

## Request for Qualifications (RFQ) for Chronic Disease Self-Management Services

### RFQ Information and Guidelines

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RFQ No. 12-001-ADR

Chronic Disease Self-Management Services

Issue Date: February 14, 2012

Closing Date: March 9, 2012

### Contact

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Brian Guthrie

Pierce County Community Connections – Aging and Disability Resources

1305 Tacoma Ave S. STE 104

Tacoma, WA 98402

Phone: (253) 798-4378

Email: bguthri@co.pierce.wa.us

### Applicant Information – Must Be Completed and Submitted by All Applicants

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Organization Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

### Return by 12:00 noon, Friday, March 9, 2012 to:

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Pierce County Community Connections – Aging and Disability Resources

Attn: Brian Guthrie

1305 Tacoma Ave S. STE 104

Tacoma, WA 98402

Phone: (253) 798-4378

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## **REQUESTS FOR REASONABLE ACCOMMODATION**

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Pierce County Community Connections (hereafter referred to as the "County") will provide reasonable accommodation to allow for equal participation in the Request for Qualification (RFQ) application and interview processes. To request a reasonable accommodation, please e-mail Brian Guthrie at [Bguthri@co.pierce.wa.us](mailto:Bguthri@co.pierce.wa.us) or call (253) 798-4378, or 711 (Telecommunications Relay Service - TRS). This document will be provided in Compact Disc format, upon request.

## **ACCESS TO REFERENCED DOCUMENTS**

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This document contains active hyperlinks. Prospective applicants who are unable to access the Internet may request copies of the documents referenced in this RFQ by calling Brian Guthrie at (253) 798-4378 or by sending an email to [Bguthri@co.pierce.wa.us](mailto:Bguthri@co.pierce.wa.us). All documents will be available on Pierce County Community Connections Aging and Disability Resources website: <http://www.PierceCountyWA.org/ADR>.

## **NOTICE OF SOLICITATION**

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Failure of the County to notify any interested party or parties directly regarding the availability of this RFQ shall not void or otherwise invalidate the RFQ process.

## **AVAILABILITY OF FUNDS**

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Pierce County has made available **\$55,872** annually of State Senior Citizens Services Act (SCSA) and Federal Older Americans Act (OAA) Funds for Chronic Disease Self-Management services. The County will be awarding at least two (2) contracts under the process described in this RFQ.

Successful applicants will receive a reimbursement of \$300 for each workshop participant age 60 and over who completes at least four (4) of six (6) consecutive workshop sessions. The reimbursement fee is to compensate for all required materials, supplies and other costs necessary to provide the workshop to a maximum of 186 participants Countywide completing at least four (4) of six (6) consecutive workshop sessions for a twelve month period.

The initial contract period shall be from April 1, 2012 to March 31, 2013. Contracts will be renewed (without advertisement or solicitation) for an additional one-year period contingent upon available funding and contractor performance.

A fifteen percent (15%) match requirement is required for recipients of Older American's Act funds and must be documented in the Contractor's internal records. The required match must be reflected on Monthly Expenditure Reports and adequately supported in accordance with 45 CFR 92.94 and OMB Circular A-110 "Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals and other Non-Profit Organizations", and Aging & Disability Services Administration (ADSA) Management Bulletin 02-11 "Use of Voluntary Contributions to Match Older American's Act Prohibited".

## **DESCRIPTION OF SOLICITED SERVICES**

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Pierce County Community Connections Aging and Disability Resources is seeking applications from eligible, qualified and interested organizations to provide Chronic Disease Self-Management Program (CDSMP) services. Chronic conditions such as heart disease, arthritis, diabetes, asthma, bronchitis, and emphysema account for 75% of medical costs in Washington State. Five percent of the Medicaid chronic care population consumes 50% of the Medicaid health care costs. Pierce County has among the state's highest prevalence of diabetes, heart

disease, and stroke. Risky health behaviors—such as tobacco use, lack of physical activity and poor eating habits—contribute to the onset and progression of chronic diseases. About half of those with chronic conditions do not receive evidence-based chronic illness care. It is worse for minorities and other populations who experience unequal access to health care services and information.

CDSMP (also known as Living Well with Chronic Conditions) is an evidence-based program developed and copyrighted by Stanford University, Patient Education Research Center. Each Program consists of a six (6) session series. Each session is 2.5 hours and meets once a week for six (6) consecutive weeks. Each class is facilitated by a team of two trained Lay Leaders and/or Master Trainers. Master Trainers are individuals who are certified by Stanford University to train new Lay Leaders. Each class session and the topics presented are taught according to the standardized curriculum as developed by Stanford University. Each participant receives a copy of the companion book, *Living a Healthy Life With Chronic Conditions, 3rd Edition*.

The Chronic Disease Self Management Program is a proven, cost effective approach for improving chronic care outcomes and reducing health care costs. The program helps individuals manage their own chronic health conditions by teaching participants; 1) techniques to deal with fatigue, pain, isolation and frustration; 2) appropriate exercise for maintaining and improving strength, flexibility and endurance; 3) appropriate use of medications; 4) communicating effectively with health professionals; 5) nutrition; and 6) how to evaluate new treatments.

### **Chronic Disease Self-Management Services Reporting And Outcomes**

Selected applicants will complete all information forms contained in the CDSMP Group Leader Workshop Packet (Attachment B) for each series conducted.

Participant satisfaction and feedback will be measured using the Workshop Evaluation form (Attachment C).

A pre- and post-assessment tool (Attachment D) will be used to measure outcomes in the following areas:

- Health Status: At least 70% of participants completing the workshop series will report improvements in their self-rated health status.
- Health Care Utilization: At least 60% of participants completing the workshop series will report decreased physician visits, emergency department visits and/or hospitalizations.
- Self-Efficacy (Confidence): At least 70% of participants completing the workshop series will report increased confidence in dealing with symptoms and managing their chronic illnesses.

