Community Public Health Teams

Request for Proposals

Proposal submission deadline:
Monday, June 12, 2023 at 4:00PM PST

RISING COMMUNITIES

FORMERLY CHC Community Health Councils

COUNTY OF LOS ANGELES Public Health

Community Public Health Teams
Request for Proposals

Table of Contents

Statement of Intent

Potential proposers are encouraged to submit a statement of intent to apply for funding to participate in the Los Angeles County Department of Public Health (LACDPH) Community Public Health Teams (CPHT) pilot project by **May 16, 2023**. CPHTs must consist of a partnership between a community-based organization (CBO) and health care partner (HCP) (e.g., not-for-profit community hospitals, clinics, community health centers, etc.) or a Federally Qualified Health Center (FQHC) (HCP/FQHC). CPHT proposals that are selected will each have a LACDPH staff member partnered with their team. The primary organization will be responsible for serving as the lead administrative entity. Either the CBO or the HCP/FQHC can serve as the primary organization (*see Core Partner Roles and Responsibilities and Proposals section in the Request for Proposals (RFP) document*). The primary organization will submit a statement of intent on behalf of their CPHT via the Microsoft Form survey here. Submission is not required to apply and CPHT's not submitting a statement of intent may still apply.

Each CPHT should only submit one joint statement of intent and proposal. The following fields are required in your statement of intent submitted via the Microsoft Form survey:

1. Name of Primary Organization
2. Primary Organization Type
    a. Community-based organization
    b. Health care partner/Federally Qualified Health Center
3. Name of Contact from Primary Organization
4. Email Address for Contact from Primary Organization
5. Which other partner organization is part of your CPHT? (include name of organization, type of organization, contact name and email address)
6. What specific community/region will your CPHT focus on? Please identify the 5 – 8 contiguous census tracts that your CPHT will use to define the community you plan to work in. If these change prior to submitting your proposal, please contact us via email at DPH_CPHT@risingcommunities.org . Refer to Appendix D: Community Selection Guidance for more information on eligible census tracts. At least 75% of the proposed census tracts must meet the eligibility threshold (*also see CPHT Communities section in the RFP document*).
7. Please provide a brief statement about why your collaborative is interested in the CPHT funding opportunity (400 word limit).

Introduction

Background of project

In Los Angeles County (LAC), the COVID-19 pandemic has highlighted the need for significant investments in the local Public Health workforce and infrastructure. The extended duration of the pandemic has strained the Los Angeles County Department of Public Health (LACDPH) infrastructure and capacity to address new and worsening conditions impacting LAC communities. Strategic investments are critical to broadening, repairing, and re-envisioning the public health infrastructure while constructing and maintaining programs that will address the needs of under-resourced and disproportionately impacted communities. Strategies to eliminate gaps in COVID-19 outcomes, increase utilization of public health mitigation practices, and address inequities in chronic conditions, communicable disease, and other public health issues require investments centered on community-driven priorities. These priorities will build the capacity of the local health department and community institutions that are integral to community-centered public health service delivery.

To protect our most vulnerable communities, LACDPH will develop and pilot a new model of public health service delivery referred to as **Community Public Health Teams (CPHTs)**. CPHTs will consist of coordinated, place-based, and community-driven health practitioners who will work together with community members to identify local health

priorities, reduce gaps in health outcomes, and improve the conditions essential for overall health and well-being in high-need communities throughout LAC.

Through a shared leadership model, staff from Community-Based Organizations (CBOs), health care partners (HCPs) (e.g., not-for-profit community hospitals, clinics, community health centers, etc.) or Federally Qualified Health Centers (FQHCs) (HCP/FQHC) and dedicated Public Health staff will work together as a CPHT to provide targeted outreach and engagement services in select high-need communities with the shared goal of improving health and well-being.

The project will consist of three terms. Term 1 will be 2 months; Term 2 will be 12 months; and Term 3 will be 12 months, with the possibility of extension of up to an additional 2 years and 10 months (for a total of 60 months or 5 years). The first term includes a two-month planning phase for the CPHT subcontractors. The LACDPH fiscal intermediary, Rising Communities (formerly Community Health Councils), will serve as the third-party-administrator and work closely with LACDPH to support the planning and deployment of the CPHTs during the first term. Rising Communities will manage and administer the disbursement of funds to CPHTs and coordinate with LACDPH to provide ongoing administrative and programmatic oversight of the CPHTs throughout Term 1, Term 2, and Term 3.

Key elements of CPHTs

The goal of the CPHT pilot project is to build a community-centered system of care and strengthen the infrastructure needed to deliver coordinated, community-based services to individuals and high-need communities. CPHTs will build upon existing community-based resources and supports including relationships with local organizations and social services agencies to address various public health issues, community-identified concerns, and respond to emerging public health threats. Each CPHT will utilize a community-driven approach and will be structured to meet the unique needs of each of the ten (10) CPHT communities. The key elements of the CPHTs will build upon existing public health community-based infrastructure to focus on the following:

Workforce Expansion	Capacity Building	Service Coordination	Strengthening Partnerships	Resource Networking
•Expand the public health workforce through partnerships with community-based organizations and local health care partners.	•Build and maintain capacity of CPHTs to develop and apply equitable policies and practices to improve health outcomes of disproportionally impacted populations.	•Expand the coordination and provision of field-based public health services to improve individual and community level health outcomes.	•Mobilize partners to advance health equity and address social determinants of health.	•Utilize a community-driven approach to build regional resource networks that address priorities within high-need communities.

CPHT activities will focus on:

CPHT Pilot Project

Framework

The core partners of each CPHT will represent diverse disciplines comprised of staff from local **CBOs**, **HCP/FQHC partners**, **and a dedicated Public Health staff member** to engage residents and address community health priorities. These partners will display a high level of readiness to leverage their credibility and expertise to convene community members, community organizations, and other local stakeholders to elevate community needs, share information, facilitate partnerships, identify community strengths and resources, and move groups into collective action. The graphic below displays the framework model of the CPHT and illustrates all core partners: **CBO, HCP/FQHC, and dedicated Public Health staff**.

CPHTs will identify and secure additional partners to provide requested community resources and services aligned with community-identified needs (e.g., businesses, education sector, social service organizations, etc.). As a community-driven project, community members also play a crucial role by providing input and feedback to ensure projects are reflective and meeting community identified needs.

Figure 1. CPHT Framework

Core Partner Roles and Responsibilities

CPHTs will operate under a shared leadership model, where each core partner takes ownership and responsibility for the role they play in meeting the project goal. All partners in the CPHT work collaboratively under a shared purpose, value each partners' contribution equally through equitable decision-making, and share accountability. One partner (CBO or

HCP/FQHC) will serve as the lead administrative entity for the CPHT and will work with Rising Communities and LACDPH Administrative Staff to oversee grant requirements and deliverables. The dedicated Public Health staff will serve as a core partner in the CPHT to provide resources and forge partnerships that will allow CPHTs to achieve designated outcomes.

Each CPHT will need to clearly define partner roles and responsibilities, identify the process for how administrative and programmatic decisions are made (e.g., based on skills, capabilities, and team responsibilities, etc.), and how communication will flow across the CPHT by developing a written internal governance structure. All CPHT Core Partners are expected to have equitable input and a voice in decision-making in alignment with the values of this initiative. Some of the anticipated roles and responsibilities of CPHT core partners and ancillary partners are outlined in the table below. Each CPHT will:

- Consist of a partnership between a CBO and HCP/FQHC organization formalized through a contractual agreement.
- Identify the primary organization and the secondary organization (either the CBO or the HCP/FQHC). The primary organization will be responsible for serving as the lead administrative entity.
- Define the roles and responsibilities of primary and secondary organizations.
- Describe how dedicated Public Health staff will be integrated into program planning and implementation efforts.

Table 1. CPHT Core Partners Roles and Responsibilities

CPHT Core Partners	**Role**	**Responsibilities** *See Scope of Work (Appendix B-1 to B-3) for more details*
Community-Based Organizations (CBOs)	Mobilize the community to identify, highlight, and address challenges to community health and raise awareness/provide health and social service-related resources and referrals to community members.	The following responsibilities can be led by the CBO and/or the HCP/FQHC: • Provide outreach and education to community members including annual household visits • Lead community action plan development and implementation • Host a minimum of two (2) community convenings each year and participate, as appropriate, in other community convenings • Support vaccination efforts including mobile clinics/events* • Offer health screenings and household assessments* • Provide systems navigation and/or referrals to health care, mental health, and social support services • Lead communications development • Collect health data • Serve on countywide CPHT Leadership Team • Identify and mobilize partners • Offer household assessments, coordination, and education
Health Care Partner (HCP)/Federally Qualified Health Center (FQHC)	Provide health-related resources and services to community members residing in designated communities to address healthcare needs. Health-related services should be inclusive of ways to access and/or provide specialty care, mental health, dental and vision with appropriate mechanisms in place to drive adherence to care and treatment plans.	

		• Perform disease investigation (case investigation/contact tracing on select communicable diseases) • Partner with LACDPH and other funders to build capacity and develop a sustainability plan • Oversee CPHT Advisory Committee, inclusive of community leaders to allow community members to participate in decision-making *(*see Proposal narrative section 3. CPHT Budget template, Unallowable costs*)
Dedicated Public Health Staff	Regional representative from LACDPH that will serve in a supportive role to provide resources and forge partnerships that will allow CPHTs to achieve designated outcomes. This LACDPH member will also provide administrative and programmatic support and guidance for public health resources or services. This core partner may also provide support around communications.	• Provide CPHT partner coordination • Support countywide CPHT Leadership Team Meetings • Support community convenings and CPHT Advisory Committee • Support development of community action plans • Serve as a liaison with other Public Health programs, County Departments, and community partners • Expand partnerships as directed by the CPHT • Provide technical assistance • Respond to requests for information and resources • Stay abreast of current and emerging health issues to assist with educating teams and informing the local community response • Assist with the development of activities that address community-driven concerns

Table 2. CPHT Ancillary Partners Roles and Responsibilities

Ancillary Partners	Role	Responsibilities
Community Members and additional community organizations	Engage in ongoing CPHT activities and provide feedback to administrative, programmatic, and evaluative components of the project to ensure they are reflective of community needs.	• Community convening participation • Identify local health priorities • Provide ongoing input • Serve in a leadership role, as identified
CPHT Advisory Committee	Opportunity for community members and partner agencies to provide guidance to CPHTs through ongoing participation and more defined roles.	• Participate as part of a leadership group • Contribute to and support community convening events (e.g., planning, managing, presenting at event)

		• Contribute to the planning, development, tracking, and evaluation of Community Action Plans
Lead Fiscal Agency (Rising Communities, formerly Community Health Councils)	Provide administrative, fiscal, and programmatic oversight to CPHTs.	• Solicit and contract with program partners • Support the development and implementation of CPHTs • Fiscal and contractual monitoring • Partnership coordination and capacity building • Training assessment and coordination • Provide technical assistance • Support program evaluation
LACDPH Administrative Staff	To provide administrative and programmatic support to Rising Communities and CPHTs.	• Provide direction and guidance to Rising Communities and CPHTs on programmatic implementation, policy, fiscal and procedural requirements

CPHT Communities

CPHTs will be geographically distributed across ten (10) high-need communities and located across all five (5) Supervisorial Districts. The ten (10) communities will be identified using a 25% threshold set using the California Healthy Places Index (HPI) and Centers for Disease Control and Prevention (CDC) Social Vulnerability Index (SVI). The eligible regions are displayed via the Public Health CPHT Proposed Communities Mapping Tool webpage and in Appendix D Community Selection Guidance. The map can display the lowest quartile regions using HPI for the least healthy communities; and the highest quartile regions using SVI for the most vulnerable communities using the map layers. All highlighted areas on the maps represent the least healthy (HPI) or most vulnerable (SVI) communities across LAC. For more information and a summary on the indices used to identify high-need communities in LAC please see Appendix C. Either one is acceptable to use to identify CPHT communities. All census tracts should be identified using one of the indices, not both.

Each CPHT will select, identify, and define the boundaries of their respective CPHT community at the census tract level. CPHT communities will include 5 – 8 contiguous census tracts with a total of approximately 8,000 – 13,000 households. Contiguous census tracts are those sharing a common border or touching/connecting to one another. CPHTs will work within their selected communities to prioritize specific issues identified by community members and develop strategies within defined geographic areas. Using the Public Health CPHT Proposed Communities Mapping Tool webpage and Appendix D Community Selection Guidance, each CPHT will identify and select the region and census tracts where their communities and partnerships lie (at least 75% of the proposed census tracts must meet the 25% threshold for least healthy (HPI) ~~and~~ or most vulnerable (SVI)). CPHTs may also choose to use additional key metrics from other community-identified health indicators (e.g., Public Health, California Department of Public Health, CDC, etc.) to assist in community selection.

CPHTs can utilize the Public Health CPHT Proposed Communities Mapping Tool webpage to identify the eligible region and census tracts that define their specific CPHT community. Having CPHTs identify their own communities is intended to leverage and build upon existing well-established networks and resources within each target community. CPHTs will have the opportunity to expand on how these community resources will be utilized in their communities through this proposal. If proposers have questions related to the selection of census tracts and/or meeting the 75% requirement, please email DPH_CPHT@risingcommunities.org.

CPHT partners will have a history of working in the selected community, which may include a physical location in the geographic area to improve access to services and information for community members, though not required.

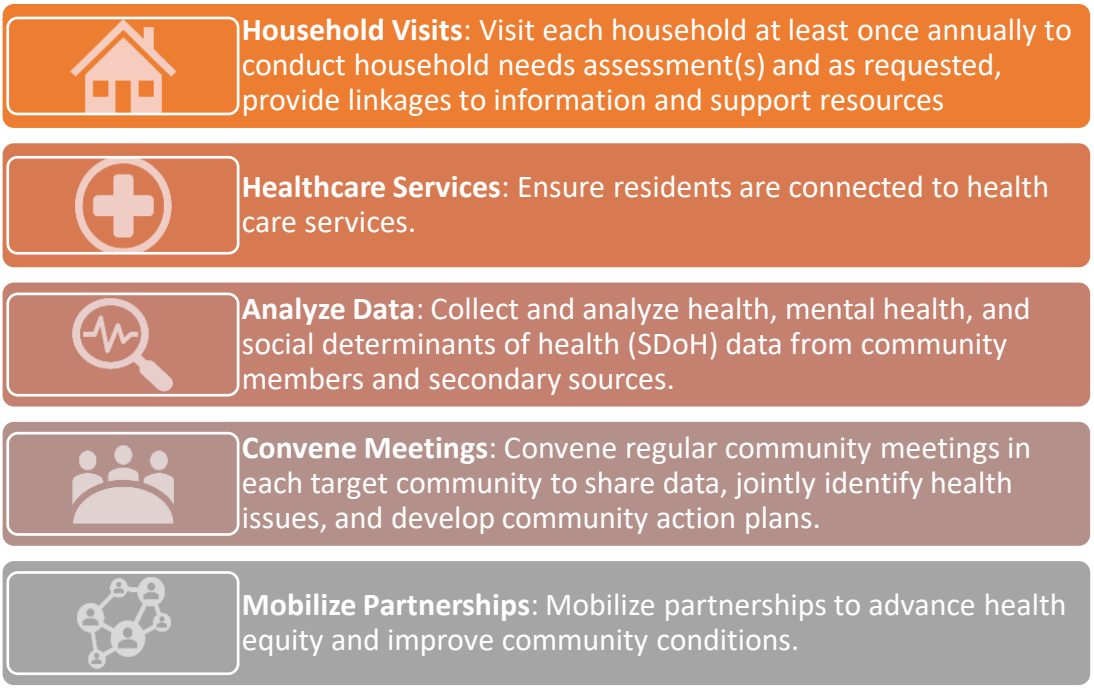
Values

The values below represent the guiding principles of the CPHTs and how partners and community members are engaged and acknowledged. CPHTs will have the opportunity to illustrate how any of the values below are reflected in the proposed intervention.

- **System equity**: CPHT partners will work with communities to ensure that all community members in the service area have access to the goods, services, resources, and power needed for optimal health and well-being.
- **Sustainability**: CPHT partners will actively plan for the continued support of community commitments, investments, and assets to achieve long-term program and population outcomes.
- **Quality assurance**: CPHT partners will build in accountability and monitoring mechanisms to ensure that ongoing program activities are implemented as planned and that the program achieves intended outcomes.
- **Anti-racism, anti-discrimination, and anti-stigma**: CPHT partners will approach work through an equity lens to help build and repair community trust; recognize and work to dismantle implicit biases in social systems; and be inclusive of all community members without judgment or labels.
- **Trust**: CPHT partners will focus on relationship-building with each other and with the community, to operate in a safe space of mutual respect, reliability, and collaboration to focus on shared goals.
- **Trauma-informed**: CPHT partners will recognize and be sensitive to the lived experience of individuals that have experienced trauma (e.g., historical, physical, emotional, psychological, etc.).
- **Accessible & Inclusive**: CPHT partners will value, honor, and respect the rights, differences, dignity, and worth of all people to create welcoming environments that invite and sustain meaningful engagement with community members and organizations that represent diversity in ability, experience, thought, language, and culture.
- **Community Engagement**: CPHT partners will ensure that community members have an important and active role in program implementation, and that activities are representative and reflective of community needs. The level of involvement ranges from information sharing, consultation, participation and involvement, collaboration, and decision-making, to shared power to guide program development and foster lasting collaboration.

