

Responses to Questions Submitted for Request for Application (RFA) #19-10704

Project Goals

- 1. Question (Q): Please confirm: while the project begins with a Needs Assessment, the proposal should include detailed activities associated with each goal area?**

Answer (A): Yes. Work Plan (Document F) must include details on how the local health jurisdiction will accomplish selected Goal Components including project objectives, activities, deliverables, time frames, and responsible parties for each state fiscal year. Work Plan (Document F) activities and time frames can be divided by state fiscal year to illustrate the sequence of project activities, at the discretion of applicants ([RFA](#), Document F, pg. 17).

- 2. Q: Under Goal 2 ([RFA](#), pg. 14), is implementation of E-1 (educate the public about brain health...) and E-3 (Increase messaging that...) dependent on E-2 (Integrate the best available evidence...)?**

A: No. At minimum: Select one component from Goal 1 and at least one component from Goal 2, Goal 3, and/or Goal 4 for implementation ([RFA](#), Document E, pg. 13).

Actions are taken from the agenda laid out by the Centers for Disease Control and Prevention's Healthy Brain Initiative Roadmap (HBI Roadmap). They are divided by the four goals, and further divided by shared desired outcomes. Compelling data may make the case for the urgency and importance of pursuing a group of actions, but this is not an RFA requirement.

- 3. Q: Is it advisable for applicants to mention current activities that align with identified Goals and Objectives, even if they don't anticipate seeking funding for these activities and don't want to be obligated to increase delivery or adopt evaluation protocols?**

For example, if the local Alzheimer's organization already does the following with the target populations, should these activities be referenced to show capacity?

- Provides info and tools to help people with dementia and caregivers anticipate, avert ([RFA](#), pg. 14)
- Delivers evidence-informed interventions and supports for people with dementia and their caregivers ([RFA](#), pg.14)

Would this unfunded work be part of the narrative rather than put on the Work Plan?

A: Current activities that align with identified Goals and Objectives can be mentioned as background. If space is limited, they can also be described in Letters of Commitment (Document D). Emphasize activities to be funded in the application. Identify and justify the associated cost for funded activities in the Detailed Budget and Budget Justification ([RFA](#), Document G, pg. 26).

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4. **Q: Some of the terminology used in the Component Description under Goal 4 “Assure a Competent Workforce” is confusing and no definition of terms is provided. Please provide definitions for "healthcare providers" (W2), "public health professionals" (W3), "health care professionals" (W4, W6, W7), and "professionals who deliver health care and other care services" (W5). It is unclear who exactly is included in each of these groups, whether some are the same or whether they differ.**

A: Overlap may exist within different types of professionals and providers. Each applicant is being asked to define these terms. Example terms are listed below as reference:

- **Healthcare Provider:** Individual licensed, certified, or otherwise authorized or permitted by the law of this state to provide health care in the ordinary course of business or practice of a profession. [Probate Code (PROB) § 4261. 1999].
- **Public Health Professionals:** Work to improve the health of families and communities by promoting healthy lifestyles, preventing disease, and removing environmental dangers. ([CDPH Office of Public Affairs](#))
- **Health Care Professionals:** Professionals who deliver health care and other health care services, whereby “health care” means any care, treatment, service or procedure to maintain, diagnose, or otherwise affect a patient’s physical or mental condition (PROB § 4615. 1999).

Programmatic Evidence

5. **Q: We are interested in applying as we have higher death rates due to Alzheimer’s disease and related dementias, but we would like to compare our data to other jurisdictions within the state. In the RFA, you did not include city jurisdictions’ rates, so we had a tough time corroborating our rates. Would you be able to run it for the city local health jurisdictions? If not, to try and replicate the analysis, we would need some additional information that wasn’t included in the RFA documentation.**

A: The RFA asks applicants to demonstrate the need for public health action on Alzheimer’s disease and related dementias within a local health jurisdiction in response to questions on Narrative Summary (Document C).

As a courtesy, county-level data resources are provided in Appendix C. Local health jurisdiction cities may use county-level as applicable, but this is not a requirement ([RFA](#), Document C, pg. 9). Applicants are not limited to these resources.

As a courtesy, Alzheimer’s death rates ([RFA](#), Appendix C, pg. 51), and other RFA public data sources for Appendix C, are listed in the References section of the [RFA](#) (pg. 64).