### **Target Population**

- Persons aged sixty (60) and older with an emphasis on minority populations.

## **PRE-APPLICATION CONFERENCE**

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The County strongly encourages prospective applicants to attend a Pre-Application Conference on:

**February 23, 2012**  
**10:00 AM**  
**Pierce County Community Connections**  
**Soundview Building**  
3602 Pacific Avenue  
Conference Room 1  
Tacoma, WA 98418

The meeting location is fully accessible. To request the services of a signer or translator, or for other special accommodations, please contact Mickie Brown at (253) 798-7376 or email: [mbrown3@co.pierce.wa.us](mailto:mbrown3@co.pierce.wa.us) by February 20, 2012.

## **ANTICIPATED TIMELINES**

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The following anticipated timeline is subject to change, at the discretion of the County:

- February 8, 2012: Notification of RFQ is published in the County's newspaper of record.
- February 14, 2012: RFQ issued to known interested applicants, and posted on the [Pierce County Community Connections Aging and Disability Resources](#) website.
- February 23, 2012: Pre-Application Conference for all prospective applicants **10 A.M. - 3602 Pacific Ave. Tacoma, WA 98418.**
- February 24, 2012: Questions from prospective applicants are due; please see page 7 for additional information.
- March 2, 2012: The County's written response to each question submitted will be sent to all known prospective applicants from whom the County has a valid email and/or postal address. The responses will also be posted on [Pierce County Community Connections Aging and Disability Resources](#) website.
- March 9, 2012: Application submission deadline; applications are due to the County no later than 12:00 noon.
- March 12-16, 2012: Final decisions on funding for CDSMP Services; awards announced.
- April 1, 2012: Effective date of contract.

## **ELIGIBLE APPLICANTS**

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Any interested organization that meets **ALL** of the following is eligible to apply:

1. Hold current CDSMP license with Stanford University.
2. Have at least one year experience in Washington State as a CDSMP provider.
3. Have a or intend to obtain a staffed office located in Pierce County, and to obtain a telephone number with local area code and/or a toll free number.

4. Organization is currently registered as an incorporated, private, not-for-profit agency, 501(c)(3) in the State of Washington, or part of a municipal government.
5. Maintains an active Stanford License and will be responsible for ensuring that all Workshop Facilitators comply with rules and regulations regarding instruction and administration of CDSMP in accordance with the Stanford licensing requirements and agrees not to create derivatives of the program nor reproduce or distribute material derived or adapted from the program *without permission*.
6. Successful applicants will be required to submit to Stanford all required information per License agreement on a yearly basis.

The meeting of the minimum qualifications, qualifying an applicant as eligible to submit an application for consideration, does not infer that a contract shall be awarded.

## **APPLICATION EVALUATION PROCEDURE AND CRITERIA**

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Applications will be evaluated and be scored according to, but not limited to, the demonstration of need for the identified target population; experience in providing Chronic Disease Self-Management services to the targeted population; and, demonstrated ability of the applicant to implement and administer the program. When evaluating applications, the County also reserves the right to consider the applicant's performance related to previous contracts that the applicant may have held with the County.

Pierce County Aging and Disability Resources staff will conduct an initial review to ensure that applications meet eligibility and submittal requirements outlined in the RFQ. Those that are determined to be acceptable will then be evaluated by an Evaluation Committee (EC) made up of individuals who are knowledgeable of CDSMP services. The EC will meet to score the applications and may interview applicants to request additional clarification and/or information from applicants. The EC will make recommendations to the Pierce County Community Connections Department Director.

In the event that the applicant organization is awarded funding as a result of this RFQ, Pierce County Aging and Disability Resources staff will meet with successful applicants to review terms and conditions that are associated with the receipt of funds.

## **UNACCEPTABLE APPLICATIONS**

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Pierce County Community Connections staff and the Department Director will determine which applications are not responsive to the requirements of this solicitation. Unacceptable applications are those which meet at least one of the following shortcomings:

1. Does not address the essential requirements of the RFQ.
2. Clearly demonstrates that the applicant does not understand the requirements of the RFQ.
3. Does not meet eligibility requirements.
4. Clearly deficient in approach.
5. Does not meet the deadline for submittal.
6. Does not contain the original and prescribed number of copies.
7. Does not include the required signed assurance document.
8. Does not include all the information and documents required as part of the application, and/or exceeds stated page limits.

## **CONTACT**

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Brian Guthrie, Program Specialist  
Pierce County Community Connections –Aging and Disability Resources  
1305 Tacoma Ave S. STE 104  
Tacoma, Washington 98402  
(253) 798-4378 • (253) 798-3812 FAX  
[BGUTHRI@CO.PIERCE.WA.US](mailto:BGUTHRI@CO.PIERCE.WA.US)

## **QUESTIONS FROM APPLICANTS AND RESPONSE BY THE COUNTY**

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Inquiries regarding the content of this RFQ must be submitted to the County in writing, no later than **4:00 PM on February 24, 2012**. Questions received after this date and time will not be answered. Questions may be submitted electronically, or via U.S. mail to the contact person identified above. The County will time- and date-stamp all questions received via U.S. mail.

The County claims no responsibility for questions transmitted using electronic media, such as FAX or E-mail, and not received by the County by the specified due date. The method of delivery shall be at the discretion of the applicant and at the sole risk of the applicant.