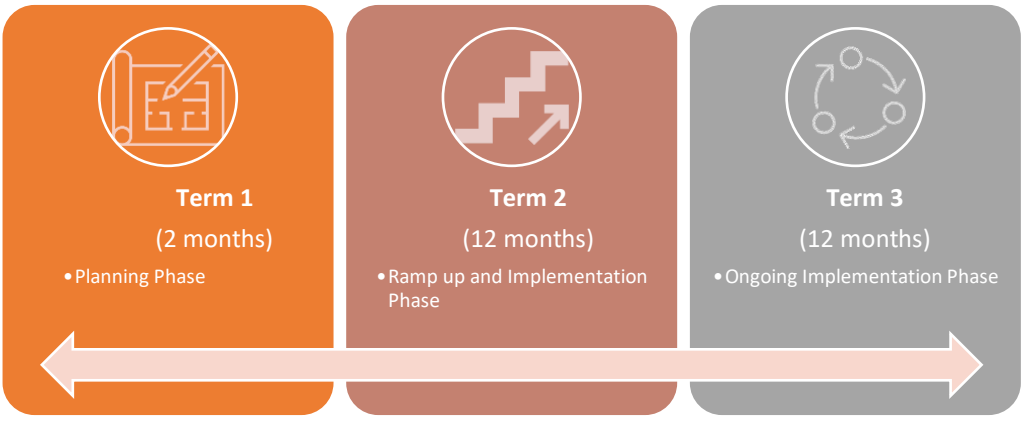
Core Strategies

The members of each CPHT will represent diverse disciplines comprised of staff from local CBOs, HCPs/FQHCs, and dedicated Public Health staff to engage community members and address health priorities utilizing the core strategies described below. Since each CPHT community will be unique, there will be room for flexibility for the implementation of these core strategies to account for the needs, comfort level, and input by community members. Additional details and the timeline for implementation of core strategies can be found in Appendix B-1 to B-3 Scope of Work for Term 1, 2, and 3.



Scope of Work Activities

As mentioned in the Key Elements of CPHTs section above, CPHT activities will focus on 3 key areas: outreach, engagement, and services. CPHTs must work with Rising Communities and LACDPH to receive programmatic oversight and guidance to ensure that they are serving their respective CPHT community and implementing program activities. Details on responsibilities and activities to be conducted by CPHTs can be found in Appendix B-1 to B-3 Scopes of Work: Term 1 (Planning Phase), Term 2 (Ramp Up and Implementation Phase), and Term 3 (Ongoing Implementation Phase). There is a possibility of extension of up to additional 2 years and 10 months (for a total of 60 months or 5 years). See below for what example activities may include, but are not limited to:



Term 1

- Develop an implementation plan approved by Rising Communities and LACDPH administrative staff to outline activities and services in their respective CPHT community.
- Each CPHT must designate two (2) FTE Program Managers to oversee the implementation of on-the-ground activities. One Program Manager will oversee programmatic requirements and the other will manage administrative duties. These Program Managers will work closely with Rising Communities, one (1) dedicated

Public Health staff, and liaise with LACDPH administrative staff. CPHTs are required to have sufficient staff to comply with all contractual obligations and determine final staffing structure.

- Designate a programmatic lead to be the main point of contact for Rising Communities and LACDPH administrative staff. Programmatic lead will be responsible for ensuring that contracted partners are aware of all project requirements and participate in meetings to provide guidance to staff. Programmatic lead will participate in regular meetings with Rising Communities and/or LACDPH administrative staff to check in on project progress.

Term 2 and 3

- Implement core strategies such as:
    - Visiting up to 8,000 – 13,000 households in the census tracts of their respective CPHT community within Term 2 and Term 3 to offer and conduct household needs assessments and provide linkages for support services.
    - Collecting and analyze health, mental health, and social determinants of health (SDoH) data from community members and secondary sources.
    - Hosting a minimum of two (2) community convenings annually in their respective CPHT community and participate, as appropriate, in other community convenings. The purpose of these community convenings will be to share data, jointly identify local health priorities, build consensus, and develop community action plans.
- Responsible for reporting on programmatic activities, data metrics, and project outcomes. Compile CPHT monthly and final progress reports in addition to year-end reports and regular invoices for submission to Rising Communities and LACDPH administrative staff.
- Participate in CPHT Leadership meetings with Rising Communities, LACDPH administrative staff, and other CPHTs to facilitate coordination, peer learning, and sharing of best practices and challenges.

Ongoing

- Provide ongoing opportunities for community engagement within CPHT communities.
- Ensure that program staff participate in centralized trainings, including orientation and refresher trainings, and provide guidance to staff to reinforce messaging and field guidelines, as coordinated by Rising Communities and/or LACDPH administrative staff.

Reporting Metrics

CPHTs will be responsible to monitor and track a core set of process and outcome evaluation metrics:

1) completed household needs assessments;
2) referrals to CPHT providers and/or other community resources; and
3) improvements in the health and wellness of communities in priority regions.
4) other outcome metrics as identified

Rising Communities and LACDPH administrative staff will work with each CPHT to standardize data collection methods and determine the best strategies to collect and share data. The process evaluation metrics collected will be utilized to gauge the project's success. The outcome evaluation metrics will ensure that program activities are being implemented as planned. Data will be compiled and shared across all CPHTs and with community members for participatory analysis and to guide program implementation and further develop project goals. Additionally, Rising Communities and LACDPH administrative staff will work with partners to identify metrics based on action plans, with the possibility of including additional metrics. LACDPH can adjust the core set of process and outcome evaluation metrics as needed. Examples of the types of metrics that will be collected by CPHTs may include, but is not limited to:

- **Process Metrics**
    - Staffing count and type

        - Number of staff funded by CPHT pilot project by job classification and program area
        - Staff retention rate
        - Time to fill staff positions
    - Number of households visited
    - Number of households visits completed
    - Number of individuals served
    - Number of household needs assessments completed
    - Number of referrals made
        - Type of referrals (e.g., health services, mental health, social services, etc.)
        - Referral outcome
            - Number of appointments scheduled
            - Number of appointments refused/canceled
            - Number of appointments completed
                - Service type provided
                - Follow-up provided
        - Number of screenings for chronic conditions
    - Number of ancillary partners engaged to support referrals
    - Number of community members enrolled in social services programs (participation in income benefit programs among eligible residents)
    - Number of residents enrolled in health insurance (increased % of residents with insurance and a medical home)
    - Number of community convenings
        - Number of community partner participants
        - Number of community member participants
    - Developed Community Action Plan
    - Developed and convened CPHT Leadership Group
    - Developed and implemented Communication Plan
    - Developed and deployed a process for service coordination
    - Identified and defined long-term outcomes (5 year) for each CPHT community

- **Outcome Metrics**
    - Utilize ongoing service coordination among CPHT partners to improve long-term outcomes
    - Improve long-term outcomes identified by each CPHT community

AmeriCorps

As LACDPH continues to build and expand the public health workforce, existing career pathway programs such as Public Health AmeriCorps will be leveraged to support the CPHT program. Public Health AmeriCorps is a national service opportunity created by AmeriCorps and the CDC to support the recruitment, training, and development of the next generation of public health leaders. Participating CPHT CBOs and/or HCP/FQHCs will be expected to coordinate with LACDPH to host, supervise, and track service hours of 5-8 AmeriCorps members (anticipated to begin in Term 2) through the member's term of service (12 months). AmeriCorps members will be assigned to CPHTs to support direct service to community members through community outreach and engagement, health education, and resource sharing. Members will gain onsite public health experience and training throughout their term of service. Members will serve in a part-time (half-time/three-quarter-time) capacity and must complete the required service hours within 12 months. Members will spend approximately 80% of their service hours on in-person service activities and 20% of their time on training. LACDPH will oversee all administrative activities related to the AmeriCorps program, provide regular training opportunities to Members, and will work with each CPHT to develop a Site Agreement. Member living allowance, associated benefits (FICA, Worker's Compensation), and mileage will be covered by LACDPH through a grant received by

AmeriCorps. Host sites will be expected to provide office and program supplies, equipment, and other Member needs (e.g. key card, parking pass, volunteer pass, etc.).

Proposals

LACDPH and Rising Communities are committed to leading with a community-driven approach that collaborates with impacted communities to identify and address public health concerns. LACDPH and Rising Communities will strengthen the capacity of the public health workforce to engage and empower community members, build trust, establish local networks, and encourage cross-sector collaboration and shared learning. LAC's diversity requires that we create and maintain strong partnerships with community stakeholders with a long-standing history in target communities and possess a deep understanding of the culture, social dynamics, disinvestments, and community assets that contribute to the health status of community members.

CPHT proposals need to be submitted by one organization and consist of a partnership between a CBO and HCP/FQHC formalized through a contractual agreement. The contractual agreement does not need to be in place at the time proposals are submitted. If the CPHT is selected, the contractual agreement needs to be in place within 30 days of award. Each CPHT should identify the primary organization and the secondary organization (either the CBO or the HCP/FQHC). The primary organization will serve as the anchor and be responsible for serving as the lead administrative entity. The primary organization with contract directly with Rising Communities and subcontract with the secondary organization. The primary organization will be responsible for all associated administrative responsibilities related to the primary contract and subcontract(s) (e.g. invoice submission, payment processing, contract monitoring, reporting, etc.). The CPHT will need to clearly define the roles and responsibilities of primary and secondary organizations. CPHTs will utilize a data-driven approach to identify high-need, high-priority census tracts in communities throughout Los Angeles County and work as part of a multidisciplinary team, inclusive of the CBO, HCP/FQHC, and dedicated Public Health staff, to address various public health issues and community-identified concerns and respond to emerging public health needs.

This funding opportunity is intended to support up to 10 CPHT high-need communities at $250,000 for Term 1 (2 months), $1,500,000 for Term 2 (12 months), and $1,500,000 for Term 3 (12 months), with the possibility of extension of up to additional 2 years and 10 months (for a total of 60 months or 5 years). Rising Communities, through a diverse review panel of subject matter experts, will select CPHTs to ensure representation across all 5 Supervisorial Districts in LAC.

Eligibility Requirements

Proposers are organizations partnering to create a CPHT. Interested and qualified Proposers must meet each of the Eligibility Requirements (can be one or both organizations) on the day the proposals are due. Proposers should address these requirements through the Proposal narrative sections indicated below:

- This funding opportunity is only open to organizations located within LAC and excludes Long Beach and Pasadena (these cities fall outside the jurisdiction of LAC for the purposes of this initiative)
- Consist of a partnership between a CBO/non-profit organization and HCP/FQHC organization. A HCP/FQHC organization may be a not-for-profit community hospital, clinic, community health center, etc. For profit organizations are not eligible to apply. (*see Proposal narrative section 1. CPHT Collaborative, Proposed core CPHT partners*)
- Identify the primary and secondary organization (i.e., either the CBO or the HCP/FQHC). The primary organization will serve as the lead administrative entity and have the capacity to subcontract with the secondary organization and will oversee all administrative responsibilities. This award is strictly cost reimbursement. Payment will be provided on a monthly basis for allowable costs incurred by the CPHT after work/services have been provided and invoiced with appropriate supporting documentation. (*see Proposal narrative section 1. CPHT Collaborative, CPHT internal governance structure*)

- Identify and select the region and census tracts where communities and partnerships lie (at least 75% of the proposed census tracts must meet the 25% threshold for least healthy (HPI) and most vulnerable (SVI)). It is a minimum eligibility requirement that 75% of census tracts need to meet the 25% threshold. (*see Proposal narrative section 2. CPHT program proposal, Census tracts*)

Proposer must have a minimum of three (3) years of experience within the last five (5) years providing community outreach and engagement services, which must include the following:

- Coordinating and conducting community outreach with diverse community stakeholders (*see Proposal narrative section 1. CPHT Collaborative, CPHT partners' experience in community outreach and engagement*)
- Utilizing various engagement strategies to conduct community outreach (*see Proposal narrative section 1. CPHT Collaborative, CPHT partners' experience in community outreach and engagement*)

Proposer must have a minimum of three (3) years of experience within the last five (5) years working in multi-disciplinary collaborative partnerships, which must include the following:

- Coordinating and/or participating in a collaborative partnership with diverse community stakeholders (*see Proposal narrative section 1. CPHT Collaborative, CPHT partners' experience in community outreach and engagement*)
- Advancing the work of collaborative partnerships by coordinating and mobilizing resources (*see Proposal narrative section 2.CPHT program proposal, Community Resources*)

Proposer must have a minimum of three (3) years of experience within the last five (5) years coordinating and/or delivering health care services, which can include the following (*see Proposal narrative section 1. CPHT Collaborative, CPHT partners' experience in community outreach and engagement*):

- Supporting vaccination efforts
- Offering health screenings, health care assessments, and education
- Providing systems navigation and/or referrals to health care, mental health, and social support services
- Performing disease investigation such as case investigation/contact tracing on communicable diseases

Proposal Narrative

Proposer must provide a written narrative of a maximum 15 pages (1 in. margins, 8.5x11in. page size, Times New Roman font, font size 11, single spacing) that clearly demonstrates that they meet the requirements below and previous experience conveys their ability to implement the proposed scope of work (Appendix B-1 to B-3). The narrative must include a description of:

a) The number of years of experience and meet minimum eligibility requirements as indicated,
b) The types and names of the organizations worked with; and
c) The type of work performed.

1. **<u>CPHT Collaborative—6 pages max</u>**
    - **Proposed core CPHT partners—CBO and HCP/FQHC (*minimum eligibility requirement*)**
        i. Background: Provide a description and background information for each of the two organizations (CBO and HCP/FQHC) that will be applying to lead the CPHT collaborative including each organization's history, mission, and structure
        ii. History of collaboration: Describe the history of the collaborative partnership including past and current initiatives, projects, and activities and positive outcomes from work done in partnership.
        iii. Existing investments: Describe demonstrated investments or new innovations in the community by partners and how the CPHT can build upon the existing structure of well-established community work to not duplicate efforts

iv. Partnership building: Describe core CPHT partners' experience coordinating or forging new partnerships to meet the needs of the community
v. Integration: Describe how you will work collaboratively with LACDPH and how you will integrate the one (1) Public Health staff dedicated to serve as the liaison into the core CPHT partnership? (see Figure 1. CPHT Framework and Table 1. CPHT Core Partners Roles and Responsibilities)
vi. Commitment to equity: Provide any justice, equity, diversity and inclusion statement your organization has created and shared.

- **Experience managing collaborative partnerships**
  i. Convening experience: Describe experience managing and convening multi-disciplinary committees, including CBOs, HCP/FQHCs, governmental agencies, and community stakeholders
  ii. Team and trust building: Describe any history of enhancing familiarity and trust across multi-disciplinary committees to support teambuilding, diversity, and problem solving
- **Capacity building**
  i. Capacity building: Describe how the CPHT partnership can be leveraged to build capacity of community-based organizations, HCP/FQHCs, and/or community stakeholders to foster leadership and skills development in high-need communities
- **CPHT partners' experience in community outreach and engagement (*minimum eligibility requirement*)**
  i. Outreach and engagement experience: Provide each organizations' experience conducting community outreach and engagement around the social determinants of health in high-need communities throughout LAC;
    1. Optional: Provide any methodological and/or evidence-based practices, you are using as the basis to your community outreach and engagement strategies, with references.
  ii. Experience with diverse stakeholders: Include direct experience working in partnership with community stakeholders such as parents, community members, CBOs, HCP/FQHCs, governmental agencies, and/or other key leaders or groups
  iii. Community engagement strategies: Provide examples that demonstrate a deep understanding of community engagement strategies to reduce gaps in health outcomes in high-need communities throughout LAC;
    1. Optional: Provide any methodological and/or evidence-based practices, , you are using as the basis to your community engagement strategies, with references.
  iv. Experience delivering and/or coordinating health care services: Describe experience delivering or coordinating health care services in high-need communities;
    1. Optional: Provide any methodological and/or evidence-based practices, you are using as the basis to your health care delivery strategies, with references.
- **CPHT internal governance structure (*minimum eligibility requirement*)**
  i. Governance structure: Describe the proposed CPHT internal governance structure or the process the CPHT will use to develop the governance structure and partner agreements. Identify the primary and secondary organization.
  ii. Partner roles and responsibilities: Describe how partners envision operationalizing CPHT implementation, including outlining roles and responsibilities for each CPHT partner (see Figure 1 CPHT Framework)
  iii. Decision making process: Identify the process for how administrative and programmatic decisions are made
  iv. Communication process: Describe how communication will flow across the CPHT between partners
  v. Continuity of services: Identify a process to control any changes to program after funding is awarded if a partner changes, so as not to change the overall goals and/or outcomes

2. **<u>CPHT program proposal—9 pages max</u>**

- **Community needs**
    i. Community needs: It is expected that community input will drive and prioritize much of the work that CPHTs focus on. With that understanding, please describe the community issues/needs that the CPHT has already identified in the proposed community. Describe the methods used by the CPHT to identify these needs/priorities. Provide data that supports the identified needs and gaps.
- **Community selection**—refer to Appendix C Information on the Social Vulnerability Index (SVI) and California Healthy Places Index (HPI) and Appendix D Community Selection Guidance
    i. Community name and index: Identify the community the CPHT will provide services in and the index (SVI or HPI) and/or additional data used to select the location
    ii. Census tracts: List the numbers of the 5 – 8 contiguous census tracts with up to 8,000 – 13,000 households where the community will be provided services. At least 75% of the proposed census tracts must meet the 25% threshold for least healthy (HPI) ~~and/~~or most vulnerable (SVI). **(*minimum eligibility requirement*)**
    iii. Experience with proposed community: Describe CPHT partners' understanding and experience working within the proposed community.
    iv. Partner locations: Are the CPHT and partners located in the selected community?
- **Intervention**
    i. Implementation: Describe how the CPHT will implement the core strategies and any other proposed community-driven intervention to address community needs and achieve the goal of the CPHT (see Appendices B-1 to B-3 Scope of Work and Core Strategies section above)
    ii. CPHT values: Describe how any of the CPHT values align with the proposed interventions and program implementation
- **Populations**
    i. Populations of concern: Explicitly identify and define populations of concern and the strategies the CPHT will utilize to engage hard to reach priority populations that may not have critical mass within the community (e.g. individual's living with disabilities, monolingual populations, etc.)
    ii. Community member integration: Describe how community members will be integrated into CPHT leadership/advisory structures and decision-making.
- **Community resources (*minimum eligibility requirement*)**
    i. Community resources: Identify and define existing community resources and how they can be leveraged to support the CPHT program
        1. Physical infrastructure within the community such as parks, community centers, senior centers, playgrounds, bike paths, transportation systems, etc.
        2. Social networks within the community such as existing relationships, partnerships, community coalitions, neighborhood councils, resident advisory boards that can provide input, etc.
    ii. Community readiness: Describe how community members are positioned/ready to accept and participate in this work

3. CPHT Budget template—this is not included in the total page count

- Use the budget templates (Appendix E-1, E-2, E-3) to describe and provide a brief justification for each of the amounts listed on the budget to implement CPHT services during Terms 1, 2, and 3. The budget justification must provide sufficient detail(s) to enable the reviewer to determine how they arrived at each proposed cost, and how each line item will assist in providing the proposed program services. The budget template should include budget details for both the primary and secondary organizations. There is a column in each budget template to identify if a cost is for the primary or secondary organization. The budget justification must:

i. Be submitted utilizing the format provided, and must include accurate calculations, (refer to Appendix E-1, E-2, E-3);
ii. Be clear, and in line with the line-item budget. The budget justification must explain how each of the costs fiscally supports the activities in Appendix B-1, B-2, B-3 Scopes of Work, staffing requirements, organizational requirements, necessary supplies, and any one-time costs;
iii. Be feasible, and cost-effective for the required quantity and quality of activities in Appendix B-1, B-2, B-3 Scopes of Work;
iv. Include the minimum staffing requirements as outlined in Appendix B-1; and
v. Provide operating costs that are consistent with the quantity and type of activities to be performed, and appropriate in terms of the scope of the project.