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- 6. Q: If a project uses emerging, promising, or established best practices in order to help to establish an evidence base, would that be allowable? This is of particular concern since so little of the existing Alzheimer's disease and related dementias research has included diverse populations—and certain racial/ethnic groups have disproportionate rates of dementia and poorer outcomes.**

A: Yes. However, implementation of the Centers for Disease Control and Prevention's Healthy Brain Initiative Road Map action items, just like their development, should take into consideration the latest evidence and adopt newly-identified best practices when possible ([HBI Road Map](#), pg. 41).

- 7. Q: I wanted to confirm that any programs that would be proposed for the Healthy Brain Initiative RFA do not already need to be established Evidence-Based Programs at the time of proposal? If a program has a proven track record, and would be expanded under the Health Brain Initiative, but is not an evidence-based program, that would be acceptable?**

A: Yes, if a program has a proven track record, but is not an evidence-based program it would be acceptable to apply for expansion under this RFA.

- 8. Q: The RFA frequently refers to “evidence-based” practices as well as “evidence-informed” practices. Can you please clarify what the expectations are around these terms? For example:**

- **Goal 1 “monitoring data and evaluating programs to contribute to evidence-based practice”**
- **E7: “Improve access to and use of evidence-informed interventions, services, and supports...”**

Given the status of the evidence in the field, how rigorous a definition of EBP or EIP are you using? Are you expecting fidelity to existing models or are adaptations of them allowed to serve specific populations who might not have been included in the original research/evidence gathering?

A: Yes. Any of these practices may be utilized. Definitions are provided below:

- **Evidence-Based:** Proven success of past effectiveness ([RFA](#), Document F, pg. 18). Healthy Brain Initiative goals promote widespread diffusion of an evidence-based model or invest in capacity. Such resources can take many forms: physical, such as spaces, tools, and materials; financial, such as direct funding or discounts; social, such as networks of people or organizations, norms, shared understanding, and trust; and intellectual, such as data, skills, knowledge, time, and competencies of stakeholders ([HBI Road Map](#), pg. 12).

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- **Evidence-Informed:** Public health can also facilitate access to affordable, evidence-informed services, programs, interventions, and supports to reduce stress and improve coping, self-efficacy, and overall health. Well-designed programs have been shown to benefit persons with dementia and caregivers, and should be readily accessible ([HBI Road Map](#), pg. 18).
- **Innovation:** Novel theoretical concepts, approaches or methodologies, instrumentation or interventions to be developed or used, and any advantage over existing methodologies, instrumentation, or interventions. Explain any refinements, improvements, or new applications of theoretical concepts, approaches or methodologies, instrumentation, or interventions ([RFA](#), Document F, pg. 18).

Applicants may view examples from state and local public health agencies who responded to the growing dementia crisis by implementing actions from the HBI Road Map. Short summaries are included in the [HBI Road Map](#) (pg. 44).

Work Plan

- 9. Q: Are the 6 objectives listed in the work plans ([Required Application Documents](#), pgs. 8 – 14) in the Required Grant Application Documents examples or must we complete all of those objectives? Are we required to complete these 6 objectives as well as objectives from at least 1 additional goal as stated on Page 13 in the Goals and Components Instructions?**

A: Yes, the six objectives listed in the Required Application Documents template for Work Plan (Document F) are provided as examples for Goal 1 and are not all required. At minimum for Goal 1, one Goal Component and one Goal Component Objective is required.

For additional Goal(s), please refer to Goals and Components (Document E) that can be selected on the [Required Application Documents](#) (pg. 5). Be mindful of the overall 20-age limit of the Work Plan (Document F).

- 10. Q: Can you provide a working doc for the Work Plan templates for years 1-3? Can you provide an unlocked, working doc for the budget templates for years 1-3?**

A: Yes. Unlocked, working documents of the application materials are made available on the [ADP Local Funding Opportunities](#) of the ADP website and labeled “Required Application documents (WORD)”.

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Applicant and Partnership Eligibility

11. Q: Is this something a Provider Service Area (PSA)/Area Agency for Aging (AAA) could apply for as a Joint Powers Agreement? If so, how does that work if a PSA represents two counties? Do we need to have one of our contractors apply? What are the reporting requirements?

A: No. ADP is soliciting applications from local health jurisdictions. Local health jurisdictions are defined in this RFA as the 58 county health departments, and 3 city health departments—Berkeley, Long Beach, and Pasadena ([RFA](#), Appendix B, pg. 49). Local health jurisdictions must apply individually, and no consortium (or Joint Powers Agreements) between eligible local health jurisdictions will be accepted.