No later than **March 2, 2012**, the County will provide a written response to each question received, and, as applicable, will issue any resulting amendments to this RFQ. A response will be provided directly to the applicant, and, simultaneously, to any other interested party who has obtained a copy of the RFQ, provided that the County has a valid e-mail or postal address on record. Responses will also be posted on the [Pierce County Community Connections Aging and Disability Resources](#) website.

## **SUBMITTAL DUE DATE AND INSTRUCTIONS FOR SUBMITTAL**

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To be eligible for consideration, applications must be received by Pierce County Community Connections, Aging and Disability Resources, 1305 Tacoma Ave South STE 104, Tacoma, Washington 98402 no later than **12:00 noon on Friday, March 9, 2012**. Applicants are strongly encouraged to carefully review the anticipated timelines associated with this solicitation, as identified on page 5.

- Applicants must submit their application in hard copy, and provide one (1) original and six (6) copies of their complete application, inclusive of the Acknowledgement of Required Assurances. Applications which do not contain an original and the prescribed number of copies will be deemed unresponsive and receive no further consideration.
- Covers are not necessary and three-ring binders must not be used.
- When mailed, applicants are strongly encouraged to send information to the County using certified mail, return receipt requested.
- All applications must be received by the deadline.
- Applications postmarked prior to the deadline but not received by the County will be considered unresponsive and are ineligible for consideration.
- Applications must be typewritten using 8-1/2 inch by 11-inch paper (double-sided printing in keeping with Pierce County's sustainability program), without artwork or photographs.

- Each page of the application must be numbered.
- Document footers must also contain the name of the applicant organization, and the Request for Qualification number.
- All applicants must complete and submit the required Applicant Information, as identified on the Request for Qualifications Cover Sheet.

## **OWNERSHIP OF MATERIAL**

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Applications and other materials submitted in response to this RFQ become the property of the County, are documents of public record, and will not be returned. By submitting an application, applicants acknowledge and agree that they and/or their organization claim no proprietary rights to the ideas or approaches contained in their applications.

## **APPLICATION COSTS AND CONTINGENT FEES**

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The County is not liable for any costs incurred by an applicant prior to the issuance of a contract. All costs incurred in response to this solicitation, including travel costs to attend Pre-Application Conference, meetings of the Evaluation Committee, and/or contract negotiation sessions, are the responsibility of the applicant.

In the event that the application was developed with the assistance of other individuals (i.e., non-employees) and/or organizations, the applicant understands and agrees that no contingent fees will be paid under any resulting contract.

## **ACCEPTANCE OF TERMS AND CONDITIONS**

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By submitting an application, the applicant acknowledges and accepts all terms and conditions of this request and all County and State regulations and requirements related to the delivery of the solicited services. If the applicant is awarded a contract, the application will become part of the contract agreement. The applicant is bound by the terms of the application, unless the County agrees that specific parts of the application are not part of the agreement. The County reserves the right to introduce different or additional terms and/or conditions during final contract negotiations. Applicants are strongly encouraged to review the County's current Basic Agreement prior to submitting an application. A copy of the County's current Basic Agreement is available on the [Pierce County Community Connections Aging and Disability Resources](#) website; this document is subject to change.

## **RIGHT TO REJECT OR NEGOTIATE**

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The County reserves the right to reject any or all applications, if such a rejection is in the County's best interest. This RFQ is a solicitation for offers and shall not be construed as an offer, a guarantee or a promise that the solicited services will be purchased by the County. The County may withdraw this RFQ at any time and for any reason without liability to applicants for damages, including, but not limited to, bid preparation costs.

Additionally, the County reserves the right to negotiate with selected applicants and may request additional information or modification from an applicant. When deemed advisable, and before a contract is issued, the County reserves the right to arrange an on-site visit/review to determine the applicant's ability to meet the terms and conditions of the RFQ.

The County reserves the right, with or without cause, to cancel any contract resulting from this RFQ.

## **CONTRACT AWARD AND NOTIFICATION TO SELECTED APPLICANTS**

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Decisions regarding contract awards for services solicited by this request will be made no later than **March 16, 2012**. Contracts become effective on the date signed by the County Executive or representative.

## **RIGHT TO APPEAL**

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Applicants whose applications are not selected have the right to appeal the decision of the County, limited to procedural errors in the selection process. In the event that no such procedural errors are found to have occurred, the decision of the County shall be final.

An aggrieved applicant may, within two (2) business days after the selection of the prospective contractors, appeal in writing to the Director of Pierce County Community Connections. The appeal must state all facts and arguments upon which the appeal is based. The Director will review the content of the County's solicitation document, the application, and the facts which form the basis for the appeal. The Department Director will render a written decision within thirty (30) business days of the receipt of the appeal.

## **REQUIRED ASSURANCES**

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Applicants who are awarded a contract agree to provide services in accordance with the requirements of the contract, and with the statutes, regulations, requirements, and policies identified below, including but not limited to:

- Terms of Pierce County's standard contract, and any specific requirements resulting from the contract associated with this RFQ;
- Compliance with the policies of Pierce County Community Connections;
- Compliance with federal and state laws requiring the safeguarding and disclosure of confidential information;
- Purchase of comprehensive liability insurance and bonding, as required by the County;
- Copy of most recent financial audit, and/or providing the County with audited financial statements;
- Completion and subsequent renewal of background checks for all employees, volunteers, or interns who will or may have unsupervised contact with children or vulnerable adults;
- Verification of a new employee's eligibility to work legally in the United States. The County requires that all businesses which contract with the County in excess of \$25,000 and of duration longer than 120 days, and are not specifically exempted by [PCC 2.106.022](#), be enrolled in the Federal [E-verify](#) Program. The requirement extends to every subcontractor meeting the same criteria;
- Certification that the firm, association or corporation or any person in a controlling capacity or any position involving the administration of federal, state or local funds is not currently under suspension, debarment, voluntary exclusion, or a determination of ineligibility by any agency; has not been suspended, debarred, voluntarily excluded or determined ineligible by any agency within the past three (3) years; does have a proposed debarment pending; has not been indicted, convicted or has not had a civil judgment rendered against said person, firm, association or corporation by a court of competent jurisdiction in any matter involving fraud or misconduct with the past three (3) years;
- Maintaining program and financial records for audit review, and providing access to documentation upon request by the County; and
- Submission of program and financial reports, as required by the County.