- The funding should not exceed $250,000 for Term 1 (2 months), $1,500,000 for Term 2, and $1,500,000 for Term 3. In the budget template, describe the following costs for each category, provide a justification, and identify what is necessary to implement CPHT activities and services.
    i. Personnel—justification of positions, understand the role these positions will be playing in program implementation or administration and identify if they are assigned to the primary or secondary organization. There is a column in each budget template to identify if a cost is for the primary or secondary organization.
        1. Full-time salaries: List the position title and name of each full-time employee that will provide services under the proposed project. A "full-time employee" is an individual who works 40 hours per week for the Proposer and is determined by the fact that Proposer reports and pays payroll taxes (SUI, FICA, etc.) and pays employee's income taxes as basic legal requirements. Specify "vacant" for the employee's name if the employee has not been identified and/or hired.
            a. Monthly Salary: For each full-time position, enter the employee's monthly salary.
            b. Number of Months: For each full-time position, enter the budgeted number of months each employee will work under the proposed project.
            c. Percentage (%) of Time: Enter the total percentage of time that each full-time employee will work under the proposed project. If all of an employee's time will be spent under the proposed project, enter 100% (100% means 40 hours per week). If less than 40 hours per week will be spent on the proposed project, enter the appropriate percentage of time. If an employee is a part-time staff member (working for the Proposer less than 40 hours a week) list the employee under part-time staff.
            d. Total: The salary amounts should automatically calculate in the Total column on the Excel spreadsheet provided. (For each full-time position, the monthly salary should be multiplied by the number of months and by the percentage of time.) This amount should be automatically entered in the Total column.
            e. Subtotal Full-time Salaries: The subtotal amounts for Full-time salaries should be automatically added and entered in the Total column.
        2. Part-time salaries: List the position title and name of each part-time employee that will provide services under the proposed project. A "part-time employee" is an individual who works for the Proposer on a part-time basis only and is paid on an hourly basis. Specify "vacant" for the employee's name if the employee has not been identified and/or hired. (Note: If an employee works 40 hours per week but only 40% of the employee's time is charged to the project and 60% charged to another project, the employee should be listed under full-time staff.)
            a. Hourly Salary: For each part-time position, enter the employee's hourly rate.

b. Number of hours worked annually: For each part-time position, enter the budgeted number of hours each employee will work annually under the proposed project.
c. Percentage (%) of Time: Enter the total percentage of time that each part-time employee will work under the proposed project.
d. Total: The salary amounts should automatically calculate in the Total column. (For each part-time position, the hourly rate should be multiplied by the number of hours worked annually and by the percentage of time.) This amount should automatically be entered in the Total column.
e. Subtotal Part-time Salaries: The subtotal amounts for Part-time salaries should automatically be added and entered in the Total column.

ii. Employee Benefits—Ensure employee benefits are calculated accurately for primary and secondary agencies. Adjustments to the formula in the total column may need to be made based on what is entered for full-time and part-time salaries.
1. Full-time benefits
a. Full-time Employee Benefits Rate: Enter the estimated total full-time employee benefits percentage (%) rate for which the Proposer is responsible (e.g., FICA, SUI, Workers' Compensation, retirement, etc.). The total amount of full-time employee benefits should automatically calculate in the Total column. (The Full-time Employee Benefits Rate should be multiplied by the Subtotal Full-time Salaries.)
2. Part-time benefits
a. Part-time Employee Benefits Rate: Enter the estimated total part-time employee benefits percentage (%) rate for which the Proposer is responsible (e.g., FICA, SUI, Workers' Compensation, retirement, etc.). The total amount of part-time employee benefits should automatically calculate in the Total column. (The Part-time Employee Benefits Rate should be multiplied by the Subtotal Part-time Salaries.)
3. Employee Benefits Totals: The total amount of Employee Benefits should automatically calculate in the Amount column. (The amount of Full-time Employee Benefits and the amount of Part-time Employee Benefits should be automatically added.)

iii. Fixed costs: The following fixed costs have been pre-populated in the budget forms provided and may not be altered by the Proposer:
1. Community convenings: As specified in the Scopes of Work (Appendix B-1 to B-3), each CPHT must plan and facilitate community convenings in their respective CPHT community to share data, jointly identify health issues, and develop community action plans. The fixed costs for community convenings are: $12,000 for Term 2; and $12,000 for Term 3. A portion of this funding can be used to provide meeting refreshments [e.g., food and drinks for participants of community convenings].

iv. Operating Expenses
1. Identify the type of expense (e.g., office or facility rent/lease, software licenses, cell phones, tablets, hotspots for WiFi, office supplies, printing/reproduction, general liability insurance, equipment, computers, telephone expenses, etc.) that will be required for the provision of services under the proposed project. Proposer must also provide a short description of the expense and/or methodology for arriving at the expense amount. Enter the total cost of the expense item in the Total column. The costs for operating expenses should conform to the proposed project's objectives. Please

note, there will be no reimbursement for mortgage expenses for property owned by the Proposer.

v. Mileage and Travel
    1. Identify the costs of mileage required for the provision of services under the proposed project. This may be calculated by multiplying the estimated number of miles each employee will be required to travel by the lower of the Proposer's current mileage rate or the County's prevailing rate (Los Angeles County mileage reimbursement rate is currently 61.50 cents per mile). Proposer must also identify the travel costs required for the proposed project (e.g., parking fees). Provide a short description of the expense and/or methodology for arriving at the expense amount (e.g., indicate the total number of miles and mileage rate used) and enter the total cost of the expense item in the Amount column.

vi. Other Costs: Identify other costs required for the provision of services under the proposed project (e.g., costs of printing and distributing reports and meeting refreshments [e.g., food and drinks for participants of community convenings]). Proposer may also include costs of hiring subcontractors and/or consultants (e.g., event planners, translators, subject matter experts, graphic design artists, etc.). Proposer should include costs for ongoing participant costs related to community engagement activities and improved access to CPHT services. Provide a short description of the expense and/or methodology for arriving at the expense amount (e.g., provide the type of consultant/subcontractor and indicate their hourly rate) and enter the total cost of the expense item in the Total column.
    1. Engagement Incentives—Cost for targeted community engagement incentives in the form of gift cards (in an amount no larger than $50 but could be less depending on the activity or level of involvement) will be provided to community members or partner agencies that contribute to the implementation of the activities below. The estimated allowance for this category is up to $8,000 for Term 2 and $8,000 for Term 3.
        a. CPHT community member leadership group—For community members that provide ongoing input and feedback to CPHTs as part of a leadership group.
        b. Community convenings—For community members and partner agencies who support the event (e.g., planning, managing, presenting at event). The minimum number of community convenings per year is an estimate. CPHTs have the flexibility to determine the number of community convenings they will hold based on the goals of the CPHT.
        c. Community Action Plan sessions— For community members and partner agencies that contribute to the planning, development, tracking, and evaluation of Community Action Plans.
    2. Food/meal costs for participants—CPHTs can utilize funding to cover the costs associated with food for events that will require community member participation. The estimated allowance for this category is up to $2,200 per CPHT for Term 2 and $2,200 for Term 3. Please note that a portion of the fixed costs funding for community convenings (Section iii above) can be used to provide food.
    3. Other participation costs— CPHTs have the flexibility to allocate funds accordingly to meet the needs of participants and reduce barriers to participation in CPHT activities and services. This can include costs related to childcare, transportation services (e.g. bus tokens, ride sharing, etc.), and/or interpretation services for language access to increase participation and ensure access to services by community members. The estimated costs for this category should be sufficient to ensure program implementation.

vii. Direct Costs

1. The Total Direct Costs should automatically calculate in the Amount column. (The total amounts of categories A through F should be automatically added.) Proposer must ensure that formulas/calculations are accurate.

viii. Indirect Costs
   1. Enter indirect costs required for the provision of services under the proposed project. Indirect costs are costs that are incurred for a common or joint purpose benefiting more than one cost objective, and not readily attributable to any project or service. These costs may include salaries, wages, and fringe benefits of administrative personnel whose effort benefits more than one cost objective; operational and maintenance costs that benefit more than one cost objective; and/or expenses such as rent for percentage of space occupied by administrative personnel, etc. Indirect costs should not exceed 10% of total ~~personnel costs~~ direct costs.

ix. Unallowable costs—Please note that allowability can change at any time and may be subject to approval by funding agency, CDC or CDPH.
   1. CPHTs must follow federal guidelines for unallowable costs. Please refer to this website, https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200#sp2.1.200.e for more detailed information on allowability of costs.
   2. Funding cannot be used to pay for the delivery of direct clinical services to individuals (e.g., treatment for chronic conditions, provider consultation, diagnostic procedures, etc.), except for the provision of vaccinations. All vaccination related events or activities require approval from Rising Communities and LACDPH prior to implementation.
      a. Clinical care is defined as direct treatment of an individual.
         i. Clinical care is tied to medical treatment of an individual whether it be physical or mental health.
         ii. Behavioral health services, both in-person and remote, are considered clinical care.
         iii. Testing is *not* considered clinical care.
   3. Funding is allowed to be used to assess (e.g., health-related screenings) and provide wrap-around and supportive services, which may include but are not limited to, care coordination needed to link and offer referrals to community members to increase access to health, preventative services, and social services such as healthcare assessments and screenings, scheduling appointments, transportation etc.

Selection Criteria and Scoring

Proposals will be assessed based on the comprehensiveness of the proposed CPHT program. It is anticipated that up to 10 CPHTs will be selected and will be geographically represented across high-need communities and located across all five (5) Supervisorial Districts. The scoring breakdown below provides an overview for how proposals will be evaluated.

Proposal can earn a maximum of 100 points total:

- **CPHT Collaborative—35 points—6 pages max**
   i. CPHT partners (10 points): Clearly conveys the strength of each CPHT partner (CBO and HCP/FQHC) separately, demonstrates a history of collaboration between the partners, describes investments or new innovations in the community that can be leveraged by partners, describes how the CPHT partnership can be leveraged to build capacity, describes experience forming new partnerships to meet community needs, and describes experience managing collaborative partnerships. Describes how dedicated Public Health staff will be integrated into program efforts.

ii. Community outreach and engagement (10 points): Examples of extensive experience from CPHT partners working with diverse partners, and conducting community outreach and engagement using various strategies are provided.
iii. Health care services (10 points): Examples of extensive experience from any CPHT partner delivering or coordinating health care services in high-need communities.
iv. CPHT internal governance structure (5 points): Provides a clear plan that indicates the CPHT structure (e.g. partner agreements, decision making process, communication process, continuity of services etc.), including operationalizing CPHT implementation and outlining roles and responsibilities for each CPHT partner (see Figure 1 CPHT Framework) has been thoughtfully considered and discussed between partners.

- **Proposed CPHT program—55 points—9 pages max**
  i. Community needs (15 points): Identifies the needs and gaps to be addressed through the CPHT. Supportive data is provided (may be either primary and/or secondary data).
  ii. Community populations (10 points): Identifies populations of concern within CPHT community and demonstrates a clear plan for how to engage hard to reach priority populations that may not have critical mass within the community (e.g. individual's living with disabilities, monolingual populations, etc.). Demonstrates CPHT partners' understanding and experience working within the proposed community. Describes how community members will be integrated into CPHT leadership/advisory structures and decision-making.
  iii. Intervention (25 points): Outlines the core strategies and any other proposed community-driven intervention to meet the needs of the CPHT community and achieve the goal of the CPHT. Identifies how any of the CPHT values align with the proposed intervention.
  iv. Community resources (5 points): Defines the existing community resources (physical infrastructure and social networks) and how they can be leveraged to support the CPHT program. Includes information on community readiness for CPHT program and services.
- **Budget template—10 points**
  i. Provides accurate costs and sufficient narrative and justification for all budget categories (Personnel, Employee Benefits, Fixed Costs, Operating Costs, Mileage and Travel, Other costs, Direct Costs, Indirect Costs) for Terms 1, 2, and 3. The funding should not exceed $250,000 for Term 1 (2 months), $1,500,000 for Term 2, and $1,500,000 for Term 3.

Submission Information

Submit the narrative proposal and Term 1-3 budget excel files via email to DPH_CPHT@risingcommunities.org with the subject line CPHT Proposal_[*Organization Name]* by **Monday June 12, 2023 at 4PM** . Contact DPH_CPHT@risingcommunities.org if you have any questions or concerns.

Appendices

- Appendix A: Proposal Definitions
- Appendix B-1: Scope of Work Term 1
- Appendix B-2: Scope of Work Term 2
- Appendix B-3: Scope of Work Term 3
- Appendix C: Information on the Social Vulnerability Index and California Healthy Places Index
- Appendix D: Community Selection Guidance
- Appendix E-1: Budget excel template Term 1
- Appendix E-2: Budget excel template Term 2
- Appendix E-3: Budget excel template Term 3
- Appendix F: Frequently Asked Questions (FAQs) from Informational Meeting

Community Public Health Teams (CPHTs)

Request for Proposals Definitions

The following are operational definitions for key terms used within the Request for Proposals (RFP) document and to describe activities within the CPHTs. A list of common abbreviations used throughout the RFP is also provided below.

1. **Lead Fiscal Agency**: Rising Communities, formerly Community Health Councils will provide administrative, fiscal, and programmatic oversight to CPHTs.

2. **Community-Based Organization**: Nonprofit organization within Los Angeles County that is representative of a community or significant segments of a community; and provides educational or related services to individuals in the community.

3. **Health Care Partner/Federally Qualified Health Center:** Community-driven, non-profit clinics, not-for-profit community hospitals, community health centers, or a Federally Qualified Health Center located in medically underserved areas or serving populations that are medically underserved and provide affordable, comprehensive primary and preventative care to all regardless of income level or insurance status.

4. **Primary Organization**: CPHT partner that will contract with the Lead Fiscal Agency (Rising Communities); the Primary Organization may be a Health Care Partner (HCP)/Federally Qualified Community Health Center (FQHC) or Community-Based Organization (CBO) and cannot be a for profit entity.

5. **Secondary Organization**: CPHT partner that will contract with the Primary Organization; the Secondary Organization may be a HCP/FQHC or CBO and cannot be a for profit entity.

6. **Community-driven**: Community members provide input on the design and implementation of programmatic activities to meet the community identified needs.

7. **Shared leadership model**: a high level of community engagement where the purpose is to establish partnerships and share power and decision making. It involves strong partnership structures to share decision-making with the community.

8. **Community resources**: Community-based assets and supports including relationships with local organizations and social services agencies or physical infrastructure such as parks and community centers that can be utilized to address various public health issues and community-identified concerns.

9. **Service Planning Area (SPA):** Simply a specific geographic region within Los Angeles County. Due to the large size of LA County (4,300 square miles), it has been divided into 8 geographic areas. These distinct regions allow the Department of Public Health to develop and provide more relevant public health and clinical services targeted to the specific health needs of the residents in these different areas.

10. **Health equity:** State in which everyone has a fair and just opportunity to attain their highest level of health.

11. **Place-based public health:** Community-led activities to promote health that are based on community needs and priorities.

12. **Social determinants of health (SDoH):** Nonmedical factors that influence health outcomes. Conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.[1]

13. **CPHT Values**
    a. **System equity**: CPHT partners will work with communities to ensure that all community members in the service area have access to the goods, services, resources, and power needed for optimal health and well-being.
    b. **Sustainability**: CPHT partners will actively plan for the continued support of community commitments, investments, and assets to achieve long-term program and population outcomes.
    c. **Quality assurance**: CPHT partners will build in accountability and monitoring mechanisms to ensure that ongoing program activities are implemented as planned and that the program achieves intended outcomes.
    d. **Anti-racism, anti-discrimination, and anti-stigma**: CPHT partners will approach work through an equity lens to help build and repair community trust; recognize and work to dismantle implicit biases in social systems; and be inclusive of all community members without judgment or labels.
    e. **Trust**: CPHT partners will focus on relationship-building with each other and with the community, to operate in a safe space of mutual respect, reliability, and collaboration to focus on shared goals.
    f. **Trauma-informed**: CPHT partners will recognize and be sensitive to the lived experience of individuals that have experienced trauma (e.g., historical, physical, emotional, psychological, etc.).
    g. **Accessible & Inclusive**: CPHT partners will value, honor, and respect the rights, differences, dignity, and worth of all people to create welcoming environments that invite and sustain meaningful engagement with community members and organizations that represent diversity in ability, experience, thought, language, and culture.

