

APPLICATION FOR GRANTS AND SUBSIDIES (PP OBJECT CLASS)

Name/Title of Grant: Wellness in the Community, School, and Workplace

Document File Number: 805709

1. Description Or Purpose of Grant:

Under the new leadership of Commissioner John Auerbach, the Massachusetts Department of Public Health (MDPH) held 8 community health dialogues that sought input from residents across the Commonwealth to identify public health priorities.¹ Hundreds of citizens gave voice to local concerns and from this process, the need for a wellness initiative that focuses on fitness, healthy eating, tobacco cessation, oral health, health relationships and stress reduction. In response, the Commissioner has decided to initiate programs that cut across traditional funding lines and support more integrated models of service delivery.

This grant program seeks to stimulate collaborative approaches to improving wellness and health outcomes by building upon existing programs, initiating new activities, and identifying innovative program models that increase health and reduce costs associated with disease, absenteeism and lost productivity. Wellness programs of various types have been shown to make substantial contributions to reducing the morbidity and mortality associated with overweight, obesity, and the many serious illnesses that flow from these conditions, as well as smoking and poor oral health. These include diabetes, cancer, asthma, heart disease and stroke, among others. This funding will encourage providers to select from several program models or to develop and evaluate an innovative model that builds upon what is currently known about wellness interventions.

Oral health is a primary contributor to an individual's or community's wellness. Therefore, included in the grant program is an opportunity for prevention activities that will have an impact on the oral health of the targeted community.

Eligible entities include private not-for-profit entities, local health departments, and public and private not-for-profit schools within Massachusetts. Collaborative entities are encouraged to apply and may do so through either a private not-for-profit entity or a local health department. While collaborative entities are encouraged, they are not required. Here are some examples of potential applicants:

- Municipalities throughout the Commonwealth in conjunction with a community agency or coalition
- A local coalition such as a community health network area (CHNA) applying through an approved entity
- A regional center for healthy communities applying in partnership with local grass-roots community organizations
- A community health center working collaboratively with a school or workplace wellness program
- A local health department working with a community board of interested parties
- A cluster of small communities working together with regional planning agencies
- A school district working together with the local board of health

¹ Massachusetts Department of Public Health. Regional Health Dialogue Summaries and Status Indicators Reports. Available at http://www.mass.gov/dph/comm/health_dialogues.htm.

2. Contact Information

Contact Person: Stewart Landers

Title: Senior Program Director

Address: 250 Washington Street, 2nd Floor, Boston, MA 02108

Telephone #: 617-624-5203

Fax #: 617-624-5206

E-mail or Internet Address: Stewart.Landers@state.ma.us

3. Anticipated Payment Methodology:

Lump Sum

Periodic Scheduled Installments

Cost Reimbursement Other (specify):

4. Whether Single Or Multiple Grantees Are Required For Grant(s)

Single Grantee or

Multiple Grantees

5. Expected Duration Of Grant (Initial Duration and Any Options to Renew)

(Subject to appropriation or the availability of sufficient non-appropriated funds under the grant funding authority)

Initial Duration: one-time purchase; or: up to months, and/or up to 3 year(s)

The initial budget year is expected to be November 1, 2007 – June 30, 2008.

Renewal Options: ___2___ options to renew for up to ___2___ year(s) each option

6. Anticipated Expenditures, Funding Or Compensation For Expected Duration

Larger grants will be \$60,000 or \$120,000 (approximately 7-10)
Smaller grants will be \$10,000 (approximately 10-16)

Please include the Estimated Value of the Grant (Including Anticipated Renewal Options)

\$7,000,000

Will Federal Funds be used to fund any part of Grant(s)? NO, YES (If YES, to what extent?):

100% of funds of these grant funds will be state funds.

7. Grant Scope and Performance Requirements:

7.1. Background and Justification

Across the United States, obesity and overweight have become an increasing problem and source of ill health. Changes that are responsible for this epidemic include larger portion sizes, less physical education in schools, un-walkable communities, the fear of crime that keeps people in-doors and isolated, and the persistence of social issues that underlie health disparities. Compounded by the aging of the population, these changes are having a very detrimental affect on our health and economy.

The drivers, and the places we must make change, are in the organizations and everyday places in our society that touch our lives every day. The vast majority of these opportunities for change lie under the purview of people and organizations that may not have public health as their core mission.