## APPLICATION –CDSMP SERVICES

Applicants must answer the following questions and/or provide the requested information in their applications:

### A. ORGANIZATIONAL INFORMATION

<b>1. Organization Legal Name:</b>	
<b>2. Street Address:</b>	
<b>3. Mailing Address:</b>	
<b>4. Website Address (if applicable):</b>	
<b>5. Other Office Locations (state and nationwide):</b>	
<b>6. Business Office Hours:</b>	
<b>7. Executive Officer:</b>	<b>Phone:</b>
<b>Title:</b>	<b>E-Mail:</b>
<b>8. Primary Contact Person:</b>	<b>Phone:</b>
<b>Title:</b>	<b>E-Mail:</b>
<b>9. Type Of Organization:</b>	
<input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Limited Liability Company (LLC)	
<input type="checkbox"/> Partnership <input type="checkbox"/> Corporation, Non-Profit	
<input type="checkbox"/> Other (specify)	
<b>10. Experience:</b>	
a) Date of Incorporation: _____	
b) Number of years providing CDSMP services: _____	
<b>11. Taxpayer Identification Number:</b>	
<b>12. Washington State Unified Business Identifier (UBI) Number:</b>	
<b>13. Litigation:</b> Provide the caption, cause number, Court, Counsel, and general summary of any litigation pending or judgment rendered within the past three (3) years against the applicant, as applicable.	

**14. Suspension & Debarment:** Indicate the extent, if any, to which the firm, association or corporation or any person in a controlling capacity or any position involving the administration of federal, state or local funds is currently under suspension, debarment, voluntary exclusion, or determination of eligibility by any agency; has been suspended, debarred, voluntarily excluded or determined ineligible by any agency within the past three (3) years; does have a proposed debarment pending; has been indicted, convicted or has a civil judgment rendered against said person, firm, association or corporation by a court of competent jurisdiction in any matter involving fraud or misconduct with the past three (3) years.

**15. Provide a copy of the following documents, as applicable:**

- a. Internal Revenue Service (IRS) tax-exempt determination letter
- b. Organization chart for the CDSMP
- c. Provide any recent (within the last 24 months) site visit or program review reports received from monitoring entities (i.e. United Way, local or state government) other than Pierce County Community Connections Aging and Disability Resources.
- d. Management letter of the organization's most recent financial audit or audited financial statements. If there are findings please include the entire audit.
- e. Current CDSMP License issued by Stanford University
- f. Job descriptions, resumes and current certifications for CDSMP Master Trainers and/or Lay leaders

**16. Targeted Population To Be Served:**

**17. Language Capacity:** Indicate languages spoken by staff.

**18. Program Staffing:**

- A. Number Of Trained / Certified CDSMP Master Trainers
- B. Number Of Trained / Certified CDSMP Lay Leaders

## B. Program Qualification Requirements

Prospective providers of CDSMP services for Pierce County ADR shall fulfill and abide by the following requirements:

1. Contractor agrees to conduct all Living Well workshops in accordance with Stanford University's "CDSMP Leader Manual". Contractor also agrees not to create derivatives of the program nor reproduce or distribute material derived or adapted from the program without permission.

Describe how the program will be evaluated to ensure fidelity to the CDSMP model.

2. Contractor agrees to have a minimum of two staff trained and certified as Master Trainers and/or Lay Leaders and have met all requirements set forth in the Stanford agreement.

Describe recruitment strategies the organization will use to ensure adequate availability of trained / certified CDSMP Leaders.

3. Contractor agrees to obtain a criminal background check for each designated Master Trainer and / or Leader. Please provide a copy of the agency's policy and procedure related to criminal history background checks.

4. Contractor personnel designated to become trained as either Master Trainer or a Lay Leader must agree to the following training time commitments as outlined by Stanford University:

- Master Training, 4.5 days training
- Lay Leader Training, 4 days training.

5. Contractors are required to have a minimum of one year experience in providing the CDSMP in Washington State. Describe the organization's experience in providing CDSMP to the identified target population.
6. Priority consideration will be given to contractors proposing to serve a targeted ethnic / minority elder population. Describe the target population to be served and demonstrated need and/or analysis used in selecting this population.
7. Contractors agree to participate in the evaluation of client satisfaction and program outcomes (Attachments C and D). Describe the organization's experience conducting program evaluation and provide a summary of recent evaluation results for the CDSMP.
8. Describe any changes or improvements implemented as a result of the program evaluations described in number 7 above.

## C. Fiscal Management

1. Complete a proposed one year budget using the **Proposed Budget and Revenue Summary Form (Attachment A)**. This is a "linked object" in this document. To enter the data on the spreadsheet, double click any cell in the worksheet to open the worksheet in Excel.
2. Complete the **Salary and Wage Detail Form (Attachment A)** for all personnel/volunteers

who will provide direct or indirect support of the applicant's proposed CDSMP services.

