled Trial of a Smartphone and Web-Based Pain Self-Management Program for Youth with Sickle Cell Disease
    - https://doi.org/10.1016/j.cct.2018.10.006
  - Interventions for Patients and Caregivers to Improve Knowledge of Sickle Cell Disease and Recognition of Its Related Complications- Cochrane Library
    - https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/interventions-for-patients-and-caregivers-to-improve-0
  - Patient-Centered eHealth Interventions for Children, Adolescents and Adults with Sickle Cell Disease-
    - https://www.jmir.org/2018/7/e10940/
  - Community Health Workers as Support for Sickle Cell Care
    - https://doi.org/10.1016/j.amepre.2016.01.016
  - Living Well with Sickle Cell Disease: Self-Care Toolkit
    - https://www.cdc.gov/ncbddd/sicklecell/documents/livingwell-with-sickle-cell-disease_self-caretoolkit.pdf

Priority 11: Social Determinants of Health (SDOH)

Goal: Create social and physical environments that promote good health for all.

- Best Practice
  - Tools for Putting Social Determinants of Health into Action- CDC
    - https://www.cdc.gov/socialdeterminants/tools/index.htm
  - Protocol for Responding to and Assessing Patient's Assets, Risk, and Experiences (PRAPARE) Implementation and Action Toolkit
    - http://www.nachc.org/research-and-data/prapare/toolkit/
  - Policy Resources to Support SDOH
    - https://www.cdc.gov/socialdeterminants/policy/index.htm

Appendix B

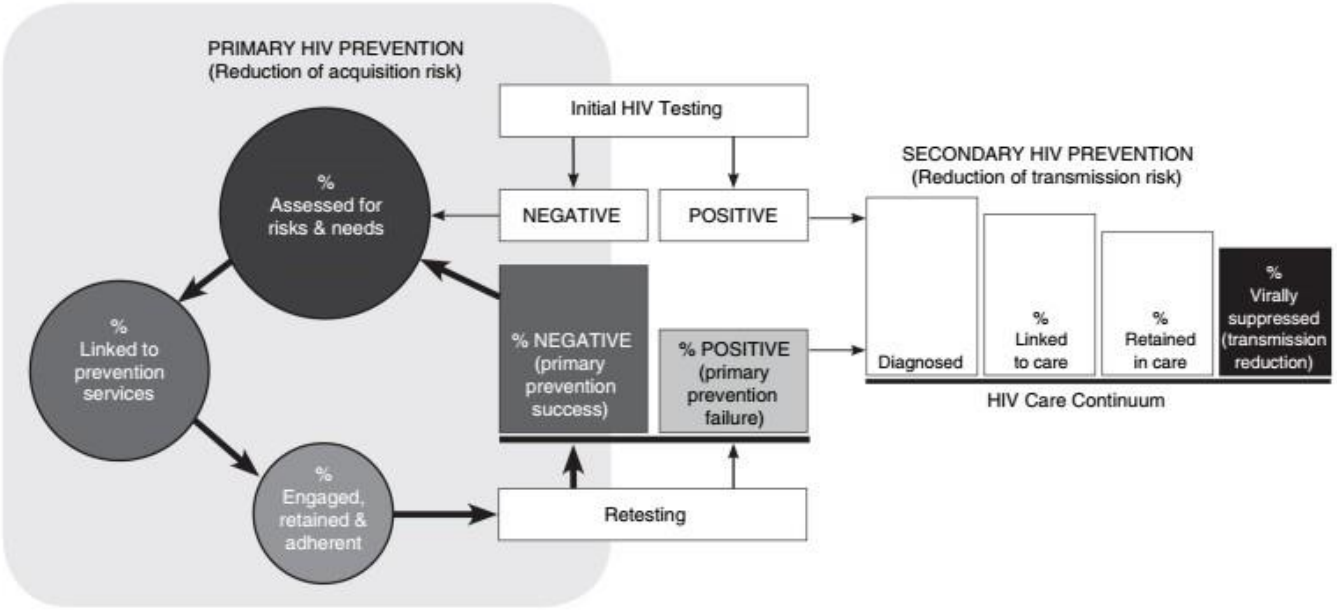
HIV Evidence-Based Intervention Resources

Effective Interventions (Diagnose, Treat, Prevent)- CDC

- https://www.cdc.gov/hiv/effective-interventions/index.html

HIV testing is the entry point in the HIV prevention cycle, as it generally provides a critical point of contact with the health care and service delivery systems for individuals who are HIV negative but are vulnerable to the infection, as well as being a gateway to treatment for people diagnosed with HIV.[1] Below is a diagram illustrating the interplay between processes to halt both the acquisition and transmission of HIV. The primary HIV prevention cycle begins with HIV testing. Risk and needs assessments, linkage to prevention and support services, engagement in risk reduction prevention interventions, and HIV testing are repeated for as long as an individual remains at risk for HIV acquisition.[1]