At the Health Dialogues conducted by Commissioner Auerbach across Massachusetts, he noted that the overall rate of overweight adults in Massachusetts rose from 45% in 1995 to 56% in 2005 and the number of obese adults in Massachusetts rose from 12% in 1995 to 21% in 2005. The prevalence of diabetes has risen from 3.8% to 6.4% over the same 10-year time period. In addition, there are racial and ethnic disparities with respect to the issue of overweight in Massachusetts. While 50% of whites in Massachusetts were overweight in 2005, 66% of Black non-Hispanics and 68% of Hispanics were overweight.

The Department of Public Health has been a co-convenor of the Massachusetts Partnership for Health Weight which produced a report in 2005 titled, “The Health of Massachusetts: A Coordinated Response to Overweight and Obesity.” (Full report available upon request.) It set a target that “at least 95 percent of children and 60 percent of adults are at a healthy weight by the year 2010.” To implement this goal, programs must address environmental, community and individual factors that influence the ability of people to engage in physical activity and eat healthy foods.

According to the National Governor’s Association report, the *National Governor’s Association on Healthy Living* (August 2006), the following opportunities and challenges face Massachusetts:

- Reducing cholesterol levels by 10 percent could cut the incidence of heart disease by as much as 30 percent, saving the Massachusetts economy \$925 million in health care spending each year.
- Each year taxpayers – regardless of health status – pay half of the nation’s \$93 billion price tag for medical expenses directly attributed to obesity. In Massachusetts that translates to \$186 per tax payer annually.
- If one in ten Massachusetts adults started a regular walking program, the state would save \$121 million in heart disease expenditures annually – equivalent to paying the college tuition of 22,036 Massachusetts students each year.
- Within the next decade, preventing disability from obesity-related diseases will decrease (by an estimated 10-25 percent) the number of people in need of nursing home care.

In addition to the problems of overweight and obesity, oral health was identified as another health need that has substantial unmet need across the Commonwealth. At the health dialogues issues concerning oral health included lack of access to services for MassHealth participants and others who lack dental insurance, insufficient attention to and awareness of the importance of oral health, lack of oral health services for youth and elders and the absence of fluoridation programs in many communities. Both the summaries of the health dialogues and the data report contain information about the needs and concerns around oral health by region.

7.2 Scope of Service

Settings

Wellness activities can take place in one of three broadly defined settings: School/youth programs; Workplace settings; and Community Settings. Applicants must apply for work in a particular setting. An applicant can submit proposals for small grants at \$10,000 or for large grants at \$60,000. Applicants for large grants can apply for up to two settings at \$60,000 per setting for a total of \$120,000. **Note that if applying for more than one setting, a separate budget and narrative must be submitted for each setting. Applicants seeking large grants are particularly encouraged to combine a Community setting with either a School-based/youth program or Worksite setting to create a comprehensive program.** See the “Questions” Section (7.5 A) for the specific questions that must be answered multiple times if applying for two settings. Additional page limits are provided if the applicant proposes Wellness programs in multiple settings. **Applicants may not submit proposals for small grants in more than one setting. Applicants may not submit proposals for both small and large grants.**

Setting 1: School-based/youth programs.

Schools provide a unique setting to improve physical activity, nutrition habits and oral health. Selected programs will work with youth 22 and under in settings including schools, pre-schools, after school programs as well as youth centers such as Boys/Girls Clubs, YM/WCAs, and other programs serving youth. Proposed programs should link to existing School Wellness Councils or Programs. Some resources for working with children can be found at the following online sites:

The Shape Up Somerville program:

http://nutrition.tufts.edu/1174562918285/Nutrition-Page-nl2w_1179115086248.html

The Children in Balance website:
www.childreninbalance.org

Setting 2: Workplace Sites

An expanding evidence base supports the positive impacts of worksite wellness programs on individual employee health and cost savings for employers. Unhealthy lifestyles and modifiable risk behaviors resulting in illness and injury account for at least 25% of employee health care expenditures. The most significant risk factors contributing to healthcare expenditures are stress, tobacco use, overweight or obesity, physical inactivity, excessive alcohol use, and poor nutritional habits.² Programs will work with medium or small employers to develop Wellness programs for their employees. One resource for workplace Wellness programs is:

The Wellness Councils of America:
www.welcoa.org/

Setting 3: Community

Community settings include community health centers, housing developments, and neighborhoods. Communities may be large cities, small towns, or clusters of towns in rural or suburban area. Activities can target populations that are served through a community health center, other provider of community health or social services, or live in a particular housing complex or neighborhood. Target populations may be cross-generational or target a specific age group such as elders. Target populations may be found in one geographic location or spread across several.