3. Contractor will receive a reimbursement of \$300 for each workshop participant age 60 and over who completes at least four (4) of six (6) consecutive workshop sessions. List the number of participants 60+ years of age projected to complete the workshop and the number of workshops you propose to hold per year.
4. Describe your organization's current financial condition and outlook for sustainability. Provide sufficient detail to illustrate your organization's financial viability to carry out the services proposed in this RFQ. If the organization is facing financial challenges, describe what steps are being taken to strengthen the organization's financial condition.
5. Please describe how the applicant will assure the proper use and safeguarding of public funds. Please include policies and procedures regarding financial operations of the organization and recent reviews or audits of the organization by a certified public accountant or other financial professional noting any weaknesses in the organization's financial internal controls and provide written report identifying the weaknesses and describe how the organization has responded to the report.
6. A fifteen percent (15%) match requirement is required for recipients of Older American's Act funds and must be documented in the Contractor's internal records. Describe how the organization will fulfill the match requirement.
7. If the program award were increased or decreased by 10%, what would the impact be on the CDSMP services?
8. In the past seven (7) years, have any bankruptcy proceedings been initiated by or against the organization (whether or not closed) or is any bankruptcy proceeding pending by or against the organization regardless of the date of filing?

## **ACKNOWLEDGEMENT OF REQUIRED ASSURANCES**

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**This page must be signed and submitted with the application.** Applicants who do not contain a signed Acknowledgement of Required Assurances are ineligible for consideration.

By submitting the accompanying application, and by my signature on this document, I understand and agree that any contract resulting from this solicitation will require compliance with the requirements of the contract, and with the statutes, regulations, requirements, and policies identified below, including but not limited to:

- Compliance with the policies of Pierce County Community Connections.
- Compliance with federal and state laws requiring the safeguarding and disclosure of confidential information.
- Purchase of comprehensive liability insurance and bonding, as required by the County.
- Completion of an annual financial audit, and/or as applicable, providing the County with a copy of the organizations audited financial statement.
- Completion and subsequent renewal of background checks for all employees, volunteers, or interns who will or may have unsupervised contact with children or vulnerable adults.
- Verification of a new employee's eligibility to work legally in the United States. Pierce County requires that all businesses which contract with the County for contracts in excess of \$25,000 and of duration longer than 120 days, and are not specifically exempted by [PCC 2.106.022](#), be enrolled in the Federal [E-verify](#) Program. The requirement extends to every subcontractor meeting the same criteria.
- Maintaining program and financial records for audit review, and providing access to documentation upon request by the County.
- Submission of program and financial reports, as required by the County.
- Certification that the firm, association or corporation or any person in a controlling capacity or any position involving the administration of federal, state or local funds is not currently under suspension, debarment, voluntary exclusion, or a determination of ineligibility by any agency; has not been suspended, debarred, voluntarily excluded or determined ineligible by any agency within the past three (3) years; does not have a proposed debarment pending; has not been indicted, convicted or has not had a civil judgment rendered against said person, firm, association or corporation by a court of competent jurisdiction in any matter involving fraud or misconduct with the past three (3) years.

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Organization

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Printed Name and Title of Person Authorized to Sign Contracts

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Signature

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Date

**ATTACHMENT A- PROPOSED BUDGET AND REVENUE SUMMARY/SALARY AND  
WAGE DETAIL**

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**PIERCE COUNTY COMMUNITY CONNECTIONS  
 PROPOSED BUDGET AND REVENUE SUMMARY  
 Chronic Disease Self-Management Services  
 April 1, 2012 to March 31, 2013**

Object	Description	COUNTY FUNDS	OTHER FUNDS					TOTAL ALL FUNDS
			Program Income	In-Kind	Donations	(Identify Source)	(Identify Source)	
11	Salaries & Wages							
20	Personnel Benefits							
31	Office & Operating Supplies							
35	Small Tools & Minor Equipment							
41	Professional Services							
42	Communications							
43	Travel & Training							
44	Advertising							
45	Rentals							
46	Insurance							
47	Public Utilities							
48	Repairs & Maintenance							
64	Machinery & Equipment							
90	Other							
	Indirect (Admin.)							
	<b>GRAND TOTAL</b>							

\*Please provide details on Salary and Wage Detail form



**ATTACHMENT B- CDSMP GROUP LEADER WORKSHOP PACKET**

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# Living Well With Chronic Conditions

## Better Choices, Better Health

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### ***About this Workshop Packet***

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To the Group Leaders:

Thank you for leading this Workshop! Your help in collecting information using the forms described below will enable us to learn about the people who are taking this workshop, so that we can determine how best to serve all members of the community. We appreciate your help.

#### **1. Overview of Forms**

**Example:** This packet includes the forms required for your Workshop. These include the following:

<b>Form</b>	<b>Description</b>	<b>Purpose</b>	<b>How to Use</b>
<b>1. Workshop Information Cover Sheet</b>	1 page, <b>double-sided</b> . One per workshop.	Records all the details about the location, dates, leaders, and enrollment of this workshop.	Fill in the requested details about your workshop. Use as a cover sheet for the packet of forms that you return to Pierce County Aging & Disability Resources (ADR).
<b>2. Attendance Log</b>	1 page, single-sided. One per workshop.	Records attendance by session for each participant.	At the first session, write the names of participants as they are provided on their <i>Participant Information Survey</i> (see below). Each person will initial that they are present at each session.
<b>3. Welcome</b>	1 page, single-sided. One for each enrolled participant.	This form provides participants with information about the <i>Participant Information Survey</i> . Participants may keep for their reference.	Distribute to participants at the beginning of the workshop with the <i>Participant Information Survey</i> (see below), and read the contents aloud to them.
<b>4. Participant Information Survey</b>	1 page, <b>double-sided</b> . One for each enrolled participant.	Participants are asked to provide a small amount of demographic information about themselves on this Survey.	Please copy as a double-sided page. Distribute to participants at the beginning of the workshop, with the Welcome form (see above).