[1] Social Determinants of Health at CDC https://www.cdc.gov/about/sdoh/index.html

h. Community Engagement: CPHT partners will ensure that community members have an important and active role in program implementation, and that activities are representative and reflective of community needs. The level of involvement ranges from information sharing, consultation, participation and involvement, collaboration, and decision-making, to shared power to guide program development and foster lasting collaboration.

Acronyms

14. LACDPH – Los Angeles County Department of Public Health

15. CPHTs – Community Public Health Teams

16. HCP/FQHC – Health Care Partner/Federally Qualified Health Center, a member of the CPHT that is not the CBO partner; cannot be for profit entities.

17. CBO – Community Based Organization is a non-profit organization, a member of the CPHT that is not the HCP/FQHC.

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 1: Two (2) months from Date of Execution (DOE)

The CPHTs must achieve the following goals and objectives. Objectives are achieved by following the work plan, composed of implementation and evaluation activities. Activities must be completed according to the stated timelines and must be documented as specified.

Goal: Strengthen internal CPHT relationships, increase and/or maintain institutional capacity, plan and coordinate strategies and activities, and implement CPHT core strategies to provide targeted outreach, engagement, and services in select communities with the shared goal of improving health and well-being.

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
1.0 Maintain minimum staff requirements	A sufficient number of staff are needed to manage the administrative and programmatic functions of the CPHT. CPHTs may need to adjust staffing to meet the needs of the program. At a minimum, the CPHT will operate with the following staffing positions: 1.1 Position: Administrative Program Manager (1.0 FTE) 1.1.1 Experience and Educational Requirements: Master's Degree in Public Health, Public Policy, Social Work, or other relevant degree AND a minimum of one (1) year of experience implementing public health or social service programs in underserved communities OR Bachelor's Degree in a similar field and a minimum of three (3) years of experience managing grant-funded public health, social service and/or similar programs. Candidate must have experience providing administrative oversight (e.g., budget management, program tracking, reporting, staff management), assessment and evaluation, and program implementation in underserved communities, with minimum of one (1) year administering community engagement programs 1.1.2 Job Duties: This individual is responsible for overall administrative oversight over staff management, finances and budget, reporting, coordinating with partners and acts as the liaison to Public Health for administrative matters 1.2 Position: Program Manager (1 staff member @ 1.0 FTE) 1.2.1 Experience and Educational Requirements: Master's Degree in Public Health, Public Policy, Social Work, or other relevant degree AND a minimum of one (1) year of experience implementing public health or social service programs in underserved communities OR Bachelor's Degree in a similar field and a minimum of three (3) years of experience managing grant-funded public health, social	Hire/assign within 60 days of DOE and as needed	1.1. Documentation of recruitment efforts, job descriptions, job applications, resumes of hired staff, etc. 1.2. Documentation of recruitment efforts, job descriptions, job applications, resumes of hired staff, etc.

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 1: Two (2) months from Date of Execution (DOE)

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
	service and/or similar programs. Candidate must have experience providing programmatic oversight (e.g., program operations, monitoring and tracking, reporting), assessment and evaluation, and program implementation in underserved communities, with minimum of one (1) year implementing community engagement programs. The Program Manager will assign a lead person to attend meetings focused on data, assessment, and evaluation with Public Health. 1.2.2 Job Duties: This person is responsible for overall program management, planning, execution of the process objectives, program deliverables, reporting, supervising the day-to-day activities of staff, and coordinating with secondary recipients and community members and acts as the liaison to Public Health for programmatic matters. 1.3 Position: Data/Evaluation Manager (1 staff member at least @ 0.5 FTE) dedicated to data, assessment, and evaluation 1.3.1 Experience and Educational Requirements: Bachelor's Degree in Public Health, Public Policy, Epidemiology, Public Health Statistics, Public Health Microbiology or Communicable Disease Control, or other relevant degree AND a minimum of three (3) years of experience evaluating public health or social service programs in underserved communities OR a minimum of five (5) years of experience managing data or evaluation of grant-funded public health, social service and/or similar programs. Candidate must have experience providing oversight for all aspects of data management, assessment, and program evaluation (e.g., data collection and cleaning, survey/questionnaire design, program outcomes tracking, reporting outcomes), in underserved communities, with minimum of one (1) year evaluating community engagement programs 1.3.2 Job Duties: This person is responsible for oversight of data collection, tracking and management of assessments, program evaluation planning and implementation, monitoring and reporting of outcomes, supervising data staff, coordinating with secondary recipients on data requirements, and acting as the liaison to Public Health for data and evaluation matters		1.3. Documentation of recruitment efforts, job descriptions, job applications, resumes of hired staff, etc.

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 1: Two (2) months from Date of Execution (DOE)

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
2.0 Perform administrative, fiscal, and programmatic activities	2.1 Contractual agreement between CBO and HCP/FQHC finalized.	Within 30 days of DOE	2.1 Contract agreements on file with Rising Communities
	2.2. Submit monthly invoices and maintain backup expense documentation for CPHT and any secondary recipients	Monthly	2.2 Monthly invoices, general ledgers, expenditure receipts to be submitted to Rising Communities. Backup documentation submitted to Los Angeles County Department of Public Health administrative staff (LACDPH) upon request.
	2.3. Submit monthly reports completed by the end each month, the last of which will include a year-end summary and success story.	Monthly	2.3 Monthly Report using LACDPH-provided template kept on file and submitted to Rising Communities & LACDPH
	2.4. Participate in quarterly check-in calls/meetings with Rising Communities and LACDPH on administrative issues (all 10 CPHTs), more meetings may be scheduled as needed to support administrative and program goals.	Quarterly	2.4 Agenda and notes (completed by Rising Communities staff, agency staff invited to edit and correct) Kept on file at Rising Communities

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 1: Two (2) months from Date of Execution (DOE)

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
3.0 Develop a written internal governance structure	3.1. The CBO and HCP/FQHC will jointly develop a written internal governance structure document to outline roles and responsibilities of each partner; identify the process for how administrative and programmatic decisions are made; describe how communication will flow across the CPHT between partners; and identify a process to control any changes to program after funding is awarded if a partner changes, so as not to change the overall goals and/or outcomes. CBO/HCP/FQHC shared roles and responsibilities may include: • Provide outreach and education to residents through Community Health Workers • Support vaccination efforts including mobile clinics/events • Offer health screenings and family assessments • Provide systems navigation/referrals for health care/mental health services and social support • Lead communication development • Collect health data • Serve on countywide CPHT Leadership Team • Lead community action plan development • Host a minimum of two (2) community convenings each year and participate, as appropriate, in other community convenings • Offer health care assessments, coordination, and education • Perform disease investigation (Case investigation/contact tracing on select communicable diseases) • Partner with LACDPH and other funders to build capacity and develop a sustainability plan Dedicated LACDPH Staff roles and responsibilities may include: • Provide CPHT partner coordination • Support countywide CPHT Leadership Team Meetings • Support community convenings • Support development of community action plans	Within 60 days of DOE	3.1 Written internal governance structure document

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 1: Two (2) months from Date of Execution (DOE)

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
	• Serve as a liaison with other Public Health programs, County Departments, and community partners • Expand partnerships as directed by the CPHT • Provide technical assistance • Respond to requests for information and resources • Inform and educate teams about outbreaks in the area guiding the local community response • Assist with the development of activities that address community-driven concerns		
4.0 Plan, coordinate, and participate in CPHT Leadership Meetings	4.1. Conduct and/or participate in a minimum of four (4) meetings with internal CPHT partners (CBO, HCP/FQHC, and dedicated Public Health staff), to plan and coordinate program strategies, activities, and logistics within the first 2 months of pilot launch (2-month planning phase).	Within 60 days of DOE	4.1 Number of attendees, key attendees, key objectives and outcomes from meetings, and next steps, if applicable

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 2: Twelve (12) months

The CPHTs must achieve the following goals and objectives. Objectives are achieved by following the work plan, composed of implementation and evaluation activities. Activities must be completed according to the stated timelines and must be documented as specified.

Goal: Strengthen internal CPHT relationships, increase and/or maintain institutional capacity, plan and coordinate strategies and activities, and implement CPHT core strategies to provide targeted outreach, engagement, and services in select communities with the shared goal of improving health and well-being.

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
1.0 Perform administrative, fiscal, and programmatic activities	1.1. Submit monthly invoices and maintain backup expense documentation for CPHT and any secondary organizations.	Monthly	1.1. Monthly invoices, general ledgers, expenditure receipts to be submitted to Rising Communities. Backup documentation submitted to LACDPH upon request
	1.2 Submit monthly reports completed by the end each month, the last one for each year will include a year-end summary and success story.	Monthly	1.2 Monthly Report using LACDPH-provided template kept on file and submitted to Rising Communities & LACDPH
	1.3 Maintain sufficient staff needed to carry out all fiscal, administrative, and programmatic functions of this project.	Ongoing and as needed	1.3 Documentation of recruitment efforts, job descriptions, job applications, resumes of hired staff, staffing structure, organizational chart, etc.
	1.4 Complete one (1) annual Programmatic and Fiscal Contract Review and Audit by the Contractor.	Annually	1.4 Signed Audit Documents kept on file with Rising Communities and with LACDPH. Letter of Completion kept on file

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 2: Twelve (12) months

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
	1.5 Participate in evaluations or site visits, including preparation and maintenance of documents, from funding agencies.	Upon request	1.5 Letter of Completion from site visits
	1.6 Participate in 4 quarterly check-in calls/meetings with Rising Communities and LACDPH Administrative staff on administrative issues (all 10 CPHTs).	Quarterly	1.6 Meeting notes, agendas, etc.
2.0 Plan, coordinate, and participate in CPHT Leadership Meetings	2.1 Conduct and/or participate in ongoing monthly meetings with internal CPHT partners (CBO, HCP/FQHC, and dedicated Public Health staff) to plan and coordinate program implementation following the 2-month planning phase.	Monthly	2.1 Number of attendees, key attendees, key objectives and outcomes from meetings, and next steps, if applicable
	2.2. Participate in countywide CPHT leadership group meetings where the leads from each of the 10 CPHTs gather to share program progress, best practices, problem solve, and guide pilot progression.	Quarterly	2.2 Meeting agenda and notes taken by CPHT staff
	2.3. Participate in on-site meeting with Rising Communities, CPHT core partners, and LACDPH Administrative staff to ensure program activities are being implemented in alignment with CPHT values.	Annually, upon request	2.3 Summary report kept on file
3.0 Increase staff knowledge and skills through training	3.1. Have key staff members attend capacity building trainings.	Ongoing and as needed	3.1 Training completion verification checklist submitted to Rising Communities and LACDPH and kept on file
	3.2. Have newly hired staff participate in onboarding training provided by the Rising Communities, LACDPH, or any CPHT partner.	Ongoing and as needed	3.2 Training record and agenda to be kept on file
4.0 Build infrastructure and support sustainability	4.1. Begin initial discussions on sustainability planning to actively plan for the continued support of community investments and assets to achieve long-term program and population outcomes.	Within 6 months of start of Term 2	4.1 Draft sustainability plan kept on file and submitted to Rising Communities and LACDPH
	4.2. Foster relationships with ancillary partners and other entities to respond to community-identified needs and support the infrastructure of the CPHT work.	Ongoing and as needed	4.2 Activities and partnerships to be described in monthly reports

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 2: Twelve (12) months

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
5.0 In partnership with community members, offer initial household assessments	5.1. Visit each household at least once annually to offer and conduct a household assessment with individuals and as requested, link community members to education and support resources.	Annually	5.1 Completed household assessment forms kept on file
	5.2. Identify alternate locations for home visits outside of the home for community members to connect with CPHTs.	Within 3 months of start of Term 2	5.2 List of alternative locations kept on file
6.0 Ensure residents are connected to needed health care and social services	6.1. Establish a workflow process to track referrals and include accountability measures to ensure that community members receive and benefit from being connected to services.	Within 3 months of start of Term 2	6.1 Workflow process diagram that illustrates feedback loop for referrals and linkages
	6.2. Track referrals, activities, and share data on referrals and outcome metrics using a specified software platform determined by LACDPH.	Ongoing	6.2 Documentation of number of users for specified software platform
7.0 Collect and analyze health, mental health, and social determinants of health (SDOH) data from community members and secondary sources	7.1. Utilize the data collection tool developed by LACDPH to collect data during household visits on health, mental health, and SDoH. Each CPHT is allowed to add specific questions to meet the needs of the community. 7.2. Work with LACDPH to analyze and contextualize data for the CPHT.	Ongoing	7.1 Completed household assessment forms kept on file 7.2 Reports summarizing findings from data analysis
8.0 Convene regular community meetings in each target community to share data, jointly identify health issues, and develop Community Action Plans	8.1. At a minimum, host two community convenings annually. Input from the community should guide community convenings on the purpose, structure, participants, and frequency of convenings.	Biannually	8.1 Number of attendees, key attendees, key objectives and outcomes from meetings, and next steps, if applicable
	8.2. Identify specific strategies and activities for ongoing community engagement.	Within 3 months of start of Term 2	8.2 Community engagement plan using template provided by LACDPH
	8.3. Develop community action plans in coordination with community members to incorporate community feedback on needs, metrics, and long-term outcomes.	Within 6 months of start of Term 2	8.3 Community Action Plan using template provided by LACDPH

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 2: Twelve (12) months

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
	8.4. Develop and meet with a CPHT Advisory Committee to allow community members and partner agencies opportunities to provide guidance to CPHTs through ongoing participation and more defined roles such as part of a leadership group, contribution to and support of community convening events (e.g., planning, managing, presenting at event), and contribution to the planning, development, tracking, and evaluation of Community Action Plans, etc.	Meet at a minimum quarterly; frequency of meeting can be set by CPHT	8.4 Schedule of CPHT Advisory Committee meetings and meeting notes
9.0 Mobilize partnerships to advance health equity and improve community conditions	9.1. Identify ancillary partner engagement strategies and how they can be leveraged to support the work of the CPHT.	Within 3 months of start of Term 2	9.1 Ancillary Partner engagement plan using template provided by LACDPH
10.0 Work with LACDPH to evaluate program impact	10.1. Participate in process and program evaluation activities as requested by LACDPH.	As needed	10.1 Documentation to be determined
11.0 Share information about program implementation	11.1. At the request of LACDPH, participate in a media, conference, press event, publication, and other publicity opportunities to promote program activities and achievements.	As needed	11.1 Documentation to be determined

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 3: Twelve (12) months

The CPHTs must achieve the following goals and objectives. Objectives are achieved by following the work plan, composed of implementation and evaluation activities. Activities must be completed according to the stated timelines and must be documented as specified.

Goal: Strengthen internal CPHT relationships, increase and/or maintain institutional capacity, plan and coordinate strategies and activities, and implement CPHT core strategies to provide targeted outreach, engagement, and services in select communities with the shared goal of improving health and well-being.

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
1.0 Perform administrative, fiscal, and programmatic activities	**1.1.** Submit monthly invoices and maintain backup expense documentation for CPHT and any secondary organizations.	Monthly	1.1. Monthly invoices, general ledgers, expenditure receipts to be submitted to Rising Communities. Backup documentation submitted to LACDPH upon request
	1.2 Submit monthly reports completed by the end each month, the last one for each year will include a year-end summary and success story.	Monthly	1.2 Monthly Report using LACDPH-provided template kept on file and submitted to Rising Communities & LACDPH
	1.3 Maintain sufficient staff needed to carry out all fiscal, administrative, and programmatic functions of this project.	Ongoing and as needed	1.3 Documentation of recruitment efforts, job descriptions, job applications, resumes of hired staff, staffing structure, organizational chart, etc.
	1.4 Complete one (1) annual Programmatic and Fiscal Contract Review and Audit by the Contractor.	Annually	1.4 Signed Audit Documents kept on file with Rising Communities and with LACDPH. Letter of Completion kept on file

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 3: Twelve (12) months

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
	1.5 Participate in evaluations or site visits, including preparation and maintenance of documents, from funding agencies.	Upon request	1.5 Letter of Completion from site visits
	1.6 Participate in 4 quarterly check-in calls/meetings with Rising Communities and LACDPH Administrative staff on administrative issues (all 10 CPHTs).	Quarterly	1.6 Meeting notes, agendas, etc.
2.0 Plan, coordinate, and participate in CPHT Leadership Meetings	2.1 Conduct and/or participate in ongoing monthly meetings with internal CPHT partners (CBO, HCP/FQHC, and dedicated Public Health staff) to plan and coordinate program implementation following the 2-month planning phase.	Monthly	2.1 Number of attendees, key attendees, key objectives and outcomes from meetings, and next steps, if applicable
	2.2. Participate in countywide CPHT leadership group meetings where the leads from each of the 10 CPHTs gather to share program progress, best practices, problem solve, and guide pilot progression.	Quarterly	2.2 Meeting agenda and notes taken by CPHT staff
	2.3. Participate in on-site meeting with Rising Communities and CPHT core partners, and LACDPH Administrative staff to ensure program activities are being implemented in alignment with CPHT values.	Annually, upon request	2.3 Summary report kept on file
3.0 Increase staff knowledge and skills through training	3.1. Have key staff members attend capacity building trainings.	Ongoing and as needed	3.1 Training completion verification checklist submitted to Rising Communities and LACDPH and kept on file
	3.2. Have newly hired staff participate in onboarding training provided by the Rising Communities, LACDPH, or any CPHT partner.	Ongoing and as needed	3.2 Training record and agenda to be kept on file
4.0 Build infrastructure and support sustainability	4.1. Begin initial discussions on sustainability planning to actively plan for the continued support of community investments and assets to achieve long-term program and population outcomes.	Ongoing and as needed	4.1 Draft sustainability plan kept on file and submitted to Rising Communities and LACDPH
	4.2. Foster relationships with ancillary partners and other entities to respond to community-identified needs and support the infrastructure of the CPHT work.	Ongoing and as needed	4.2 Activities and partnerships to be described in monthly reports

