Lead Safe Cleveland Coalition
Lead Screening and Testing RFQ
Frequently Asked Questions

Q: Are we expected to collaborate with other organizations to pre-bundle activities before submitting our proposal, or will the review process match complementary proposals after submission?

A: Yes, we encourage applicants to discuss and submit joint applications with partners they believe are best suited to meet our objectives.

Q: What level of detail is required for the budget? Do you need line-item justifications for specific subcontracted personnel, or would a high-level overview of allocated funds (e.g., system-level subcontracting, key personnel, indirect costs) suffice?

A: We prefer more detailed budgeting information upfront, such as expected subcontracting needs, involved employees, and program expenses, rather than just high-level estimates. While additional budget specifics can be finalized post-selection, initial detailed information helps guide the selection and contracting process.

Q: For Program Two (distributing a Lead-Safe Training Toolkit) in the RFQ, is the primary focus on expanding dissemination of existing materials through partnerships and community outreach, rather than creating new content?

A: Yes, the focus is on dissemination. The toolkits are complete, and the role involves promoting their use in the community, collecting feedback, and coordinating updates with Environmental Health Watch (EHW). Additionally, EHW seeks to expand training for medical providers and others, ensuring they not only have the toolkit but also can effectively communicate its contents to families. The administrator may also support this training to ensure accuracy and sustainability within the provider context.

Q: For the first program, you had one metric to test 500 children. For Programs Two and Three, do you have specific metrics in mind, or is that open for us to propose in our response?

A: We are open to feedback from respondents regarding the metrics for the other two programs.

Q: To reduce duplication, should applicants prioritize working through established community advisory networks, like those with the City of Cleveland Public Health Department or the Lead Safe Cleveland Coalition, especially those involved in toolkit creation, or is it encouraged to create new community advisory relationships?

A: Both approaches are welcome. While there is an established system in place, the administrator can bring in additional networks or relationships if beneficial.

Q: Could you clarify the specific problems that Programs Two and Three aim to address? For Program One, the goal is clear (increased child testing), but for Programs Two and Three, could you elaborate on the underlying issues these activities seek to resolve?

A: For Program One, the 500 tests represent a baseline target, not an upper limit. Ideally, we aim to exceed this number to address the decline from 11,000 to 8,000 tests. Reaching 8,500 would be a step toward our broader goal, though we expect efforts to go beyond this. The 500 figure was set to be sustainable and achievable, but higher participation is encouraged.

The main issue Program Two aims to address with the toolkit is ensuring consistent messaging. Currently, families may receive varied information depending on their source (city, county, coalitions, or medical providers), leading to potential confusion. The toolkit serves as a unified resource for everyone to provide the same information to families, with specific versions tailored for different audiences, like medical providers, educators, and property owners. This approach helps ensure clarity and guidance on available resources and support.

For Program Three, the goal is to improve outreach to families with children showing elevated lead levels. For levels above 10, the health department makes extensive efforts to contact families for a home inspection. However, for levels between 3.5 and 9.9, current guidance is minimal, usually limited to a phone call or mail. The program seeks to enhance engagement with these families to prevent future poisonings and protect siblings. Suggested metrics include contact rate, follow-up testing within 3-6 months, and overall family engagement.

Q: For Program Three, are you looking for the administrator to perform follow-up work directly, or to provide consultation and guidance on how best to conduct this follow-up? It seems there may be flexibility in the approach.

A: City of Cleveland Public Health Department teams will handle family outreach, but additional support is needed.

Q: **Does Program Three focus solely on the City of Cleveland, or is it intended to improve systems with potential spillover benefits for Cuyahoga County, including the Cuyahoga County Board of Health? Can you clarify the jurisdictional scope?**

A: Yes, the primary focus is the City of Cleveland, as it uses city ARPA funding. However, Cuyahoga County is a valuable partner, and any regional improvements would be beneficial.

Q: Can you explain the hard deadline for ARPA funding? If there's a delay, does that reduce the grant's timeline, requiring it to end by a specific date (e.g., May) regardless of delays, due to final funding availability?

A: Currently, ARPA funding must be spent by June 30, 2026. If this changes, adjustments would be welcome, but for now, this is the final spending deadline.

Q: Does the deadline require funds to be disbursed by Cleveland to a vendor by June 30, 2026, or fully spent by the vendor by that date?

A: Funds must be fully spent by the vendor by June 30, 2026. We are interested in project solutions that extend beyond the contract period and welcome ideas for co-creating sustainable impacts, given the shorter timeframe.

Q: What is the current status of outreach to hospitals regarding mandatory lead testing? Has there been progress in establishing a standard of care for children in Cleveland?

A: All three hospital systems and the major FQHC have incorporated mandatory lead testing.

Q: Is it standard practice to test all one- and two-year-olds annually for lead, and is this the intended goal?

A: Yes, the goal is to make annual lead testing standard for all one- and two-year-olds, moving away from conditional questions like the age of the home.

Q: Has there been any communication or advocacy efforts with the Ohio Department of Medicaid regarding this process?

A: All payers indicate they cover lead testing, but costs can still impact patients due to deductibles. There's interest in understanding how often this affects families in Cleveland, where testing might incur deductible expenses rather than being fully covered.