Program Activities

There are several activities related to wellness that can be supported under this program. These focus on the diverse but related areas of physical activity, healthy eating, and oral health. Initiatives are encouraged to focus their efforts on developing policy and environmental change strategies. Behavior is determined to a large extent by the physical, social and cultural environment. Policy and environmental change strategies focus on influencing community standards, institutional structures and attitudes that shape behavior and can be used to create environments that make it easier for people to engage in healthy behaviors.

Simply put, a “policy” is a rule or an adopted course of action that guides the way a group of people or an organization operates, be it a family or school, a government or other workplace. An example of this is a workplace flextime policy that encourages employees to be physically active during breaks or the lunch hour. “Environmental changes” that support wellness are those that design or make adaptations to an existing environment so that “the

² Anderson D.R., Whitmer, R.W., Goetzel, R.Z., Ozminkowski, R.J., Wasserman J., & Serxner, S. (HERO Research Committee) (2000). The relationship between modifiable health risks and group-level health care expenditures. *American Journal of Health Promotion*, 15:45-52 as cited in Zank D. & Friedsam, D. (2005) Issue Brief: Employee Health Promotion Programs: What is the Return on Investment? *Wisconsin Public Health & Health Policy Institute Issue Brief*, 6(5).

healthy choice is the easy choice.” Examples of these include providing healthful food and beverage choices in vending machines or in cafeterias within schools, a community center or in a workplace; working with community planners to redesign walkways so that residents may have more opportunities to be physically active, e.g., walking to school, commuting to work, shopping or for leisure; designing stairways to be adjacent to escalators and/or elevators in new construction projects.

Several of the activities suggested below have been adapted from “The Community Guide” developed by CDC and can be accessed in greater detail at <http://www.thecommunityguide.org/>

Activity 1: Physical Activity

- A) Increasing access to and use of attractive and safe locations for engaging in physical activity.
- B) Programs to provide adequate physical education for all students throughout the school year and increasing opportunities for physical activity before, during, and after school.
- C) Community-wide interventions that include messaging through various media combined with strategies such as support groups, physical activity counseling, risk factor screening, and community health fairs.
- D) Environmental changes such as the creation of walking trails or safe pathways (including sidewalks and countdown cross signals in neighborhoods.)
- E) Creation of walking clubs or other social supports that encourage physical activity.
- F) Point-of-decision prompts that encourage use of stairs or walking the last stop of your bus or subway route.
- G) Individually-adapted behavior change programs that incorporate goals-setting, social support, behavioral reinforcement and structured problem solving to implement and maintain behavioral change.

Activity 2: Healthy Eating

- A) Programs to increase healthy food choices in restaurants, grocery stores, worksites, schools, and other community settings.
- B) Strategies to increase farmers markets, fresh fruits and vegetables, and community gardens for residents.
- C) Activities that increase access to supermarkets with more healthy and affordable food choices in communities where healthy foods are not widely available or are too expensive.
- D) Programs that influence school foods contracts to include more fruits and vegetables and whole grain foods.
- E) Community-wide campaigns that incorporate messaging through various media in combination with didactic nutrition education and counseling.

F) Programs that support and increase the use and length of breastfeeding.

Activity 3: Oral Health

A) Environmental change such as Community Water Fluoridation: Community water fluoridation is safe and the most cost-effective, and practical way to prevent cavities in a population/community. Grant funding could educate residents and decision-makers on the benefits of fluoridation, as well as purchase and installation of fluoridation equipment and supplies.

B) School/School Children Oral Health: This would support programs to prevent dental disease in schools such as a fluoride mouthrinse or tablet program for a community that does not fluoridate their water and with school-based prevention (sealant) programs in communities with or without fluoridation. Communities may use funds from this program to implement the state's fluoride mouthrinse or tablet program if they are not fluoridated or implement a school-based sealant program working with the Office of Oral Health, and may work with the state's Dental Society and Dental Hygiene Association, dental and dental hygiene schools, local dentists and dental hygienists and community health center dental programs.