Local health jurisdictions are encouraged to collaborate with local stakeholders (e.g. California Alzheimer's Disease Centers, AAA's, Caregiver Resource Centers, community organizations, etc.). Collaborators may be listed as subcontractors in the application budget, per the discretion of the applying local health jurisdiction.

Subcontractors are allowed and should be reported in Category v. Subcontracts and Consultants (RFA, Document G, pg. 26). The salary/hourly rate must correspond to education and experience. (RFA, Document G pgs. 32-33). Salaries should be comparable to California Department of Human Resources (CALHR). Refer to CALHR Pay Scales. Applicants may reference the Civil Service Pay Scales alphabetically by class title to identify personnel titles and applicable salary cap(s). For local assistance agreements, subcontracting is unlimited only when subcontractors are justified and not circumventing the state contracting manual (SCM 3.06.D).

12. Q: Is there a list of counties that have applied?

A: No. *Notices of intent to award* will be posted on the ADP webpage on 2/4/2020. A list of the 61 *eligible* local health jurisdictions is located in the [RFA](#) (Appendix B, pg. 49).

Contracts and Budgets

13. Q: Is this a 25-month grant? Can you please explain the timeline?

A: Yes. The term of the expected agreements is anticipated to be a 25-month term and to be effective from 6/1/2020 to 6/30/2022 ([RFA](#), Agreement Term, pg. 3).

- Year 1: June 1, 2020 upon approval through June 30, 2020
- Year 2: July 1, 2020 through June 30, 2021
- Year 3: July 1, 2021 through June 30, 2022

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14. Q: How often and when will we be able to revise the Work Plan and budgets?

A: Once contracts are executed on 6/1/2020 there will be no revisions to the Work Plan and Budget. CDPH ADP reserves the right to withdraw any award or request modifications to the Work Plan and/or Budget of any application component(s) as a condition of the grant award ([RFA](#), Part IV. Administrative Requirements, pg. 46).

15. Q: Does funding roll over from Fiscal Year 1 since it is only a month long? What is the expectation on what to complete in 1 month and how much to spend? Does the funding roll over from year 2 to year 3?

A: No, funding does not roll over from Fiscal Year 1. There is no expectation on what to complete in one month and how much to spend. Funding does not roll over from year 2 to year 3.

Once contracts are executed on 6/1/2020 there will be no revisions to the Work Plan and Budget. CDPH ADP reserves the right to withdraw any award or request modifications to the Work Plan and/or Budget of any application component(s) as a condition of the grant award ([RFA](#), Part IV. Administrative Requirements, pg. 46).

Activities for Goal 1 will commence in the first month—with the following milestone dates of completion in the first seven months of the grant period ([RFA](#), Document F, pg. 17):

- Complete Project Planning by 1/4/2021
- Initiate Project Implementation by 1/5/2021
- Provide a written Project Evaluation to CDPH, ADP by 6/30/2022

Applicants must justify their expenditure of the one-time \$750,000 award over the 25-month grant period in the Work Plan (Document F) and Detailed Budget and Budget Justification (Document G).

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16. Q: What other items should be considered in the budget...travel [Conferences/meetings? Where, when (year), how many days?]; and/or specific things to purchase (software, gift cards...)?

A: Develop a Detailed Budget, for *each state fiscal year* of funding.

- Year 1: June 1, 2020 upon approval through June 30, 2020
- Year 2: July 1, 2020 through June 30, 2021
- Year 3: July 1, 2021 through June 30, 2022

Identify and justify the costs related to the implementation of the Work Plan. Use the seven budget categories to sort expenses and determine level of detail needed per category ([RFA](#), Document G, pgs. 29-35).

1. Personnel Costs
2. Fringe Benefits
3. Operating Expenses
4. Travel/Per Diem and Training
5. Subcontracts and Consultants
6. Other Costs
7. Indirect Expenses: See [Indirect Cost Rates for local health jurisdictions](#)

17. Q: Are Subcontractors allowed? Min-max funding?

A: Subcontractors are allowed and should be reported in Category v. Subcontracts and Consultants ([RFA](#), Document G, pg. 26). The salary/hourly rate must correspond to education and experience. (RFA, Document G pgs. 32-33). Salaries should be comparable to California Department of Human Resources (CALHR). Refer to [CALHR Pay Scales](#). Applicants may reference the Civil Service Pay Scales alphabetically by class title to identify personnel titles and applicable salary cap(s). For local assistance agreements, subcontracting is unlimited only when subcontractors are justified and not circumventing the state contracting manual ([SCM](#) 3.06.D).