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 3: Twelve (12) months

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
5.0 In partnership with community members, offer initial household assessments	5.1. Visit each household at least once annually to offer and conduct a household assessment with individuals and as requested, link community members to education and support resources.	Annually	5.1 Completed household assessment forms kept on file
	5.2. Identify alternate locations for home visits outside of the home for community members to connect with CPHTs.	Ongoing and as needed	5.2 List of alternative locations kept on file
6.0 Ensure residents are connected to needed health care and social services	6.1. Establish a workflow process to track referrals and include accountability measures to ensure that community members receive and benefit from being connected to services.	Ongoing and as needed	6.1 Workflow process diagram that illustrates feedback loop for referrals and linkages
	6.2. Track referrals, activities, and share data on referrals and outcome metrics using a specified software platform determined by LACDPH	Ongoing	6.2 Documentation of number of users for specified software platform
7.0 Collect and analyze health, mental health, and social determinants of health (SDOH) data from community members and secondary sources	7.1. Utilize the data collection tool developed by LACDPH to collect data during household visits on health, mental health, and SDoH. Each CPHT is allowed to add specific questions to meet the needs of the community. 7.2. Work with LACDPH to analyze and contextualize data for the CPHT.	Ongoing	7.1 Completed household assessment forms kept on file 7.2 Reports summarizing findings from data analysis
8.0 Convene regular community meetings in each target community to share data, jointly identify health issues, and develop community action plans	8.1. At a minimum, host two community convenings annually. Input from the community should guide community convenings on the purpose, structure, participants, and frequency of convenings.	Biannually	8.1 Number of attendees, key attendees, key objectives and outcomes from meetings, and next steps, if applicable
	8.2. Identify specific strategies and activities for ongoing community engagement.	Ongoing and as needed	8.2 Community engagement plan using template provided by LACDPH

COMMUNITY PUBLIC HEALTH TEAMS (CPHT)
SCOPE OF WORK

TERM 3: Twelve (12) months

OBJECTIVES	IMPLEMENTATION ACTIVITIES	TIMELINE	DOCUMENTATION/ DELIVERABLES
	8.3. Develop community action plans in coordination with community members to incorporate community feedback on needs, metrics, and long-term outcomes.	Ongoing and as needed	8.3 Community Action Plan using template provided by LACDPH
	8.4. Develop and meet with a CPHT Advisory Committee to allow community members and partner agencies opportunities to provide guidance to CPHTs through ongoing participation and more defined roles such as part of a leadership group, contribution to and support of community convening events (e.g., planning, managing, presenting at event), and contribution to the planning, development, tracking, and evaluation of Community Action Plans, etc.	Meet at a minimum quarterly; frequency of meeting can be set by CPHT	8.4 Schedule of CPHT Advisory Committee meetings
9.0 Mobilize partnerships to advance health equity and improve community conditions	9.1. Identify ancillary partner engagement strategies and how they can be leveraged to support the work of the CPHT.	Ongoing and as needed	9.1 Ancillary Partner engagement plan using template provided by LACDPH
10.0 Work with Public Health to evaluate program impact	10.1. Participate in process and program evaluation activities as requested by LACDPH.	As needed	10.1 Documentation to be determined
11.0 Share information about program implementation	11.1. At the request of LACDPH, participate in a media, conference, press event, publication, and other publicity opportunities to promote program activities and achievements.	As needed	11.1 Documentation to be determined

Information on the Social Vulnerability Index and California Healthy Places Index

This document is intended to provide a high-level summary of key features of the two indices that could be used to identify Community Public Health Team (CPHT) communities. While both indices use different approaches, there is a high correlation in the identification of high-need areas. Additionally, both indices consider many of the same social factors. For more comprehensive information about each index please visit the websites listed below.

Social Vulnerability Index (SVI) https://www.atsdr.cdc.gov/placeandhealth/svi/index.html	**California Healthy Places Index (HPI)** https://www.healthyplacesindex.org/
Background and Intention	
The CDC Social Vulnerability Index (SVI) was designed to help public health officials and local planners better prepare for and respond to emergency events like hurricanes, disease outbreaks, or exposure to dangerous chemicals. A number of factors, including poverty, lack of access to transportation, and crowded housing may weaken a community's ability to prevent human suffering and financial loss in a disaster. These factors are known as social vulnerability. The SVI data is ranked using percentiles and is visualized through a mapping tool. The higher percentile rank represents greater vulnerability.	Developed by the Public Health Alliance of Southern California, the Healthy Places Index (HPI) is a data and policy platform created to advance health equity through open and accessible data. HPI provides data for community leaders, policymakers, academics, and other stakeholders to compare the health and well-being of communities, identify health inequities and quantify the factors that shape health. The HPI data is ranked using percentiles. The lower the percentile rank, the less healthy conditions are in the community.
Geography	
The SVI uses 2020 census tracts.	The HPI uses 2010 census tracts.
Data Source	
SVI uses U.S. census data from the American Community Survey.	HPI uses U.S. census data and data from multiple peer reviewed sources such as Well-being In the Nation (WIN) indicators.
Indicators	
The SVI uses 16 indicators that are separated into four themes: **Socioeconomic status** • below 150% poverty • unemployed • housing cost burden • no high school diploma • no health insurance **Household characteristics** • aged 65 or older • aged 17 or younger • civilian with a disability • single-parent households	HPI uses a set of 23 broader indicators: **Economic** • Above Poverty percentile: Percent of people earning more than 200% of federal poverty level • Employed percentile: Percent of people aged 25-64 with a job • Per Capita Income percentile: Average income computed for every man, woman **Education** • Bachelor's Education or Higher percentile: Percent of people over age 25 with a bachelor's education or higher

- English language proficiency

Racial and ethnic minority status

- Hispanic or Latino (of any race);
- Black and African American, Not Hispanic or Latino;
- American Indian and Alaska Native, Not Hispanic or Latino;
- Asian, Not Hispanic or Latino;
- Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino;
- Two or More Races, Not Hispanic or Latino;
- Other Races, Not Hispanic or Latino

Housing type & transportation

- multi-unit structures
- mobile homes
- crowding
- no vehicle
- group quarters

- High School Enrollment percentile: Percent of 15–17-year-old in school
- Preschool Enrollment percentile: Percentage of 3- and 4-year-olds in school

Social

- 2020 Census Response Rate percentile: Percent of households who completed the 2020 decennial census
- Voting percentile: Percent of registered voters who voted in the 2020 general election

Transportation

- Automobile Access percentile: Percent of households with access to an automobile.
- Active Commuting percentile: Percent of workers (16 years and older) who commute to work by transit, walking, or cycling

Neighborhood

- Park Access percentile: Percent of people living within walkable distance (half-mile) of a park, beach, or open space.
- Retail Density percentile: Number of retail, entertainment, services, and education jobs per acre
- Tree Canopy percentile: Percent of land with tree canopy (weighted by number of people per acre)

Housing

- Homeownership percentile: Percent of people who own their home
- Housing Habitability percentile: Percent of households with basic kitchen facilities and plumbing.
- Low-Income Homeowner Severe Housing Cost Burden percentile: Percent of low-income homeowners who pay more than 50% of their income on housing costs.
- Low-Income Renter Severe Housing Cost Burden percentile: Percent of low-income renters who pay more than 50% of their income on housing costs.
- Uncrowded Housing percentile: Percent of households that are not crowded.

Clean environment

- Diesel PM percentile: Average daily amount of particulate pollution (very small particles) from diesel sources, measured in kilograms/day
- Drinking Water Contaminants percentile: Index score combining information about 13 contaminants and 2 types of water quality

	violations that are sometimes found when drinking water samples are tested. • Ozone percentile: Average amount of ozone in the air during the most polluted 8 hours of summer days, measured in parts per million • Particulate Matter 2.5 percentile: Yearly average of fine particulate matter concentration (very small particles from vehicle tailpipes, tires and brakes, powerplants, factories, burning wood, construction dust, and many other sources), measured in micrograms/meter^3 **Healthcare access** • Insured Adults percentile: Percent of adults aged 18 to 64 years with health insurance. Additionally, there are a number of indicators available for Decision Support that include: priority equity indicators; equity, diversity, and inclusion; climate change; community conditions; health outcomes; health risk behaviors; etc.
Race/ethnicity	
The SVI accounts for race/ethnicity when calculating the index score.	The HPI does not account for race/ethnicity when calculating the index score. There is a mapping feature where a layer for race/ethnicity can be added to the map that can be used for decision support, but race/ethnicity is factored into the index score.

Community Public Health Teams (CPHTs)
Community Selection Guidance

CPHTs will be geographically distributed across ten (10) high-need communities and located across all five (5) Supervisorial Districts. The ten (10) communities will be identified using a 25% threshold set using the California Healthy Places Index (HPI) and Centers for Disease Control and Prevention (CDC) Social Vulnerability Index (SVI). Proposers should utilize the following resources for assistance in identifying their CPHT communities and selecting 5-8 contiguous census tracts (at least 75% of the proposed census tracts must meet the 25% threshold for least healthy (HPI) ~~and/~~or most vulnerable (SVI)). It is a minimum eligibility requirement that 75% of census tracts need to meet the 25% threshold.

- **Appendix C Information on the Social Vulnerability Index and California Healthy Places Index**: Proposers can learn more about the indices used to identify high-need communities in LAC. Either one is acceptable to use to identify CPHT communities. All census tracts should be identified using one of the indices, not both.
- **CPHT Proposed Communities Mapping Tool**: https://experience.arcgis.com/experience/3a356f96d40642b8a8fa0897243e0cdb/ The map can display the lowest quartile regions using HPI for the least healthy communities; and the highest quartile regions using SVI for the most vulnerable communities using the map layers. All highlighted areas on the maps represent the least healthy (HPI) or most vulnerable (SVI) communities across LAC. Here is more information on the mapping tool map layers:
    - **LACDPH Health Districts 2022 (Regions):** As subdivisions of Service Planning Areas (SPAs), health districts are used by Public Health to plan and manage health service delivery across the county. For the CPHTs, health districts are used as regions to plan and manage service delivery of the CPHTs within LA County.
    - **Social Vulnerability Index 2020 – Most Vulnerable (highest 25%):** Layer displays all 2020 Census Tracts that fall within the highest 25% threshold for most vulnerable according to SVI.
    - **HPI 3.0 – Least Healthy Conditions (lowest 25%):** Layer displays all 2010 Census Tracts that fall within the lowest 25% threshold for least healthy according to HPI.

- **Appendix D Community Selection Guidance**: This document is intended to supplement the CPHT Proposed Communities Mapping Tool. This document lists all eligible census tracts based on both the HPI and SVI indices according to Service Planning Area (SPA) and Region. Please note that the HPI 3.0 index uses 2010 Census Tracts and the SVI index uses 2020 Census Tracts.
    - **Use this menu to navigate to the SPA your CPHT will serve**:
        - **SPA 1**
        - **SPA 2**
        - **SPA 3**
        - **SPA 4**
        - **SPA 5**
        - **SPA 6**
        - **SPA 7**
        - **SPA 8**

Black text: Overlapping CTs for HPI and SVI
Blue text: CTs unique to HPI
Orange text: CTs unique to SVI

Note that the HPI 3.0 uses 2010 Census Tracts, and the SVI uses 2020 Census Tracts. Census Tracts were redrawn between 2010 and 2020, as is typically done with each decennial census. Though most of the codes remained the same, some have been combined or separated which is why some Census Tracts have two values associated with them. The Census Tracts within the parentheses (0000.00) show the corresponding 2010 Census Tract for HPI 3.0. Please reference the 2010 Census Tract when using the CPHT Proposed Communities Mapping Tool to view the HPI 3.0. The mapping tool displays 2010 Census Tracts for HPI 3.0.

SPA 1

Regions	Eligible Census Tracts		
	SVI & HPI 2020 (2010)*	HPI Only 2010	SVI Only 2020
Antelope Valley	9001.03 (9100.01)*	9005.01	9107.07
	9001.04 (9100.01)*	9005.04	9107.2
	9005.05	9005.06	9007.05
	9006.02 (9006.09)*	9005.07	
	9006.09	9006.06	
	9007.01	9006.07	
	9007.03	9006.08	
	9008.04	9006.05	
	9008.05	9007.04	
	9008.06	9008.03	
	9104.05 (9104.02)*	9005.08	
	9105.01	~~9008.03~~ (duplicate)	
	9105.02	9009	
	9106.01	9010.08	
	9106.02	9003	
	9106.05	9100.02	
	9106.06	9104.04	
	9106.08 (9106.03)*	9105.04	
	9107.06	9105.05	
	9110.01 (9100.02)*	9106.03	
	9111 (9100.01)*	9107.12	
		9107.14	
		9107.15	
		9003	

SPA 2

Regions	Eligible Census Tracts		
	SVI & HPI	HPI Only	SVI Only

	2020 (2010)*	2010	2020
East Valley	1012.21 (1012.1)*	1012.2	1032.01
	1012.22 (1012.1)*	1042.01	1041.05
	1041.08	1043.1	1190.03
	1042.03	1043.2	1221.2
	1042.04	1044.01	1239.01
	1043.22 (1043.2)*	1044.03	1241.02
	1044.04	1045	1249.03
	1046.2	1046.1	1220
	1047.01	1048.1	
	1047.03	1211.02	
	1047.04	1222	
	1048.21	1232.04	
	1048.22	1232.05	
	1194	1241.03	
	1212.1	1241.05	
	1212.22	1242.03	
	1218.01	1243	
	1218.02		
	1219		
	1221.21		
	1221.22		
	1224.1		
	1224.2		
	1230.1		
	1230.2		
	1232.03		
	1232.06		
	1233.03		
	1233.04		
	1242.04		
Foothill		1042.04	
Glendale	3015.02 (3107.03)*	3107.03	3017.02
	3016.01	3016.01	3018.01
	3022.01		3019.02
	3022.02		3021.04
	3023.02		3025.06
	3024.01		3106.01
	3025.03		3107.04
	3025.04		3020.02
	3025.05		3020.04
			3021.03
San Fernando	1061.14	1064.03	1065.2
	1064.05	1070.1	1091
	1064.07	9203.36	1113.02
	1064.08	9203.36	1114.02
	1066.04	9203.37	9200.38
	1066.48		1065.1

	1095 3202.01 3203 9203.41 (9203.36)*		1096.03 9200.47 9200.48
West Valley	1153.02 1172.01 1174.05 1174.07 1174.08 1175.1 1175.2 1175.3 1193.1 1193.4 1200.1 1200.2 1200.3 1201.03 (1200.2)* 1201.04 1201.05 1201.06 1201.07 1201.08 1234.2 1235.1 1235.2 1271.02 1272.1 1272.2 1275.2 1276.03 1276.05 1277.12 1278.03 1278.05 1278.06 1279.1 1281.02 1282.1 1283.02 1283.03 1325.01 1325.02 1343.05 1345.2 1345.21 1345.22 1347.1	1154.03 1193.42 1234.1 1271.04 1274	1132.39 1134.25 1154.01 1193.2 1193.41 1236.01 1273 1278.04 1286.01 1310.21 1132.34 1204 1318.01 1321.01 1321.02 1327 1331.02 1340.02 1341.01 1341.03 1341.04 1343.06 1349.04 1393.03

	1393.02		

SPA 3

Regions	Eligible Census Tracts		
	SVI & HPI 2020 (2010)*	**HPI Only 2010**	**SVI Only 2020**
Alhambra	4336.02 4817.11 4817.14 4823.01 4823.04	4809.03 4047.03 4081.41	4336.01 4809.02 4810.01 4817.12 4822.02 4809.01 4811.01 4820.02 4823.03
El Monte	4047.03 4070.01 4076.01 4077.01 (4081.38)* 4081.38 (4082.11)* 4081.4 (4082.11)* 4082.13 (4082.11)* 4323 (4327)* 4327 (4323)* 4328.01 (4327)* 4328.02 4331.03 (4331.01)* 4332 (4331.01)* 4333.04 4333.05 4333.07 4334.02 4334.03 4335.05 (4334.01)* 4335.06 (4331.01)* 4338.04 (4334.01)* 4339.01 4339.03 (4338.01)* 4340.01 4340.03 4341 (4334.01)*	4340.01 4082.02 4082.11 4333.02 4081.4 4335.01 4050.02 4028.03 4062 4816.03 4822.01 4050.02 4075.01 4076.02 4081.39 4082.02 4083.01	4048.06 4052.02 4071.02 4324.01 4324.02 4325.01 4333.06 4047.01 4051.02 4072.01 4082.12 4315.01
Foothill	4043.01		4011.02 4041 4301.01 4312 4610

			4045.03 4045.04
Pomona	4023.01 4023.03 4023.04 4025.01 4025.03 (4025.02)* 4025.04 (4025.02)* 4026.01 (4026)* 4027.02 4028.01 4028.04 4029.02 4029.03 4030 4061.03 (4062)* 4062.01 (4062)* 4087.24 4088 4090 (4024.02)*	4082.02 4326.01 4024.05 4024.06 4026 4062	4013.12 4017.07 4017.06 4027.03 4037.21 4053.01 4059 4087.05 4087.25

SPA 4

Regions	Eligible Census Tracts		
	SVI & HPI 2020 (2010)*	**HPI Only 2010**	**SVI Only 2020**
Central	1927 1957.1 2060.1 2060.5 2060.53 (2060.32)* 2060.54 (2060.32)* 2062.01 (2062)* 2062.02 (2062)* 2071.01 2071.02 2071.03 2080.02 (2080)* 2083.01 2083.02 2084.01 2084.02 2085.02 2086.1 2087.2	2080 2091.02 2111.21	1871.02 1914.1 1956 1957.2 1958.02 1977 2063.03 2075.02 2086.2 2087.1 2092.02 2111.24 9800.1