C) In schools, Wellness programs can incorporate oral health education in the school curriculum, and work with the local dentists and dental hygienists and community health center dental programs to provide oral hygiene education as needed at the start of kindergarten and as needed in grades K-12, as well as mouth guard use could be promoted with physical fitness and healthy eating programs.

D) Community-based education and prevention activities regarding oral health needs: For the general population, programs may seek to increase oral screenings by increasing prevention information in collaboration with area dentists and dental hygienists. For elders, nursing home residents need their mouths and dentures periodically cleaned and refitted. Applicants may apply for funds to incorporate oral health education into nursing staff trainings.

Category 4: Cross-cutting activities

A) Enlisting the support of organizations and settings to encourage and support healthy behavior, such as physical activity, good nutrition, and tobacco cessation (coalition building.)

B) Establishing linkages between health systems and community services that encourage a range of healthy behaviors.

Program Guidelines

While the settings and activities should form the core of the proposed program(s), the goal of this Wellness Initiative is to develop programs that are holistic in their approach to health and not implemented without cognizance of other issues that are critically important to the Common-*health* of Massachusetts. Please read each of the guidelines below and be prepared to address them in your response to this RFR. **Note: We encourage all grant applicants to be familiar with and think about these guidelines. However, only applicants**

requesting large grants need to specifically address and respond to these guidelines in their proposal.

Guideline 1: Coordination with tobacco control efforts

The reduction of tobacco use is essential to improving the health of Massachusetts residents. Smoking increases incidence of cancer, lung disease, asthma, heart disease and stroke. A number of new and expanded initiatives in the area of tobacco control are currently being implemented by the Massachusetts Tobacco Control Program. Thus, this RFR will not specifically fund efforts in this area.

However, linkage and collaboration with tobacco control efforts will be viewed as a desirable and necessary component to a successful applicant. Evidence of collaboration with or inclusion of tobacco control efforts may be provided by 1) inclusion of letter(s) of support from local tobacco control programs 2) linkages through memoranda of understanding with organizations or service providers providing tobacco cessation services or 3) incorporation of evidence-based tobacco control efforts into a cross-cutting wellness initiative. If choice (3) is selected, it must be shown to be cost-effective in that the proposed does not duplicate or supplant existing tobacco control efforts.

Guideline 2: Understand the concept of healthy relationships into wellness efforts

Research is beginning to uncover the link between experiences of trauma including violent or sexual assault and subsequent difficulty in maintaining healthy behaviors. The Adverse Childhood Experiences (ACE) Study³, found links between adverse experiences in childhood (such as childhood sexual abuse) and adult rates of smoking, coronary obstructive pulmonary disease, intravenous drug use and hepatitis. Another study found that intimate partner violence is independently correlated with substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality.⁴

In response to the growing awareness of these connections, a group within the Department of Public Health has drafted the following vision statement:

We celebrate respect, mutuality, and equality in all of our relationships, sexual and non-sexual. Communities are sustainably engaged at all levels (individual, relational, communal, and societal) in effectively sharing responsibility and accountability for everyone's well-being. We do this work from an understanding of historical oppressions and socio-political contexts.

Our communities share a definition and norm of healthy sexuality that is safe, fosters connection, honors boundaries, respects developmental stages, and is inclusive of diverse and fluid gender identities, sexual orientations, cultures, disabilities, and ages. Sexual respect is based upon open communications and accountable constructions of masculinity, femininity, and gender. Sexuality is joyful and never violently commodified.

³ Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, et al JS. The relationship of adult health status to childhood abuse and household dysfunction. [American Journal of Preventive Medicine](#). 1998;14:245-258.

⁴ Silverman JG, Raj A, Mucci LA, and Hathaway JE. Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. [Journal of the American Medical Association](#). 2001; 286:572-579.

While the scope of this RFR is not at this time able to support program models aimed at reduction of intimate partner violence and childhood sexual abuse, recognition of the nature of the relationship of these issues to unhealthy behaviors is necessary in developing holistic approaches to wellness.