Figure 1. Comprehensive HIV Prevention Continuum



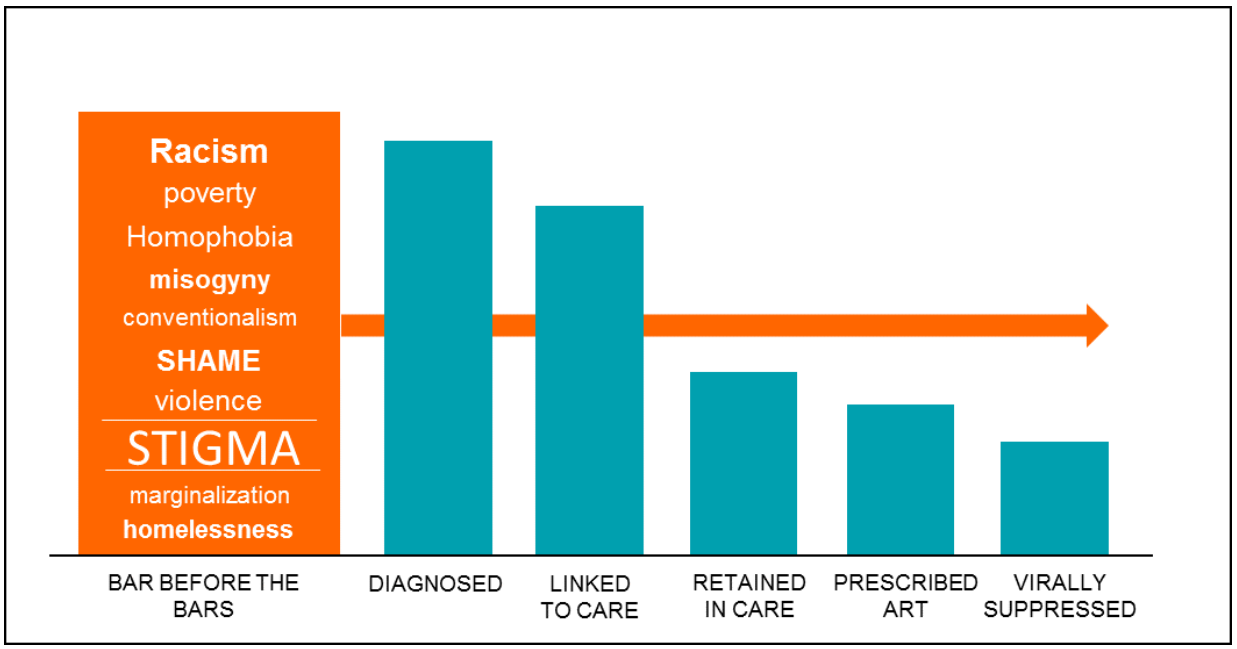
Source: Horn et al. *Journal of the International AIDS Society* 2016, 19:21263

Health Disparities and Health Equity

Health disparities in HIV are tied to a mix of social determinants that impact populations most severely affected by this disease. Health equity is defined as the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities. Social determinants of health affect disparities in HIV, viral hepatitis, and sexually transmitted infections (STIs). Environmental factors such as housing conditions, social networks, and social support are also key indicators for infection with HIV, viral hepatitis, and STIs.

Factors driving the HIV epidemic within priority populations are as diverse as Florida's communities themselves. In all communities, **lack of awareness of HIV status** contributes to HIV risk. People who do not know they have HIV cannot take advantage of HIV care and treatment and may unknowingly pass HIV to others. The **greater number of PLWH (prevalence)** in these populations mean that sexual and injection drug sharing networks in these populations face greater risks of HIV transmission. Some of these populations also experience higher rates of **other STIs** than other communities in Florida; having another STI can significantly increase a person's chance of acquiring or transmitting HIV. **Stigma, fear, discrimination, and homophobia also place individuals from priority populations** at higher risk for HIV. The **socioeconomic issues** associated with poverty—including limited access to health care, housing, and education—directly and indirectly increase the risk for HIV acquisition and affect the health of people living with and at risk for HIV. Stigma and other social determinants influence the HIV Care Continuum before a diagnosis is even made, hence why these factors appear in the 'bar before the bars' on the continuum.[2]

Figure 2. The Bar Before the Bars



Source: Addressing Stigma: A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black and Latino Gay Men. National Association of State and Territorial AIDS Directors (NASTAD) and National Coalition of STD Directors (NCSD). May 2014. Accessed May 25,

Work Plan Template

ATTACHMENT 1

Please use this template to complete the work plan and include it with the application. Work Plan should be completed for one year only (August 1, 2020 - June 30, 2021)

*Assessment Method - details of how each activity under this goal will be measured

Goal 1:			Measures of Effectiveness:	
Objectives	Activities Planned to Achieve This objective	*Assessment Method	Timeframe for Assessing Progress	Person/s Responsible
Goal 2:			Measures of Effectiveness:	
Objectives	Activities Planned to Achieve This objective	*Assessment Method	Timeframe for Assessing Progress	Person/s Responsible
Goal 3:			Measures of Effectiveness:	
Objectives	Activities Planned to Achieve This objective	*Assessment Method	Timeframe for Assessing Progress	Person/s Responsible
Goal 4:			Measures of Effectiveness:	
Objectives	Activities Planned to Achieve This objective	*Assessment Method	Timeframe for Assessing Progress	Person/s Responsible

Project Management Plan Instruction

ATTACHMENT 2

The management plan defines how the organization is run both day-to-day and over the long term. The objective of the management plan is to define how the project is executed, monitored and controlled. It describes the agency's ability to successfully carry-out the proposed project and to sustain the program once grant funding ends. Address the following in narrative form:

A. Personnel:

1. Discuss any assumptions and constraints associated with the staffing estimates described in the organizational overview.

2. Describe the appropriate procedures used to manage staff on the project.

3. Describe the process for transitioning staff once the project is completed. Describe how the project or organization will help to place staff. Indicate how consultant/contractor staff will be released.

b. Deliverable Timelines:

1. Discuss the process getting the project on tract if deliverables aren't being met as specified in by the criteria set forth in contract.

c. Contingency Plan:

1. Discuss how applicant plans to handle any issues that might arise during the course of the proposed project funding period.