	2088.01 2088.02 2089.02 2089.03 2089.04 2091.03 2091.04 2091.05 (2091.02)* 2093 2094.01 2094.02 2094.03 2095.1 2095.2 2098.1 2098.2 2100.1 2111.22 2122.02 2122.03 2122.04 2134.01 2134.02 2211.1 2211.2 2240.1 2240.2 2242 2243.1 2243.2 2260.01 2260.02		
Hollywood-Wilshire	1902.01 1903.02 (1903.01)* 1903.03 (1903.01)* 1905.1 1905.2 1908.01 1908.02 1909.01 1909.02 1911.1 1911.2 1912.03 1916.1 1916.2 1917.1 1917.2	1902.02 1918.1 2119.21	1904.01 1907.01 1912.01 1912.04 1915 2114.1 2117.03 2118.02 2126.1 2126.2 2181.1 2125.02 2127.01 2172

	1925.1 1925.2 1926.1 1926.2 2112.0 2112.02 2113.1 2113.2 2114.2 2118.0 2119.1 2119.22 2121.02 2123.03 2123.04 2123.05 2123.06 2124.1 2124.2 2129 2131 2132.01 2132.02 2133.1 2133.2 2181.2 2182.1 2212.1 2212.2 2213.02 2213.03 2213.04		
Northeast	1835.2 1853.2 1864.01 1991.1 1991.2 1992.01 1994 1997 1998.01 (1998)* 1999 2014.01 2015.03 2016.02 2031 2032 2033	1838.2 2015.04 2016.01 1852.03 1853.2 1998 2036 2037.1	1814 1834.01 1864.03 1864.04 1990.01 1992.02 2013.01 2014.02 2015.01 1836.1 1838.1

	2035 (2060.32)* 2036.01 (2036)* 2037.2 2038 2039 2041.1 2041.2 2042 2043 2044.1 2044.2 2046 2047 2048.1 2048.2 2049.1 2049.2 2051.1 2051.2		

SPA 5

Regions	Eligible Census Tracts		
	SVI & HPI 2020 (2010)*	HPI Only 2010	SVI Only 2020
West	2755	2653.03 2653.04 2653.05 2696.01	2696.02 7018.01

SPA 6

Regions	Eligible Census Tracts		
	SVI & HPI 2020 (2010)*	HPI Only 2010	SVI Only 2020
Compton	5402.01 5413 5429 5400 (5418.02)* 5402.02 5402.03 5405.01 5405.02 (5416.04)*	5535.03 5400 5403 5414 5418.02 5538.02 5400	5401.01 5412 5430 5535.02 5536.02 5539.01 5539.02

	5406 5407 5409.01 5409.02 5411 5414.01 (5414)* 5415 5416.03 5416.04 5416.05 (5420)* 5416.06 5417 5418.01 5418.02 (5400)* 5420 5421.03 5421.05 5421.06 5422 5424.01 5424.02 5425.01 5425.02 5426.01 5426.02 5427 5428 5431 (5432.02)* 5432.01 5432.03 (5432.02)* 5535.04 5536.01 (5400)* 5537.02 (5421.04)* 5538.01 5538.02		
South	2397.01 2397.02 2398.01 2398.02 2400.1 2400.2 2402 2403.01 (2403)* 2403.02 (2403)* 2404.01 2404.02 2405 2406	2430 5349	

	2407 2408 2409.01 (2409)* 2409.02 (2409)* 2410.01 2410.02 2411.1 2411.2 2412.01 2412.02 2413 2414 2420 2421 (5354)* 2422.01 (2422)* 2422.02 (2422)* 2423 2426 2427 2430.01 (2430)* 2431 5350.01 5350.02 5351.01 5351.02 5352 5353 5354 5404		
Southeast	2395.02 2396.02 2246 2264.1 2264.2 2267.02 (2267)* 2270.1 2270.2 2281 2282.1 2282.2 2283.1 2283.2 2284.1 2284.2 2285 2286 2287.1 2287.2	2267 2294.1 2393.3	

	2288 2289 2291 2292 2293 2294.2 2311 2318 2319.01 (2319)* 2319.02 (2319)* 2328 2392.01 2392.02 2393.1 2393.2 2395.01 2396.01 5328 5329		
Southwest	2197 2218.1 2244.2 2322 2323 2324.01 (2324)* 2371.01 2376 2377.1 2377.2 2379 2380 2381 2382 2383.1 2383.2 2187.02 2189 2190.2 2193 2198 2199.01 2200 2214.01 2214.02 2215 2216.01 2216.02 2217.1	2185 2199.02 2218.2 2219 2313 2316 2324 2326 2345.02 2361 2372.01 2374.01	2187.01 2188 2201 2225 2315 2340.02 2345.01 2346 2378 2384

	2220.02 2221 2222 2226 2244.1 2312.1 2312.2 2313.01 (2313)* 2314 2316.03 (2316)* 2317.1 2317.2 2321.1 2321.2 2325 2326.02 (2326)* 2327.01 (2327)* 2327.02 (2327)* 2347 2349.01 2349.02 2352.01 2352.02 2361.01 (2361)* 2362.03 2362.04 2362.05 (2362.02)* 2362.06 (2362.02)* 2371.02 2372.02 2374.02 2375		

SPA 7

Regions	Eligible Census Tracts		
	SVI & HPI 2020 (2010)*	**HPI Only 2010**	**SVI Only 2020**
Bellflower	5526.02 5540.02 5544.03 5552.11 5522 5541.01 5541.05	5543.01 5502.01 5552.12	5521 5529 5531 5542.04 5543.02 5544.04 5544.05 5549 5550.01

			5520.02 5542.03 5544.06 5548.02 5551.06
East LA	5303.01 5311.01 5312.01 5312.02 5313.01 5313.02 (5323.02)* 5316.02 5316.03 5316.04 5317.01 5317.02 5318 5319.01 5320.01 5320.02 5321.01 5322 5323.02 5323.03 (5319.01)* 5323.04 (5337.03)* 5301.01 5301.02 5303.02 5305 5309.01 5309.02 5311.02 5315.02	5315.03 5315.04 5306.02 5308.01 5310	5300.06 5304
San Antonio	5325 5326.05 5326.06 5326.07 (5326.03)* 5330.01 5330.02 5331.03 (5330.02)* 5331.04 5331.05 5331.08 (5331.06)* 5332.01 5332.04 (5332.02)* 5333 5334.02 5334.03	5327 5338.06 5345.02 5348.04 5357.02 5359.01 5323.02	5334.01 5361.03 5514.01 5362.02 5509.01 5511.02 5513

	5335.01 5335.04 (5335.03)* 5336.01 5336.02 5337.01 5337.02 5337.03 (5323.04)* 5338.03 5338.04 5338.06 5339.01 5339.02 5340.01 5340.02 5341.01 5341.02 5342.01 5342.02 5342.03 5343.01 5343.02 (5338.06)* 5344.04 5344.05 5344.06 (5338.06)* 5345.01 5348.02 5348.03 5355.01 5355.02 5355.03 5356.03 5356.04 5356.05 5356.06 5356.07 5357.01 5358.02 5358.03 5358.04 5360 5361.04 5336.03 5511.01		
Whittier	5015.04 5018.03 5023.03 (5023.01)* 5009 (5010.01)* 5021 (5014)*	5005 5010.01 5014 5018.04 5030	5025 5024.01 5041.01

	5031.03 5042 (5028.02)*	5004.02 5004.04 5006 5008 5020.04 5023.01 5031.04 5031.06	

SPA 8

Region	Eligible Census Tracts		
	SVI & HPI 2020 (2010)*	**HPI Only 2010**	**SVI Only 2020**
Harbor	2943.02 2944.1 2944.21 2945.1 2945.2 2946.1 2947.01 2948.1 2948.2 2948.3 2949 2962.2 2966 2971.1 2971.2 2962.1 2969.02	2941.1 2946.2 2965 2971.2	2969.01 9800.15
Inglewood	2911.1 2911.2 2912.1 2912.2 6001 6002.02 6006.02 6009.02 6011 6014.01 6015.01 6015.02 6020.03 6021.03 6021.04 (6017)* 6030.07 (6030.01)*	2920 6003.02 6016 6018.01 6030.05 6020.04	6004 6010.01 6010.02 6013.02 6013.03 6018.02 6020.02 6021.05 6024.03 6024.04 6025.04 6025.07 6025.11 6025.1 6026.02 6037.06

	6002.01 6003.03 6003.04 6012.11 6012.12 6017 6019 6025.05 6025.06 6028.01 6029 6030.08 (6030.01)*		6038.01 6038.02 6039.02 6040.01
Torrance	2932.05 (2932.02)* 2932.06 (2932.02)* 5439.05 2920.01 (2920)*	2920	2932.03 2933.04 2933.07 5410.03 5435.01 5435.03 6506.06

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 1 OF 3

Proposer Name:	
Budget Period:	**Two (2) Months**

A. FULL-TIME AND PART-TIME SALARIES

Full-time Salaries (Position Title and Name)	Primary or Secondary Organization	Monthly Salary	No. of Months	% of Time	Total
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
				Subtotal Full-time Salaries	**$ -**

Full-time Salaries Justification:

Part-time Salaries (PositionTitle and Name)	Primary or Secondary Organization	Hourly Salary	No. of hours worked annuall	% of Time	Total
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 1 OF 3

		Subtotal Part-time Salaries	**$ -**
Part-time Salaries Justification:			
		TOTAL SALARIES:	**$ -**
B. EMPLOYEE BENEFITS	**Primary or Secondary Organization**		**Total**
	enter % rate		
Full-time Employees Benefits Rate:			$ -
Full-time Employees Benefits Rate:			$ -
Part-time Employees Benefits Rate:			$ -
Part-time Employees Benefits Rate:			$ -
		Total Employee Benefits:	**$ -**
Employee Benefits Justification:			
		TOTAL SALARIES & EMPLOYEE BENEFITS (A + B):	**$ -**

C. FIXED COSTS (Proposers may not alter the pre-populated fixed costs below)

Expense Type	**Short Description**	**Total**
	There are no fixed costs in Term 1.	
	TOTAL FIXED COSTS:	**$ -**

D. OPERATING EXPENSES

Expense Type	**Short Description**	**Primary or Secondary Organization**	**Total**

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 1 OF 3

TOTAL OPERATING EXPENSES:			**$ -**
Operating Expenses Justification:			

E. MILEAGE AND TRAVEL			
Expense Type	**Short Description**	**Primary or Secondary Organization**	**Total**
TOTAL MILEAGE & TRAVEL:			**$ -**
Mileage & Travel Justification:			

F. OTHER COSTS			
Expense Type	**Short Description**	**Primary or Secondary Organization**	**Total**

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 1 OF 3

		TOTAL OTHER COSTS:	**$ -**
Other Costs Justification:			
G. TOTAL DIRECT COSTS (A - F)			**$ -**
H. INDIRECT COSTS			
		TOTAL INDIRECT COSTS:	
Indirect Cost Justification:			
I. TOTAL TERM BUDGET (Term 1 of 3)			**$ -**

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 2 OF 3

Bidder Name:	
Budget Period:	**Twelve (12) Months**

A. FULL-TIME AND PART-TIME SALARIES

Full-time Salaries (Position Title and Name)	Primary or Secondary Organization	Monthly Salary	No. of Months	% of Time	Total
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
				Subtotal Full-time Salaries	**$ -**

Full-time Salaries Justification:

Part-time Salaries (PositionTitle and Name)	Primary or Secondary Organization	Hourly Salary	No. of hours worked annually	% of Time	Total
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 2 OF 3

		Subtotal Part-time Salaries	**$ -**
Part-time Salaries Justification:			
		TOTAL SALARIES:	**$ -**
B. EMPLOYEE BENEFITS	**Primary or Secondary Organization**		**Total**
		enter % rate	
Full-time Employees Benefits Rate:			$ -
Full-time Employees Benefits Rate:			$ -
Part-time Employees Benefits Rate:			$ -
Part-time Employees Benefits Rate:			$ -
		Total Employee Benefits:	**$ -**
Employee Benefits Justification:			
		TOTAL SALARIES & EMPLOYEE BENEFITS (A + B):	**$ -**

C. FIXED COSTS (Bidders may not alter the pre-populated fixed costs below)

Expense Type	Short Description	Primary or Secondary Organization	Total
Community Covenings	Community Convenings for CPHTs		$ 12,000
		TOTAL FIXED COSTS:	**$ 12,000**

Fixed Costs Justification:

D. OPERATING EXPENSES

Expense Type	Short Description	Primary or Secondary Organization	Total

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 2 OF 3

TOTAL OPERATING EXPENSES:			**$ -**

Operating Expenses Justification:

E. MILEAGE AND TRAVEL

Expense Type	Short Description	Primary or Secondary Organization	Total
TOTAL MILEAGE & TRAVEL:			**$ -**

Mileage & Travel Justification:

F. OTHER COSTS

Expense Type	Short Description	Primary or Secondary Organization	Total

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 2 OF 3

		TOTAL OTHER COSTS:	**$ -**
Other Costs Justification:			
G. TOTAL DIRECT COSTS (A - F)			**$ 12,000**
H. INDIRECT COSTS			
		TOTAL INDIRECT COSTS:	
Indirect Cost Justification:			
I. TOTAL TERM BUDGET (Term 2 of 3)			**$ 12,000**

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 3 OF 3

Bidder Name:	
Budget Period:	**Twelve (12) Months**

A. FULL-TIME AND PART-TIME SALARIES

Full-time Salaries (Position Title and Name)	Primary or Secondary Organization	Monthly Salary	No. of Months	% of Time	Total
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
				Subtotal Full-time Salaries	**$ -**

Full-time Salaries Justification:

Part-time Salaries (PositionTitle and Name)	Primary or Secondary Organization	Hourly Salary	No. of hours worked annually	% of Time	Total
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 3 OF 3

Subtotal Part-time Salaries	**$ -**
Part-time Salaries Justification:	
TOTAL SALARIES:	**$ -**

B. EMPLOYEE BENEFITS	**Primary or Secondary Organization**		**Total**
		enter % rate	
Full-time Employees Benefits Rate:			$ -
Full-time Employees Benefits Rate:			$ -
Part-time Employees Benefits Rate:			$ -
Part-time Employees Benefits Rate:			$ -
Total Employee Benefits:			**$ -**
TOTAL SALARIES & EMPLOYEE BENEFITS (A + B):			**$ -**
Employee Benefits Justification:			

C. FIXED COSTS (Bidders may not alter the pre-populated fixed costs below)

Expense Type	**Short Description**	**Primary or Secondary Organization**	**Total**
Community Convenings	**Community Convenings for CPHTs**		**$ 12,000**
		TOTAL FIXED COSTS:	**$ 12,000**
Fixed Costs Justification:			

D. OPERATING EXPENSES

Expense Type	**Short Description**	**Primary or Secondary Organization**	**Total**

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 3 OF 3

TOTAL OPERATING EXPENSES:			**$ -**
Operating Expenses Justification:			

E. MILEAGE AND TRAVEL			
Expense Type	**Short Description**	**Primary or Secondary Organization**	**Total**
TOTAL MILEAGE & TRAVEL:			**$ -**
Mileage & Travel Justification:			

F. OTHER COSTS			
Expense Type	**Short Description**	**Primary or Secondary Organization**	**Total**

COMMUNITY PUBLIC HEALTH TEAMS (CPHTs)

BUDGET FOR TERM 3 OF 3

TOTAL OTHER COSTS:			**$ -**
Other Costs Justification:			
G. TOTAL DIRECT COSTS (A - F)			**$ 12,000**
H. INDIRECT COSTS			
TOTAL INDIRECT COSTS:			
Indirect Costs Justification:			
I. TOTAL TERM BUDGET (Term 3 of 3)			**$ 12,000**

Community Public Health Teams (CPHT)
Request for Proposals Frequently Asked Questions (FAQs)

Informational Session

1. When is the project is slated to begin? (approximately)
    a. *The CPHT project is estimated to begin August 1, 2023.*

2. Will this presentation be available after the meeting?
    a. *Yes, all attendees of informational sessions will receive an email with the meeting slides and recording link. You may also find a link to the meeting slides on the Rising Communities CPHT webpage.*

3. Will transcript be available?
    a. *A link to the meeting notes will be available on the Rising Communities CPHT webpage.*

4. I will not be able to attend the May 10th session. Will the sessions be recorded and shared after the fact?
    a. *Yes, the session will be recorded and provided on the Rising Communities CPHT webpage after May 10th.*

5. Is the upcoming info session open to both potential healthcare partners and CBOs? Are there any restrictions on who can join?
    a. *The upcoming informational session on May 10, 2023, from 11am-12pm is open to potential health care partners and CBOs to attend as our target audience. However, there are currently no restrictions on who can join the session and potential ancillary*

partners of the CPHT are welcome to attend (e.g., businesses, education section, faith-based organizations, social service organizations, etc.). Please see the registration link here: https://us02web.zoom.us/meeting/register/tZIkf-yorzsqGtRLeaXZdOJGUVHpaq2ZS1a0?mc_cid=8bc6cf6fb1&mc_eid=7398459fe8#/registration

6. How do I obtain a copy of the RFP?
    a. *You may find a link to the RFP on the CPHT webpage: https://risingcommunities.org/cpht/*

7. My emails won't send to the CPHT email provided. Is there another one?
    a. *Please ensure you enter the correct email address: DPH_CPHT@risingcommunities.org. There is an underscore symbol between DPH and CPHT. If you continue experiencing issues with this email address, contact Miguel Torres at mtorres@risingcommunities.org and **CC** dph_cpht@risingcommunities.org.*