Guideline 3: Support use of the MassHealth Wellness Benefit

MassHealth has recently launched phase one of the “MassHealth Wellness Program” which is an outreach campaign that was conducted in July, 2007. It is to be followed by an incentive campaign in 2008. The seven goals of the program are to get its members to:

1. Use existing tobacco cessation pharmacotherapy and counseling services to assist with attempts to quit smoking
2. Participate in recommended screenings for breast, cervical, colorectal and oral cancer.
3. Participate in recommended screening for diabetes.
4. Re-filling prescriptions and taking as prescribed, medications for treatment of co-occurring conditions of hypertension, diabetes and high cholesterol.
5. Participate in well care visits with a primary care provider.
6. Participate in evidence-based teen pregnancy prevention programs.
7. Adopt healthy habits (such as making healthy food choices and participating in adequate physical activity) that are associated with risk reduction for certain medical conditions.

Guideline 4: Address racial and ethnic disparities

Racial and ethnic disparities were found through data analysis and the regional health dialogues to be a pervasive and persistent problem in the Commonwealth. This priority is being addressed not only by the Department of Public Health, but by the Secretary of Health and Human Services and the Governor. The disparities report indicates higher rates of overweight and obesity among Blacks (non-Hispanic) and Hispanics. It is expected that many programs will either target these communities or proactively ensure that Blacks and Hispanics have access to these services.

Guideline 5: Compliance with MDPH Community Health Worker policy

The Community Health Worker (CHW) attachment may be found at the Comm-PASS “Forms & Terms” screen for this RFR. CHWs play an increasingly recognized and important role in providing community health services and eliminating racial and ethnic disparities. To the greatest extent possible, proposals should support the use and recognition of community health workers as important partners in Wellness programs.

Guideline 6: Sustainability

Program sustainability is important to ensure that changes made as a result of this program are continued should funding no longer be available. Strategies for sustainability might include a commitment to keep any coalition in place beyond the funding of this program; the assumption of activities by using the resources of schools, worksites or community organizations; or the implementation of structural changes that are self-sustaining.

Guideline 7: Evaluation

Evaluation is essential to this program, especially to the extent that programs are implemented that are innovative or that adapt other evidence-based models. Small and large programs will be expected to identify their own process and outcome measures and large programs will be expected to participate in a cross-site evaluation led by an independent evaluator.

7.3 Performance Requirements

A coordinator (staff person or consultant) must be identified as the primary contact for the Wellness Initiative. This person is responsible for attending coordination meetings, communicating with DPH Wellness staff and timely submission of program reports and invoices. The coordinator will be responsible for participating in evaluation efforts established in coordination with the Wellness Initiative.

The following funding restrictions apply:

- Funds may only be used for personnel, stipends, training, educational materials, equipment, grant-related in-state travel, and program evaluation.
- No out-of-state travel shall be purchased using funds from this grant.
- Overhead and administrative costs are limited to 15% of this grant.

Required Task	Performance Period	Payment for Satisfactory Completion of Tasks and Submission of Deliverables
Identification of program coordinator	November, 2007	
Attend initial coordination meeting of Wellness Initiative and submit first invoice	Around December 15, 2007	25%
Submission of 1 st progress report and second invoice	January 15, 2008	25%
Participate in 2 nd coordination meeting	Around March 15, 2008	
Submission of 2 nd progress report and third invoice	March 31, 2008	25%
Participate in 3 rd coordination meeting	Around May 15, 2008	
Submission of 3 rd progress report and fourth invoice	June 30, 2008	25%

Note: This schedule of payments and deliverables is for the first year of the contract and a similar schedule will be developed for subsequent grant years.

7.4 Criteria for Evaluating Responses

Proposals will be evaluated in the following areas:

1. The degree to which the bidder meets the eligibility criteria;
2. Documentation of need, including population served, numbers served, and data on how obesity, overweight and oral health needs impact your community
3. The submission of a complete and thorough application that is responsive the grant specifications and;
4. The past performance of the municipality or agency.

7.5 Response Requirements

A. Questions

The following questions must be answered and included in all responses. When answering questions, you should list the number of the question. You do not need to provide the full question as part of the narrative.