#### **2. What Group Leaders need to know about the confidentiality of Participant Information**

Participants are asked to provide a small amount of demographic data on the *Participant Information Survey* form. Be assured that their forms will be protected.

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## ***About this Workshop Packet—continued***

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### **Sample script that Group Leaders may read to the participants regarding the confidentiality of their information:**

- We (Group Leaders) will maintain these paper forms securely and privately until we send them to Pierce County Aging & Disability Resources (ADR).
- Pierce County ADR will enter the information into a database that will include information from workshop participants around the country.
- The paper forms will be stored securely by Pierce County ADR until they are destroyed after six (6) years.
- At the beginning of the first workshop session, you are asked to complete both the *Participant Information Survey* form and the *CDSMP Pre-Workshop Outcome Evaluation* form. Summarized information from all participants will help us demonstrate how this program is serving people who will benefit the most and whether the program is meeting intended outcomes.

### **3. What to do with the completed forms**

At the end of the 6-session Workshop, please check to see that:

- ✓ participant names written on the *Attendance Log* match the names provided on the *Participant Information Survey* and the *Pre-Workshop Outcome Evaluation* forms
- ✓ all forms are as complete as possible
- ✓ clarify any unclear responses with participants (blanks, cross-outs, multiple responses when one response is requested, etc.)
- ✓ **Return original completed forms** (*Workshop Information Cover Sheet, Attendance Log, Participant Information Surveys* and *Pre-Workshop Outcome Evaluation* forms) within **5 working days** after the last session to the attention of:

Connie Kline, Social Services Supervisor  
Aging & Disability Resources  
Pierce County Community Connections  
1305 Tacoma Avenue South, Suite 104  
Tacoma, WA 98402

- ✓ Keep a copy of the completed forms for your own records

***If you have any questions or concerns about these forms, please contact Connie Kline at (253) 798-3782 or [ckline@co.pierce.wa.us](mailto:ckline@co.pierce.wa.us).***



# Living Well With Chronic Conditions

## Better Choices, Better Health

### Workshop Information Cover Sheet

**Instructions to the Group Leaders:** Please provide the requested details about this Workshop. Please print clearly. Use this as a cover sheet for the completed data collection forms to return to Pierce County Aging & Disability Resources.

1. Site Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

2. Group Leaders' Names (Please provide full first and last names.) If we may contact you with questions about these forms, please provide your daytime phone number as well.

\_\_\_\_\_  Staff or  
\_\_\_\_\_  Volunteer? Ph: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
First Name Last Name

\_\_\_\_\_  Staff or  
\_\_\_\_\_  Volunteer? Ph: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
First Name Last Name

3. Workshop Start Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
End Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_\_

4. Did you offer a "Session 0" with this workshop? ("Session 0" is an optional pre-workshop session. Not all workshops offer a "Session 0".)

- Yes
- No
- Don't know

5. What type of workshop is this? (Mark only one.)

- Chronic Disease Self-Management Program (CDSMP)
- Tomando Control de su Salud (Spanish CDSMP)
- Diabetes Self-Management Program (DSMP)
- Tomando Control de su Diabetes (Spanish DSMP)
- Arthritis Self-Management Program (ASMP)
- Programa de Manejo Personal de la Artritis (Spanish ASMP)

Please turn over 

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## **Workshop Information Cover Sheet—continued**

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6. Number of participants *enrolled*, attending at least 1 session \* : \_\_\_\_\_

7. Number of participants who *completed at least 4 sessions* \* : \_\_\_\_\_

\* *Excluding "Session 0"*

8. Number of *Participant Information Surveys* included in the returned packet: \_\_\_\_\_

9. Number of *Pre-Workshop Outcome Evaluations* included in the returned packet: \_\_\_\_\_

If the number of forms is fewer than the number of participants noted in #6 above, please provide a brief explanation (e.g., illness, refusal, loss or destruction of forms, etc.):

---

Please return the following forms to Pierce County Aging & Disability Resources (contact information below) **within 5 working days** after the final session:

- This *Workshop Information Cover Sheet*
- Attendance Log*
- All completed *Participant Information Surveys*
- All completed *Pre-Workshop Outcome Evaluations*

Note: *Post-Workshop Outcome Evaluations* are to be sent out to participants completing at least 4 of 6 workshop sessions four (4) months following the last session. Completed *Post-Workshop Outcome Evaluations* are to then be forwarded to Pierce County.

***Return to the attention of:***

*Connie Kline, Social Services Supervisor  
Aging & Disability Resources  
Pierce County Community Connections  
1305 Tacoma Avenue S, Suite 104  
Tacoma, WA 98402*

*253.798-3782  
ckline@co.pierce.wa.us*



# Living Well With Chronic Conditions

Better Choices, Better Health

## Attendance Log

**Instructions to the Group Leaders:** Please clearly print the Workshop Information and the Participant Names below. Write participants' names as they appear on their *Participant Information Surveys*.

Participants will initial in the  for each session they attend.

Workshop Information - Site Name: \_\_\_\_\_

Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Session Number / Date

Participant Name Last, First, MI	DOB	Gender M/F	Session Number / Date					
			1 _/_	2 _/_	3 _/_	4 _/_	5 _/_	6 _/_
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
16.								
17.								
18.								
19.								
20.								

(20 is maximum enrollment. However, in case of overflow, you may photocopy this page.)