Eligibility Requirements

8. Will home health agencies be able to submit RFP?
    a. *Non-profit organizations that identify as either a CBO or HCP/FQHC and meet the following eligibility requirements are welcome to submit a proposal:*
        i. *Consist of a partnership between a Community-Based Organization (CBO) and Health Care Partner/Federally Qualified Health Center (HCP/FQHC) organization formalized through a contractual agreement. The agreement does not need to be in place at the time of proposal submission, but it is required for the contract to be executed.*
            1. *A CBO is defined as a nonprofit organization within Los Angeles County that is representative of a community or significant segments of a community; and provides educational or related services to individuals in the community.*
            2. *Health care partners are defined as community-driven, non-profit clinics, not-for-profit community hospitals, community health centers, or a Federally Qualified Health Center located in medically underserved areas or serving populations that are medically underserved and provide affordable, comprehensive primary and preventative care to all regardless of income level or insurance status.*
        ii. *Upon applying, you must identify the primary organization and the secondary organization. For example, the CBO may be the primary, while the FQHC is the secondary, or the HCP is the primary and the CBO is the secondary. The primary organization will be responsible for serving as the lead administrative entity.*

iii. *CPHTs must select 5-8 high need contiguous census tracts.* 75% of census tracts need to meet the 25% threshold for California Health Places Index (HPI) or Social Vulnerability Index (SVI)
iv. *CPHTs must demonstrate at least 3 years of experience within the last 5 years for the following areas:*
    1. *Community outreach and engagement*
    2. *Working in multi-disciplinary collaborative partnerships*
    3. *Delivering health care services*

9. It would be helpful to clarify what types of nonprofits would be eligible to apply.
    a. *Non-profits that identify as either a CBO or HCP/FQHC and meet the following eligibility requirements are welcome to submit a proposal:*
        i. *Consist of a partnership between a CBO and HCP/FQHC organization formalized through a contractual agreement. The agreement does not need to be in place at the time of proposal submission, but it is required for the contract to be executed.*
            1. *A CBO is defined as a nonprofit organization within Los Angeles County that is representative of a community or significant segments of a community; and provides educational or related services to individuals in the community.*
            2. *Health care partners are defined as community-driven, non-profit clinics, not-for-profit community hospitals, community health centers, or a Federally Qualified Health Center located in medically underserved areas or serving populations that are medically underserved and provide affordable, comprehensive primary and preventative care to all regardless of income level or insurance status.*
        ii. *Upon applying, you must identify the primary organization and the secondary organization. For example, the CBO may be the primary, while the FQHC is the secondary, or the HCP is the primary and the CBO is the secondary. The primary organization will be responsible for serving as the lead administrative entity.*
        iii. *CPHTs must select 5-8 high need contiguous census tracts. 75% of census tracts need to meet the 25% threshold for HPI or SVI*
        iv. *CPHTs must demonstrate at least 3 years of experience within the last 5 years for the following areas:*
            1. *Community outreach and engagement*
            2. *Working in multi-disciplinary collaborative partnerships*
            3. *Delivering health care services*

10. Some (but not all) of our clinic partners are private businesses. For example, we work with a few pharmacy networks and urgent care clinics. Would they be eligible to apply as the health care partner under the guidelines?
    a. *Unfortunately, for profit entities would not be eligible to apply as the health care partner for a CPHT. We anticipate that the business sector may be able to participate*

as an ancillary partner of the CPHTs. Each CPHT will be uniquely designed to meet the needs of the community they serve. Business sector partners such as pharmacies or urgent care clinics, can also participate in community convenings to provide input and help identify needs of the community.

b. *For the CPHT project, the definition for Health Care Partner/Federally Qualified Health Center is as follows: Community-driven, non-profit clinics, not-for-profit community hospitals, community health centers, or a Federally Qualified Health Center located in medically underserved areas or serving populations that are medically underserved and provide affordable, comprehensive primary and preventative care to all regardless of income level or insurance status.*

11. Do you have to meet all 3 requirements outlined?
    a. *Yes, all 4 eligibility requirements must be met to qualify:*
        i. *Consist of a partnership between a Community-Based Organization (CBO) and Health Care Partner/Federally Qualified Health Center (HCP/FQHC) organization formalized through a contractual agreement. The agreement does not need to be in place at the time of proposal submission, but it is required for the contract to be executed.*
            1. *A CBO is defined as a nonprofit organization within Los Angeles County that is representative of a community or significant segments of a community; and provides educational or related services to individuals in the community.*
            2. *Health care partners are defined as community-driven, non-profit clinics, not-for-profit community hospitals, community health centers, or a Federally Qualified Health Center located in medically underserved areas or serving populations that are medically underserved and provide affordable, comprehensive primary and preventative care to all regardless of income level or insurance status.*
        ii. *Upon applying, you must identify the primary organization and the secondary organization. For example, the CBO may be the primary, while the FQHC is the secondary, or the HCP is the primary and the CBO is the secondary. The primary organization will be responsible for serving as the lead administrative entity.*
        iii. *CPHTs must select 5-8 high need contiguous census tracts.* 75% of census tracts need to meet the 25% threshold for California Health Places Index (HPI) or Social Vulnerability Index (SVI)
        iv. *CPHTs must demonstrate at least 3 years of experience within the last 5 years for the following areas:*
            1. *Community outreach and engagement*
            2. *Working in multi-disciplinary collaborative partnerships*
            3. *Delivering health care services*

12. Are City/County health departments eligible to apply?

a. *The funds are intended to support the development of CPHTs led by community-based organizations (CBO) and a local community health care partner, as defined below. These funds are not intended for local health departments. A city/County health department can support as an ancillary partner and can also participate in community convenings to provide input and help identify needs of the community. Please note that the cities of Long Beach and Pasadena receive their own funding and fall outside the jurisdiction of Los Angeles County and would not be eligible to apply.*
    i. *A CBO is defined as a nonprofit organization within Los Angeles County that is representative of a community or significant segments of a community; and provides educational or related services to individuals in the community.*
    ii. *Health care partners are defined as community-driven, non-profit clinics, not-for-profit community hospitals, community health centers, or a Federally Qualified Health Center located in medically underserved areas or serving populations that are medically underserved and provide affordable, comprehensive primary and preventative care to all regardless of income level or insurance status.*

13. Can I confirm the eligibility of a healthcare partner in advance? We partner with LA General Medical Center.
    a. *If the health care partner meets the following definition, they would be eligible to apply: Health care partners are defined as community-driven, non-profit clinics, not-for-profit community hospitals, community health centers, or a Federally Qualified Health Center located in medically underserved areas or serving populations that are medically underserved and provide affordable, comprehensive primary and preventative care to all regardless of income level or insurance status.*

14. Is Long Beach eligible even though we have our own health department?
    a. *Unfortunately, the cities of Long Beach and Pasadena fall outside the jurisdiction of Los Angeles County and would not be eligible to apply.*

15. Can we change the program from the Statement of Intent?
    a. *Yes, the Statement of Intent is not required but encouraged to submit. Therefore, the program may change from the Statement of Intent without penalty. However, if your proposed 5 – 8 contiguous census tracts for your community change prior to submitting your proposal, please contact us via email at DPH_CPHT@risingcommunities.org.*

16. Wanting to know the eligibility requirements in regard to the 3 years delivering health care services.
    a. *Please see page 13 of the RFP document that reads: Proposer must have a minimum of three (3) years of experience within the last five (5) years coordinating and/or delivering health care services, which can include the following (see Proposal*

narrative section 1. CPHT Collaborative, CPHT partners' experience in community outreach and engagement):

i. *Supporting vaccination efforts*
ii. *Offering health screenings, health care assessments, and education*
iii. *Providing systems navigation and/or referrals to health care, mental health, and social support services*
iv. *Performing disease investigation such as case investigation/contact tracing on communicable diseases*

17. Will you accept applications without having received a Statement of Intent?
    a. *Statement of Intent submission is not required to apply and CPHTs that do not submit a Statement of Intent may still apply.*

Core Partners

18. Does the health care partner need to provide primary care?
    a. *According to the definition of health care partner in the RFP, yes, the health care partner needs to provide primary care:*
        i. *Health care partners are defined as community-driven, non-profit clinics, not-for-profit community hospitals, community health centers, or a Federally Qualified Health Center located in medically underserved areas or serving populations that are medically underserved and provide affordable, comprehensive primary and preventative care to all regardless of income level or insurance status.*

19. Can a secondary partner be included in two separate proposals with two different primary organizations?
    a. *Yes, a secondary partner can be included in two separate proposals with different primary organizations. It is recommended that partners discuss the CPHT community of focus beforehand to ensure that services areas are different.*

20. Will there be any "matchmaking" assistance in advance of the proposal deadline? For example, if we have a CBO and Contracted Health Partner but need to be connected with a specific DPH partner?
    a. *No, matchmaking assistance between a CBO and HCP/FQHC will not be provided in advance of the proposal deadline. Los Angeles County Department of Public Health (LACDPH) will assign an existing dedicated LACDPH staff member to work as a core member of the CPHT. Assignment of an existing dedicated LACDPH staff member will occur after CPHTs have been selected.*

21. I am a healthcare provider, and I would like to know more information about the program and am interested in collaboration to provide health care to the community.
    a. *You may find more information on the Rising Communities CPHT webpage.*

22. In your 4/27 presentation, you mentioned that the CBO/healthcare partner would need to execute an agreement between themselves before any funds are to be distributed. Is there any specific type of agreement or language that is incorporated into that contract? I assume it is similar to a subcontractor agreement between entities but wanted to be sure.
    a. *Yes, it will need to be a subcontractor agreement because there will be flow of funding between the organizations in partnership. There is information in the Request for Proposals document that can help guide what type of information to include such as roles and responsibilities of partners, decision making processes, etc. The agreement does not need to be in place at the time of proposal submission, but it is required for the contract to be executed.*

23. Do the FQHC and the Community-Based Organization need to be separate organizations, if one has experience with both functions?
    a. *Yes, the health care partner and the CBO need to be separate organizations. The application must include a partnership between a CBO and an HCP/FQHC. The partnership between a CBO and HCP/FQHC organization will need to be formalized through a contractual agreement. The agreement does not need to be in place at the time of proposal submission, but it is required in order for the contract to be executed.*

24. Is there a distinction between Health Care Partner and a FQHC, or are they the same type?
    a. *For the purposes of this pilot project, the term health care partner encompasses an FQHC. Health care partners are defined as community-driven, non-profit clinics, not-for-profit community hospitals, community health centers, or a Federally Qualified Health Center located in medically underserved areas or serving populations that are medically underserved and provide affordable, comprehensive primary and preventative care to all regardless of income level or insurance status.*

25. Is there a limit as to how many clinics and/or CBOs can be project partners?
    a. *There will only be one primary organization and one secondary organization that will submit a joint application, identified as either a CBO or an HCP/FQHC. Each CPHT can decide to subcontract with additional ancillary partners to meet project goals within budget limits.*

26. I am curious how FQHCs, Public health and Street medicine teams can collaborate and complement and not duplicate effort.
    a. *Unfortunately, funding cannot be used to pay for the delivery of direct clinical services to individuals via Street medicine teams (e.g., treatment for chronic conditions, provider consultation, diagnostic procedures, etc.), except for the provision of vaccinations. All vaccination related events or activities require approval from LACDPH prior to implementation. Funding may be used to assess (e.g., health-related screenings) and provide care coordination needed to link and offer referrals to community members to increase access to health, preventative services, and social*

services such as healthcare assessments and screenings, scheduling appointments, etc. is allowed. Please note that allowability can change at any time and may be subject to approval by funding agency, CDC or CDPH.

b. *Street medicine teams may be part of the CPHTs as an ancillary partner to best serve people experiencing homelessness. CPHTs should connect with existing street medicine teams in the community of focus.*

27. Are faith-based initiatives automatically excluded?
    a. *If a faith-based initiative can meet the definition of a CBO or HCP/FQHC, they would be eligible to apply:*
        i. *A CBO is defined as a nonprofit organization within Los Angeles County that is representative of a community or significant segments of a community; and provides educational or related services to individuals in the community.*
        ii. *Health care partners are defined as community-driven, non-profit clinics, not-for-profit community hospitals, community health centers, or a Federally Qualified Health Center located in medically underserved areas or serving populations that are medically underserved and provide affordable, comprehensive primary and preventative care to all regardless of income level or insurance status.*

28. Will every CPHT connect with an AmeriCorps member? We are very vigilant about vetting potential employees, interns, and volunteers. Can we conduct those same screenings of AmeriCorps members before their engagement with us? Are AmeriCorps members limited to specific tasks or can they plug into any part of our CPHT work?
    a. *AmeriCorps members may be assigned to CPHTs to support direct service to community members through community outreach and engagement, health education, and resource sharing. AmeriCorps members are rigorously screened by the recruitment agency, the AmeriCorps program, and the LACDPH Human Resources Department. Organizations can require additional screening of AmeriCorps members, per organizational policies, at the cost to the program.*

29. If the community-based organization was established in 2021 does it meet the qualification timeline of the 3 years demonstration experience within the last 5 years?
    a. *Per the eligibility requirements, proposers are organizations partnering to create a CPHT. Interested and qualified proposers must meet each of the eligibility requirements on the day the proposals are due. Since proposers are submitting a joint application as a CPHT, the years of experience can be for one or both organizations. See RFP page 13 on Eligibility Requirements.*

30. What is the recommended split between the CBO and FQHC for years 2 and 3?
    a. *It will be up to each CPHT to negotiate funding allocations and roles and responsibilities of each partner. Per the RFP, each CPHT will need to clearly define partner roles and responsibilities, identify the process for how administrative and programmatic decisions are made (e.g., based on skills, capabilities, and team*

responsibilities, etc.), and how communication will flow across the CPHT by developing a written internal governance structure and partner agreements.

31. If a health screening conducted by the HCP/FQHC within the CPHT determines a need for specialized services, is the CPHT able to refer/link that individual to any health care provider, or do the referrals have to be to the HCP/FQHC identified as a partner within the CPHT?
    a. *Ideally, health care referrals will be made to the HCP/FQHC partner within the CPHT as they would be serving the same community. If the identified needs of a community member require specialized services outside the capacity of the CPHT, referrals can be made to other organizations as best determined by CPHT partners and the community member.*

32. Please clarify who is required to: "Perform disease investigation (case investigation/contact tracing on select communicable diseases)" (page 7 of the RFP). Will this be done by either the CBO/HCP, or will it be done by the DPH staff? Is there a list of communicable diseases the CPHT would be required to contact trace? Is there a protocol in place to follow? If it is the job of the CBO and/or HCP, will DPH provide training?
    a. *Disease investigation can be performed by CBO or HCP staff to respond to emerging public health threats. There is not a list of communicable diseases that the CPHTs would be required to contact trace. The DPH staff member on the CPHT team can share information about any local outbreak/situation that may need support. HCP should possess the experience and expertise to provide training to CPHT partners on contact tracing, however LACDPH can also support training needs.*

33. We must budget for an Administrative Program Manager (1 FTE), Program Manager (1 FTE), and Data/Evaluation Manager (0.5 FTE). On page 10 of the RFP under Term 1, the bullet at the top of the page states that we must, "Designate a programmatic lead to be the main point of contact for Rising Communities and LACDPH administrative staff…" Can this be one of the required program managers? OR do you expect to be a different staff person?
    a. *The main point of contact for Rising Communities and LACDPH administrative staff can be one of the required program managers.*

34. In Appendix B-1, point 1.2.1 it also mentions that the Program Manager will assign a lead person to attend meetings focused on data, assessment, and evaluation with Public Health. Could this not be a function taken on by the data/evaluation manager or do you expect it to be a different staff member on the team?
    a. *Yes, the data/evaluation manager can be assigned to attend meetings focused on data, assessment, and evaluation with LACDPH.*

35. Is our community clinic obligated to become the people (who are screened)'s PCP? Do these people become the FQHC's patients? If not, do we have the options of taking them in house for our services or referring them to an outside agency for assistance?

a. *No, there is no obligation for community members that receive screenings to become patients of the FQHC. Ideally, health care referrals will be made to the HCP/FQHC partner within the CPHT as they would be serving the same community. If the identified needs of a community member require specialized services outside the capacity of the CPHT, referrals can be made to other organizations as best determined by CPHT partners and the community member.*

Geographic Location

36. Can proposers select contiguous census tracks from Appendix D, comprised of a combination of SVI & HPI OR is it restricted to either SVI OR HPI?
    a. *All census tracts should be identified using one of the indices, not both. One index must be selected because the census tracts differ between the indices (HPI uses 2010 census tracts, SVI uses 2020 census tracts), proposers need to identify which index is used in your proposal and the census tracts from that index.*

37. We serve the South Bay and the San Fernando Valley. Would we submit two separate proposals - one for each geography?
    a. *Yes, you may submit two separate proposals with each proposal specifying the primary and secondary organizations for each geographic area and respective census tracts identified in each proposal. The goal is for CPHTs to be geographically distributed across ten (10) high-need communities and located across all five (5) Supervisorial Districts.*

38. What criteria will be used to decide the location of the sites?
    a. *The pilot project aims for CPHTs to be geographically distributed across ten (10) high-need communities and located across all five (5) Supervisorial Districts. The ten (10) communities will be identified using a 25% threshold set by the California Healthy Places Index (HPI) and Centers for Disease Control and Prevention (CDC) Social Vulnerability Index (SVI). Community boundaries will be identified at the census tract level and include contiguous census tracts that can be aggregated to reach 8,000 – 13,000 households. Contiguous census tracts are those sharing a common border or touching/connecting to one another. CPHT communities must also meet the requirement of at least 75% of census tracts must meet the 25% threshold for least healthy (HPI) and most vulnerable (SVI). As of May 5, 2023, additional criteria to identify the CPHT communities will be included in the Request for Proposals on the Rising Communities CPHT webpage.*

39. The RFP states “This funding opportunity is only open to organizations located within LAC and excludes Long Beach and Pasadena (these cities fall outside the jurisdiction of LAC for the purposes of this initiative).” Our Planned Parenthood affiliate has Admin offices in Altadena and our largest health center in Pasadena; however, we serve a much broader

geographic area and have health centers in Alhambra, Glendora, Highland Park, and Baldwin Park. Our selected tracts of focus would not be in Pasadena. Would we be eligible?

a. *Yes, if the selected census tracts are not located within Long Beach or Pasadena, and if at least 75% of census tracts meet the 25% threshold for least healthy communities (HPI) or most vulnerable communities(SVI), the organization would be eligible to apply.*

40. Are FQHCs located in cities with their own city health departments (i.e., Long Beach, Pasadena) eligible? Can we use a more population-based approach to reach certain smaller, dispersed communities rather than a place-based approach?
    a. *FQHCs located in the cities of Long Beach and Pasadena would be eligible as long as the identified community boundaries identified at the census tract level are not located within Long Beach or Pasadena and also meet the requirement of at least 75% of census tracts meeting the 25% threshold for least healthy communities (HPI) or most vulnerable communities (SVI). The CPHT pilot program will utilize a placed-based approach.*

41. I see CPHTs will be geographically distributed across ten high-need communities. Have you already selected the communities?
    a. *No, communities have not been selected and must be proposed within the application using one of the two eligible indices to identify the high need communities their CPHT will work in (see RFP page 8 CPHT Communities):*
        i. *Community boundaries will be identified at the census tract level and include 5-8 contiguous census tracts that can be aggregated to reach 8,000 – 13,000 households**.** Contiguous census tracts are those sharing a common border or touching/connecting to one another.*
        ii. *CPHT communities must also meet the requirement of at least 75% of census tracts must meet the 25% threshold for least healthy (HPI) and most vulnerable (SVI).*
        iii. *CPHTs may also choose to use additional key metrics from other community-identified health indicators (e.g., Public Health, California Department of Public Health, CDC, etc.) to assist in community selection.*

    Refer to Public Health CPHT Proposed Communities Mapping Tool webpage https://experience.arcgis.com/experience/3a356f96d40642b8a8fa0897243e0cdb/ and Appendix D: Community Selection Guidance for more information on eligible census tracts.