Small Program (\$10,000)

1. Setting/Catchment Area (1 page)
 - a) Describe the need for this program in your setting (school, workplace, municipality, neighborhood or community cluster).
 - b) Describe current wellness work in the proposed setting.
2. Description of Participating Organizations and Staff (1-2 pages)
 - (a) Describe your organization's capacity to implement this program. Include how this fits into your organization's mission. As Attachment 1, include a copy of your organization chart and mission statement.
 - (b) Identify staffing and roles for each staff person participating in this program. As Attachment 2, attach a resume for the Project Coordinator.
 - (c) Describe any collaborative or coalition efforts that currently exist or that are being initiated to implement this program. Identify how the participating organizations were selected to be part of the collaborative/coalition and who else is eligible or likely to participate going forward.
 - (d) Identify the specific role each collaborative/coalition partner will have in implementing the program. As Attachment 3, provide letters of support from key stakeholders including any collaborating organizations.
3. Program Summary (1-2 pages)
 - (a) Provide a brief description of the proposed program. (2-3 paragraphs)
 - (b) What is the proposed time frame for achieving the project's objectives? (1-2 paragraphs)
 - (c) Identify the particular activity that your program will undertake and the evidence base for utilizing this program. If there is no conclusive evidence base for this activity, indicate so and give your basis for believing the program will be effective by describing its similarity to or relationship to existing evidence-based programs.
 - (d) Identify the targeted population in terms of geography, age, race, ethnicity, gender and sexual orientation. Compare this population to the population in the geographic region generally and how addressing the target population addresses a specific health disparity.
4. Outcomes (1 page total)

- (a) Describe how you expect to obtain baseline information for your program.
- (b) Describe the expected outcomes of your proposed program
- (c) Indicate what systems are in place or will be put in place to support the ability to measure process and outcome measures.

Large Programs (\$60,000)

Note: For organizations proposing programmatic activity in two settings, please provide separate responses for questions 2 through 4. These additional responses should be no more than 4 pages and added after the Program Proposal under the heading “Setting 2.”

1. Setting/Catchment Area (1 page)

- c) Describe the need for this program in your setting (school, workplace, municipality, neighborhood or rural cluster).
- d) Describe current wellness work in the proposed setting.

2. Description of Collaborating Organizations and Staff (1-2 pages)

- (a) Describe your organization’s capacity to implement this program. Include how this fits into your organization’s mission. As Attachment 1, include a copy of your organization chart and mission statement.
- (b) Identify staffing and roles for each staff person participating in this program. As Attachment 2, attach a resume for the Project Coordinator.
- (c) Describe any collaborative or coalition efforts that currently exist or that are being initiated to implement this program. Identify how the participating organizations were selected to be part of the collaborative/coalition and who else is eligible or likely to participate going forward.
- (d) Identify any formal or informal linkages or agreements that are in place or will be put in place to ensure that each organization is aware of its responsibility. These make take the form of letters of support or memoranda of agreement as appendices to the application.
- (e) Identify the specific role each collaborative/coalition partner will have in implementing the program. As Attachment 3, provide letters of support from key stakeholders including any collaborating organizations. One letter should be from the Mayor or Town Manager.

3. Program Summary (1-2 pages)

- (a) Provide a brief description of the proposed program. (2-3 paragraphs)
- (b) What is the proposed time frame for achieving the project’s objectives? (1-2 paragraphs)
- (c) Identify the particular activity that your program will undertake and the evidence base for utilizing this program. If there is no conclusive evidence base for this activity, indicate so and give your basis for believing the program will be effective by describing its similarity to or relationship to existing evidence-based programs.

- (d) Identify the targeted population in terms of geography, age, race, ethnicity, gender and sexual orientation. Compare this population to the population in the geographic region generally and how addressing the target population addresses a specific health disparity.

4. Outcomes (1 page total)

- (a) Describe how you expect to obtain baseline information for your program.
- (b) Describe the expected outcomes of your proposed program
- (c) Indicate what systems are in place or will be put in place to support the ability to measure process and outcome measures.

5. Agreement with and understanding of guidelines (1-pages total)

- (a) Indicate how your program will link to or support efforts around tobacco control in your community.
- (b) Indicate your understanding of the relationship between healthy relationships and their importance in supporting Wellness initiatives. Indicate any linkages to program that address healthy relationships or seek to prevent domestic violence and sexual assault.
- (c) Discuss how your initiative might link to and support the effort to implement the MassHealth Wellness Program.
- (d) Describe the extent to which Community Health Workers will be used to implement this proposal. To the extent community health workers are used, describe your internal agency plan for training, supervising, integrating, and supporting CHWs according to the elements of an agency plan as outlined in the Community Health Worker attachment. Affirm that the CHW will participate in training and technical assistance services provided by contracted vendor such as CHEC or OWTI.
- (e) Indicate your willingness to support and work with the efforts of any independent evaluator associated with this initiative.