# Living Well With Chronic Conditions

Better Choices, Better Health

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## ***Welcome***

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**Thank you for taking a few minutes to answer some brief questions. While you may leave any question blank, we encourage you to complete the survey. Summarized information from all participants will help us demonstrate how this program is serving people who will benefit the most. Your responses are extremely helpful.**

**Your forms will be kept confidential. Your responses will not affect any services or programs you are getting. If you have any questions about what is being asked, please ask your Group Leader.**

**Thank you again for taking a few minutes to complete this important information.**



# Living Well With Chronic Conditions

Better Choices, Better Health

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## Participant Information Survey

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### Instructions:

Please answer the questions on both sides of this form. Please print clearly.  
Mark your choice within the box, like this: 

x
---

Your Name (Last, First, MI): \_\_\_\_\_

1. What is your date of birth?

		/			/				
Month			Day			Year			

2. What is your gender?

- Female
- Male

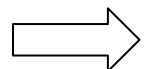
3. Are you of Hispanic, Latino, or Spanish origin?

- Yes
- No
- Unknown

4. What is your race? (Mark all that apply.)

- American Indian or Alaska Native
- Asian or Asian-American
- Black or African-American
- Hawaiian Native or Pacific Islander
- White or Caucasian
- Other: \_\_\_\_\_

Please turn over



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## ***Participant Information Survey—continued***

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**5. Has a health care provider ever told you that you have any of the following chronic conditions? (Please mark all that apply.)**

- Arthritis/ Rheumatic Disease
- Breathing/ Lung Disease (e.g., Asthma, Emphysema, Bronchitis)
- Cancer
- Depression or Anxiety Disorders
- Diabetes
- Heart Disease
- Hypertension (High Blood Pressure)
- Stroke
- Osteoporosis (Low Bone Density)
- Other Chronic Condition: \_\_\_\_\_
- None (No Chronic Conditions)

**6. What is your Zip Code?**

--	--	--	--	--	--

**7. Today, how many people live in your household (including yourself)?**

(Number of people)

**8. Have you ever taken a chronic disease self-management workshop before?**

- Yes
- No
- Unsure

***Thank you!***

**ATTACHMENT C- LIVING WELL WITH CHRONIC CONDITIONS WORKSHOP EVALUATION**



# Living Well With Chronic Conditions

## Better Choices, Better Health

### WORKSHOP EVALUATION

Workshop Sponsor: \_\_\_\_\_

Workshop Dates: \_\_\_\_\_

Please answer the following questions. Your feedback will help us make the workshops better. You do not need to include your name.

- How did you hear about the workshop? **Please check one.**
  - Previous participant
  - Senior Activity Center
  - Physician/health care provider
  - Brochure
  - Aging/Disability Resource Center (ADRC)
  - Other \_\_\_\_\_
- I took this course because **Check ALL that apply.**
  - I have arthritis
  - I have diabetes
  - I have heart disease
  - I have another chronic disease or condition (please specify): \_\_\_\_\_
  - I live with or care for someone with a chronic disease
  - I wanted to learn about self-management
  - Another reason: \_\_\_\_\_
- I am (**please check one**):  Female  Male
- I am (**please check one**):  less than 40 years old  between 40-59 years old  
 between 60-79 years old  80 years or older

**MORE ON THE BACK →**

---

5. Please circle the number that best shows **how much you agree** with these statements:

After taking the workshop, I am more confident I can manage my chronic condition(s).

Disagree      1          2          3          4          5      Agree

I have used at least one of the skills I learned. Which skill(s)?  
\_\_\_\_\_

Disagree      1          2          3          4          5      Agree

I can put together an action plan to deal with problems and challenges that come up.

Disagree      1          2          3          4          5      Agree

The workshop has helped me talk with my doctor and other members of my health care team.

Disagree      1          2          3          4          5      Agree

I would recommend this workshop to a friend.

Disagree      1          2          3          4          5      Agree

6. What did you like best about the workshop?

7. What about the workshop could be improved?

8. How many workshop sessions did you attend? (***circle total number***) 1 2 3 4 5 6

9. **If you did not attend all 6 sessions**, please check any reasons below that apply:

I was ill or didn't feel well

The workshop did not meet my needs

I had other commitments

Other: \_\_\_\_\_

---

**ATTACHMENT D- CDSMP PRE-/POST-WORKSHOP OUTCOME  
EVALUATION**

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# Living Well With Chronic Conditions

## Better Choices, Better Health

### PRE- / POST-WORKSHOP OUTCOME EVALUATION SURVEY

#### Survey Type: Check one

- Pre-Workshop: Participant is responding to this survey prior to the first workshop session.
- Post-Workshop: Participant is responding to this survey (4) months after completing the final workshop session.

#### Participant Information:

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Female  Male

Ethnic Origin: (check only one)

- White / Caucasian (not Hispanic)
- Black / African-American (not Hispanic)
- Asian / Pacific Islander
- Hispanic origin
- American Indian / Alaskan Native
- Other: \_\_\_\_\_

Chronic condition(s): (check all that apply)

- Diabetes
- Asthma
- Emphysema / COPD
- Other lung diseases: (Specify type) \_\_\_\_\_
- Heart disease: (Specify type) \_\_\_\_\_
- Arthritis or other rheumatic disease: (Specify type) \_\_\_\_\_
- Cancer: (Specify type) \_\_\_\_\_
- Other chronic condition: (Specify type) \_\_\_\_\_