42. Would 4 contiguous census tracts be considered?
    a. *CPHTs must select 5-8 high need contiguous census tracts. Contiguous census tracts are those sharing a common border or touching/connecting to one another.*

43. Does the health care partner for the CPHT need to have physical health care clinics within the tracts and/or communities that they are focusing on?

   a. *CPHT partners will have a history of working in the selected community, which may include a physical location in the geographic area to improve access to services and information for community members, though not required.*

44. Relatedly, is it permissible to partner with a CBO who has physical locations within the community, and then is connecting residents to the health care services delivered via telehealth and/or at health clinics that might fall outside of the immediate community?
    a. *CPHT partners will have a history of working in the selected community, which may include a physical location in the geographic area to improve access to services and information for community members, though not required.*

45. Can an entity submit multiple applications for different geographies? For example, could a CBO submit an application with one HCP/FQHC for census tracts in Metro LA, and another application for census tracts in South LA? Can a single entity (like a CBO) apply as lead for one geography and be a partner on a proposal in another geography? Related to this question, is there a limit to the number awards made to one entity – i.e. can a single entity only receive a maximum of one award?
    a. *Yes, an organization may submit multiple separate proposals with each proposal specifying the primary and secondary organizations for each geographic area and respective census tracts identified in each proposal. The goal is for CPHTs to be geographically distributed across ten (10) high-need communities and located across all five (5) Supervisorial Districts. It is recommended that partners discuss the CPHT community of focus beforehand to ensure that services areas are different.*
    b. *At this time there is no limit to the number of awards made to one entity, ideally there will be a diversity of organizations represented in the pilot project. The goal is for CPHTs to be geographically distributed across ten (10) high-need communities and located across all five (5) Supervisorial Districts.*

Funding

46. How many pilots will be funded?
    a. *CPHTs will be geographically distributed across ten (10) high-need communities and located across all five (5) Supervisorial Districts.*

47. Would like to know how LA County Public Health will support our disadvantaged community. What funds are available for the RFP?
    a. *This project is supported by funding from the federal and state government, specifically the CDC's Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems Grant and CDPH's Future of Public Health Funding Award. The project will consist of three terms. Term 1 will be 2 months; Term 2 will be 12 months; and Term 3 will be 12 months, with the possibility of extension of up to additional 2 years and 10 months (for a total of 60 months or 5 years). The first term includes a two-*

month planning phase for the CPHT subcontractor. The following budget amounts for each CHPT community should not be exceeded:

i. *Term 1 (2 months): $250,000*
ii. *Term 2 (12 months): $1,500,000*
iii. *Term 3 (12 months): $1,500,000*

48. Can we apply for less than $1.5 million per term?
    a. *Yes, you may apply for less than $1.5M per term. However, regardless of reduced funding, each CPHT will still be required to meet program deliverables and apply each of the core strategies. Including conducting household visits in 5-8 contiguous census tracts that can be aggregated to reach 8,000 – 13,000 households. Proposers will use the budget templates (Appendix E-1, E-2, E-3) to describe and provide a brief justification for each of the amounts listed on the budget to implement CPHT services during Terms 1, 2, and 3. The budget justification must provide sufficient detail(s) to enable the reviewer to determine how they arrived at each proposed cost, and how each line item will assist in providing the proposed program services.*

49. I understand that we have to follow federal funding CFRs. Is this federal funding with a CFDA number that will count toward our Single Audit total?
    a. *Yes, the CPHT pilot is funded by both federal and state funding. The Assistance Listing Number (formerly known as the Catalog of Federal Domestic Assistance (CFDA) Number) is 93.967. Funding awarded will count towards a Single Audit.*

50. Is there a cap on fringe rate?
    a. *The fringe rate is capped at 10% unless the organization has a Negotiated Indirect Cost Rate Agreement (NICRA) with the Federal Government. We will honor active NICRAs with appropriate documentation.*

51. Under 'Unallowable Costs' the RFP states "Funding **is allowed** to be used to assess (e.g., health-related screenings) and provide wrap-around and supportive services…" I just want to confirm that this is not a typo and that we **can** use funds to support navigation and care coordination. Is that correct?
    a. *That is correct, funding is allowed to support navigation and care coordination.*

52. Is it permissible to have the grant cover the salary of a Community Health Worker if at least some of the CHW's work is partially covered via CHW Benefit reimbursements?
    a. *Yes, funding may cover the salary of CHWs. In the budget, please provide justification of positions, including the role these positions will be playing in program implementation or administration and identify if they are assigned to the primary or secondary organization. See the RFP page 15 for more budget instructions.*

53. For the monthly reimbursements, will the primary org submit one invoice covering all expenses for the CPHT? Or can the primary and secondary orgs submit their own invoices to

CPHT? If the lead is submitting one invoice, is it the lead's responsibility to distribute funds to the secondary org?

a. *The primary or lead agency will enter into a contractual agreement with Rising Communities and as such, will be responsible for distributing funds per the Term 1-3 Budgets submitted with the proposal. The primary organization will submit, on a monthly basis, one invoice to Rising Communities detailing the expenses on the CPHT pilot, with supporting documentation (general ledger, time sheets, receipts, subcontractor agreements, etc.).*

54. We would likely need to hire a dedicated program manager(s) for this project in order to meet staffing requirements. Is there a timeline for when our dedicated project staff must be hired by? Does it need to occur within the first 2 months or is there flexibility?
    a. *An Administrative Program Manager (1 FTE), Program Manager (1 FTE), and Data/Evaluation Manager (0.5 FTE) should be hired within the first 60 days from the date of contract execution. Please see Appendix B-1 Scope of Work Term 1 for more information on Minimum Staffing Requirements.*

55. The budget template calculates indirect costs as a percentage of the total direct costs (TDC). However, the RFP states that "Indirect costs should not exceed 10% of total personnel costs." – Can you please clarify if the IDC is a percentage of the personnel or TDC?
    a. *Indirect Costs should not exceed 10% of Total Direct Costs.*

56. For the budget is the 10% IDC allowable for both the primary and partner agency?
    a. *Yes, the 10% of total direct cost applies to the primary and secondary partners. Partners would decide how to split the 10%.*

Allowable costs

57. Would funds be available to for Street Medicine for our unhoused population be eligible for these funds?
    a. *Unfortunately, funding cannot be used to pay for the delivery of direct clinical services to individuals (e.g., treatment for chronic conditions, provider consultation, diagnostic procedures, etc.), except for the provision of vaccinations. All vaccination related events or activities require approval from LACDPH prior to implementation. Funding may be used to assess (e.g., health-related screenings) and provide care coordination needed to link and offer referrals to community members to increase access to health, preventative services, and social services such as healthcare assessments and screenings, scheduling appointments, etc. is allowed. Please note that allowability can change at any time and may be subject to approval by funding agency, CDC or CDPH.*

Ancillary Partners

58. What programs and outreach do you have for K-12 education.

a. *We anticipate that the education sector may be able to participate as an ancillary partner of the CPHTs. Each CPHT will be uniquely designed to meet the needs of the community they serve. Education sector partners can also participate in community convenings to provide input and help identify needs of the community.*

59. Does it strengthen our application to include letter of support or commitment from our ancillary partners?

a. At this time, applicants are not required to submit letters of support or commitment from ancillary partners. These social networks within the community such as existing relationships and partnerships can be described in the CPHT program proposal, Community Resources section (see page 16 in the RFP PDF document).

Project Background

60. Is there a current delivery system model that is meeting the needs of its community that we can research?

a. *The following materials that focus on previous work done in Costa Rica and Cuba describe the model that the CPHT is based on:*

iii. *Costa Rica*
iv. *Cuba*

Project Goals

61. Is one goal or process objective for this 2-Year funding effort to study possible bases for standardization, either statewide or just within LAC, of minimum health training curriculum and possibly even certification, for Community Health Workers (CHW) like those currently in place in OH and some other states?

a. One of the goals of the pilot project is to expand the public health workforce through partnerships with community-based organizations and local health care partners. CHWs are expected to play large role in CPHT communities and efforts will be made to capture the number of CHWs hired and their impact on services provided. This funding is expected to run for 2 years and 2 months with the possibility of extension of up to an additional 2 years and 10 months (for a total of 60 months or 5 years).

62. Is one of the goals of the CPHT Program to develop/demonstrate to Health Plans that there are models or elements of community-based health service teams, as evidenced in the CPHT pilot program, including the role of a licensed CHW -- that can ideally become reimbursable?

a. Yes, this pilot project hopes to demonstrate that this model of public health service delivery can be successful and provide an opportunity for health plans to utilize a

similar approach to build a community-centered system of care and strengthen the infrastructure needed to deliver coordinated, community-based services to individuals and highly impacted communities.

Project Core Strategies/Focus

63. What are some examples of topics that our Community Public Health Team can focus on in their project?
    a. *CPHTs will build upon existing community-based resources and supports including relationships with local organizations and social services agencies to address various public health issues, community-identified concerns, and respond to emerging public health threats. Each CPHT will utilize a community-driven approach and will be structured to meet the unique needs of each of the ten (10) CPHT communities. Proposers will need to describe their understanding and experience working within the proposed community and describe the community issues/needs that exist in the proposed community. Community issues/needs can vary on a number of different public health topics such as high asthma rates among children, high food insecurity rates in CPHT community, low physical activity rates among older adults in CPHT community, increasing screening rates for chronic conditions, etc.*

64. Do we need to conduct a household needs assessment for every household within our identified CPHT communities?
    a. *Community boundaries will be identified at the census tract level and include contiguous census tracts that can be aggregated to reach 8,000 – 13,000 households. Since each CPHT community will be unique, there will be room for flexibility for the implementation of these core strategies to account for the needs, comfort level, and input by community members. An attempt to conduct a household assessment with each household in the CPHT community should be made and effort should be made to build trust and increase completion rates. Households may refuse to participate in the assessment as this is not mandatory.*

65. Do we determine areas of project focus after the household needs assessments are completed or at the time of writing our grant application?
    a. *Proposers will need to describe their understanding and experience working within the proposed community and describe the community issues/needs that exist in the proposed community. CPHTs will also propose community-driven interventions to address community needs and achieve the goal of the CPHT as part of the application process. Household assessments and community input provided during community convening sessions will guide development of Community Action Plans that will be implemented throughout the duration of the project.*

66. Are mental health needs considered part of this pilot?

a. *Proposers will need to describe their understanding and experience working within the proposed community and describe the community issues/needs that exist in the proposed community, this can include mental health needs. CPHTs will also propose community-driven interventions to address community needs and achieve the goal of the CPHT as part of the application process. Community input provided during community convening sessions will also identify community issues/needs.*

67. Does education to prevent intimate partner violence or identify survivors for assistance qualify as part of this collaborative?
    a. *Proposers will need to describe their understanding and experience working within the proposed community and describe the community issues/needs that exist in the proposed community, this can include intimate partner violence. CPHTs will also propose community-driven interventions to address community needs and achieve the goal of the CPHT as part of the application process. Community input provided during community convening sessions will also identify community issues/needs.*

68. Will this new program services L.A.s unhoused neighbors?
    a. *Proposers will need to explicitly identify and define populations of concern within their applications and the strategies the CPHT will utilize to engage hard to reach priority populations that may not have critical mass within the community, this can include unhoused neighbors. It is also recommended for CPHTs to engage homeless providers as ancillary partners to best serve people experiencing homelessness. CPHTs should connect with existing homeless outreach and/or street medicine teams in the community of focus.*

69. What are we doing for grant funding for oral health education.
    a. *Proposers will need to describe their understanding and experience working within the proposed community and describe the community issues/needs that exist in the proposed community, this can include oral health needs. CPHTs will also propose community-driven interventions to address community needs and achieve the goal of the CPHT as part of the application process. Community input provided during community convening sessions will also identify community issues/needs.*

70. How can we develop more mental health peer support groups? Mental health agencies have long wait lists. We need more community members trained in Mental Health First Aid so that we can recognize the symptoms and support the most vulnerable populations.
    a. *Proposers will need to describe their understanding and experience working within the proposed community and describe the community issues/needs that exist in the proposed community, this can include mental health needs. CPHTs will also propose community-driven interventions to address community needs and achieve the goal of the CPHT as part of the application process. Community input provided during community convening sessions will also identify community issues/needs.*
    b. *Mental health service providers may be able to participate as an ancillary partner of the CPHTs. Each CPHT will be uniquely designed to meet the needs of the community*

they serve. Mental health service providers can participate in community convenings to provide input and help identify needs of the community.

71. Can you explain what constitutes a household visit and provide examples of accepted ways to meet that strategy? (i.e., can it include a phone conversation? can it include a community event in which residents come to us for a screening/assessment?)
    a. *Each household will be visited at least once annually to offer and conduct a household assessment with individuals and as requested, link community members to education and support resources. CPHTs can identify alternate locations for home visits outside of the home for community members to connect with CPHTs. Since each CPHT community will be unique, there will be room for flexibility for the implementation of this core strategy to account for the needs, comfort level, and input by community members. Please see the RFP Appendix B-2 Scope of Work Term 2 for more information on household visits.*

72. Will the LACDPH provide a list of community participants that will need household visits?
    a. *Each CPHT will need to formalize a plan to identify and track household visits within proposed census tracks. LACDPH will not identify community participants but may be able to provide technical assistance on best practices to identify household locations within a census tract.*

73. How comprehensive does the household assessment need to be?
    a. *The household assessment will be developed by the LACDPH with input from CPHT partners. A set of questions will be standardized across all 10 CPHTs but each CPHT may have the flexibility to add questions specific to their community.*

74. Can you provide guidance on the estimated number of hours required to complete the household assessment?
    a. An estimated time to complete the household assessment will vary per household. The aim for the assessment is to be comprehensive enough to capture all desired elements related to physical health, mental health, and social needs, but be brief enough to be completed within a reasonable amount of time so as not to be burdensome on community members.

75. Can household assessments take place at health fairs or other community events?
    a. Yes, CPHTs will have the flexibility to allow alternate locations for home visits to account for the needs, comfort level, and input by community members. There is still an expectation that assessments will be linked to households within the census tracts. Household assessments are conducted annually to follow community members over time, therefore efforts should be made to prioritize assessments within the household.
76. Can you clarify if there is a specific protocol each CPHT would need to follow when attempting to visit each of the 8,000-13,000 households? For example, is it required to knock on the door 2-3 times?

a. *There will be a standardized protocol for visiting households developed in coordination with CPHT partners and will outline the number of attempts made.*

77. Would there need to be an attempt for each household in both term 2 and term 3?
    a. *At a minimum, CPHTs will conduct an annual visit of each household. CPHTs will have the flexibility to allow for a range of home visits per year depending on the needs of the community members and information CPHTs need to successfully meet program goals.*

78. Is there a conversion rate/minimum number of households we need to successfully make contact with? Is there some sort of documentation/reporting of attempts?
    a. *There will be a standardized protocol for visiting households developed in coordination with CPHT partners and will outline the number of attempts made and documentation required.*

79. Please clarify this statement (page 74 of the RFP): An attempt to conduct a household assessment with each household in the CPHT community should be made and effort should be made to build trust and increase completion rates. Households may refuse to participate in the assessment as this is not mandatory
    a. *If a household refuses a household assessment, efforts still need to be made to engage the household to participate in CPHT activities such as sending reminders about upcoming community convenings they could participate in or sharing information about what is being learned through the project. CPHTs will need to plan community engagement strategies that address barriers and encourage community participation.*

80. Can you provide a definition for Household Assessments and Health Screenings? Is there a predetermined form or rubric for these?
    a. *A household assessment will be a questionnaire designed to identify the physical health, mental health, and social needs of community members in order to provide referrals and linkages to supportive services. The household assessment will be developed by the LACDPH with input from CPHT partners. A set of questions will be standardized across all 10 CPHTs but each CPHT will have the flexibility to add questions specific to their community. Health screenings are tests that will be used to provide an initial assessment of health status (e.g., blood pressure screening, diabetes screening, mobile mammograms, dental screenings, etc.).*

81. Our proposed CPHT has additional questions relating to the project scope: We are curious how this model and long-term objectives are similar or different from the California Accountable Communities for Health Initiative?
    a. *Please refer to the RFP PDF pages 2-6 for more information on the project background, key elements, and framework*

82. The County is seemingly developing a health assessment for distribution by the CPHT community health workers; in developing work plans for this project, should we also develop databases for community member health data, or will the County create/mandate use of its own databases for data collection and storage for this project?
    a. *Please refer to PDF page 32 of the RFP where it references in the Scope of Work that CPHTs will need to "6.2. Track referrals, activities, and share data on referrals and outcome metrics using a specified software platform determined by LACDPH."*