B. Program Budget (2 pages)

Applications should include a twelve month budget and a pro-rated budget for eight months. The pro-rated budget should include a narrative that clearly explains the purpose of each item in the financial budget. The required “**805709 Budget Form**” form is provided in Comm-PASS. If funded, applicants will submit a budget for Year 2 and Year 3 if approved for continuation funding in those years.

C. Selection

1. The geographic region for service delivery of the proposed program will be a key factor in evaluation of applications. MDPH intends for the programs to be dispersed throughout the Commonwealth, and will provide preference to programs in communities of color which are traditionally underserved by health services.

2. MDPH expects to receive more requests than can be funded. Therefore, submission of a grant application does not guarantee receipt of an award. Furthermore, grants that are awarded may not be funded at the requested amount. Final awards will be commensurate with the size and scope of the proposed activities. MDPH reserves the right to conduct pre-award on-site assessments. There is no right to appeal decisions under this Request for Proposals.

8. Instructions for Submission of Responses:

Applicants should submit one (1) original and ten (10) copies of the complete proposal to:

Stewart Landers
Senior Program Director
Massachusetts Department of Public Health
250 Washington St., 2nd Floor
Boston MA 02108-4619

Letter of Intent

Potential applicants are asked to submit a letter of intent by September 21, 2007.

This is not binding on the applicant but will help the Department prepare for the review process. Applicants may submit proposals even if they have not submitted a letter of intent. Letters of intent should be sent to Stewart Landers at the same address as the applications or faxed to 617-624-5206.

When answering questions, list the number of the question. You do not need to provide the full question as part of the narrative. Recommended length of narrative questions is 4-5 but no longer than 6 pages for a small grant or 7-8 pages for a large grant but no longer than 10 pages. Applicants submitting proposals for large programs in more than one setting may extend to 13 pages total. The document should be single-spaced, using a 12-point font and one-inch margins throughout. Proposals should not be bound, but fastened with a clip or elastic band. Please use materials that can be easily recycled.

Please submit the proposal in the order requested: cover sheet, narrative, budget, and attachments including the required forms listed on the Comm-Pass “Forms & Terms” screen for this RFR. Attachments should be clearly labeled and placed in requested numerical order. Reviewers will only look at the required attachments. Other attachments will not be considered.

In accordance with the instructions on the screen, the forms listed on the Comm-PASS “Forms & Terms” screen for this grant application must be submitted with your response.

Faxed or emailed applications will not be accepted.

9. DEADLINE FOR RESPONSES Or:

Indicate Deadline Date: October 5, 2007

Indicate Deadline Time: 4:30 PM

Will a Bidders Conference be offered? No YES (Indicate Date, Time and Place):

- Monday, September 17, 2007: Public Health Council Room, 2nd floor, 250 Washington Street, Boston, MA 02138
 2:00 PM – 3:00 PM: Wellness in the Community, School, and Workplace
 3:00 PM – 4:00 PM: Integrated Chronic Disease Management Team Utilizing Community Health Workers
 4:00 PM – 5:00 PM: The Reduction of Racial and Ethnic Health Disparities
- Wednesday, September 19, 2007: Saxe Room, Worcester Public Library, 3 Salem Square, Worcester, MA 01608
 10:00 AM – 11:00 AM: Wellness in the Community, School, and Workplace
 11:00 AM – 12:00 PM: Integrated Chronic Disease Management Team Utilizing Community Health Workers
 12:00 PM – 1:00 PM: The Reduction of Racial and Ethnic Health Disparities

Will opportunity for written questions be offered? No YES (Indicate Deadline Date, Time and Address):

The Procurement Contact Person for this RFR must receive all questions by September 20, 2007 at 5:00 PM. Questions must be sent either by mail or e-mail; no phone calls or faxes will be accepted. Answers to the questions will be posted on Comm-PASS.

Will an electronic forum be offered? NO YES

10. Grant Procurement Calendar

RFR Release	September 7, 2007
Bidders' Conference (Boston)	September 17, 2007
Bidder's Conference (Worcester)	September 19, 2007
Deadline for Questions	September 20, 2007
Deadline for Letters of Intent	September 21, 2007
Deadline for Applications	October 5, 2007
Award Notices	October 23, 2007
Contracts Begin	November 1, 2007
Contracts End	June 30, 2010