## Health Status and Symptoms:

1. In general, would you say your health is: (Circle one)

Excellent.....1

Very Good.....2

Good.....3

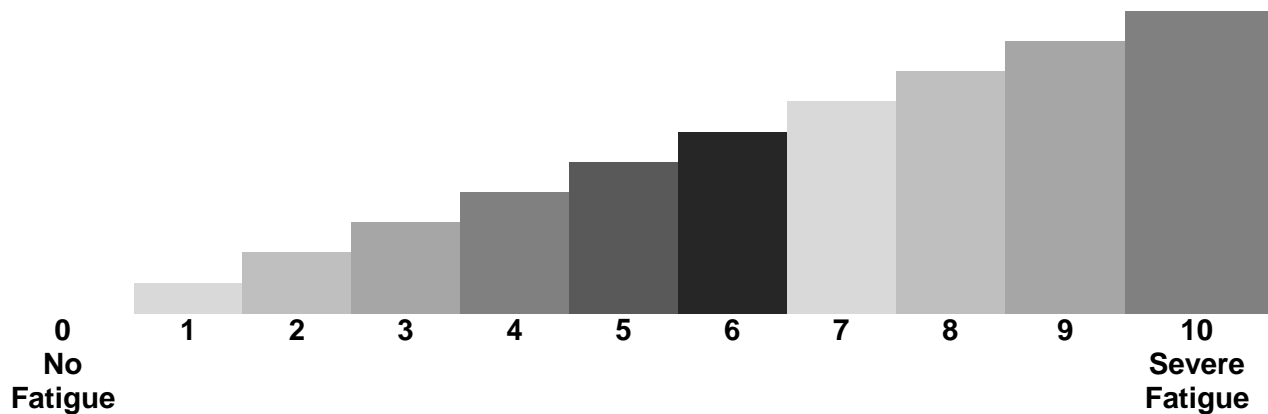
Fair.....4

Poor.....5

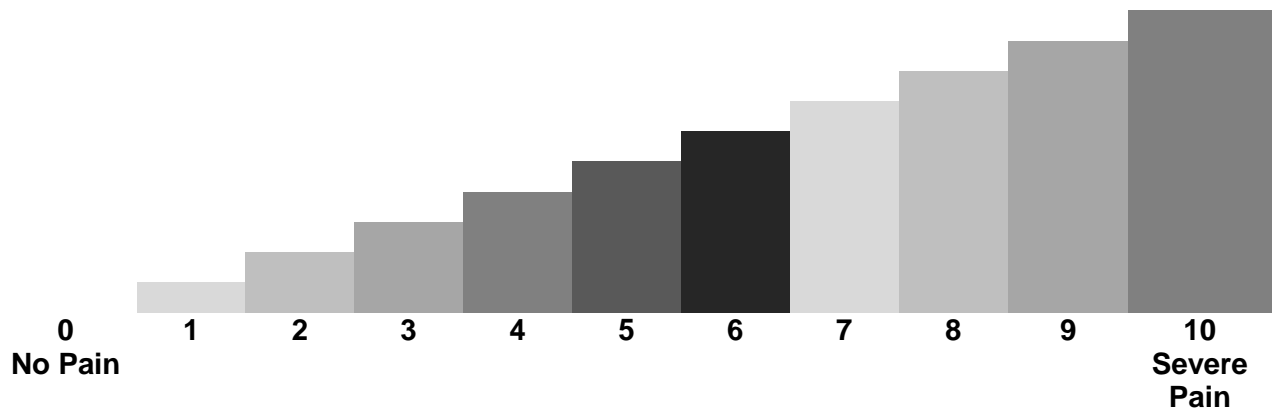
2. How much time during the **past 2 weeks**...

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
a. Were you discouraged by your health problems?	0	1	2	3	4	5
b. Were you fearful about your future health?	0	1	2	3	4	5
c. Was your health a worry in your life?	0	1	2	3	4	5
d. Were you frustrated by your health problems?	0	1	2	3	4	5

3. We are interested in learning whether or not you are affected by fatigue. Circle the number on the scale that describes your **level of fatigue** in the **past 2 weeks**:



4. We are interested in learning whether or not you are affected by pain. Circle the number on the scale that describes your **level of pain** in the **past 2 weeks**:



**Confidence:**

For each of the following questions, please **circle** the number that corresponds with your **confidence** that you can do the tasks regularly at the present time:

**How confident are you that you can...**

- |  |                              |   |   |   |   |   |   |   |   |                            |
|--|------------------------------|---|---|---|---|---|---|---|---|----------------------------|
| 1. Keep the fatigue caused by your disease from interfering with the things you want to do?              | 1<br>Not at all<br>confident | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10<br>Totally<br>confident |
| 2. Keep the physical discomfort or pain of your disease from interfering with the things you want to do? | 1<br>Not at all<br>confident | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10<br>Totally<br>confident |
| 3. Keep the emotional distress caused by yur disease from interfering with the things you want to do?    | 1<br>Not at all<br>confident | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10<br>Totally<br>confident |
| 4. Keep any other symptoms or health problems you have from interfering with the things you want to do?  | 1<br>Not at all<br>confident | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10<br>Totally<br>confident |

## Daily Activities:

During the **past 2 weeks**, how much...

	Not at all	Slightly	Moderately	Quite a bit	Almost totally
1. Has your health interfered with your normal social activities with family, friends, neighbors or groups?	0	1	2	3	4
2. Has your health interfered with your hobbies or recreational activities?	0	1	2	3	4
3. Has your health interfered with your household chores?	0	1	2	3	4
4. Has your health interfered with your errands and shopping?	0	1	2	3	4

## Health Care Use:

1. **In the past 4 months**, how many times did you visit a physician or health care provider?  
\_\_\_\_\_ visits (*Do not count hospital or emergency room visits*)
2. **In the past 4 months**, how many times did you go to a hospital emergency department?  
\_\_\_\_\_ times
3. **In the past 4 months**, how many times were you hospitalized for one night or longer?  
\_\_\_\_\_ times
4. **In the past 4 months**, how many nights did you spend in the hospital?  
\_\_\_\_\_ nights

**Thank you for your help completing this survey.**

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