



Community-Campus Partnerships for Health

Transforming Communities & Higher Education

COMMUNITY PARTNER CONFERENCE CALL

Wednesday June 3, 2009

12:30-2 pm pacific time / 3:30-5 pm eastern time

AGENDA

10 minutes Welcome, overview of agenda & introduction of speakers (see speaker bios on p.2-3)

40 minutes Moderated panel discussion

- Community involvement in research
- Why & how to obtain a federally negotiated indirect rate (see p. 4-6 & Handout #1)
- Why & how to register with grants.gov: <http://www.grants.gov> (see Handout #2)
- Why & how to register with NIH eRA Commons: <http://commons.era.nih.gov/> (see p. 7)

10 minutes Audience Q&A

15 minutes Moderated panel discussion

- Ethics review of community-based research
- Why and how to obtain a Federal Wide Assurance (see p. 8 & Handouts #3 and #4)

10 minutes Audience Q&A

5 minutes Closing comments

SPEAKER BIOS

ELMER FREEMAN, MSW

Executive Director

Center for Community Health Education Research and Service, Inc.

Boston, MA

Mr. Elmer Freeman is the Executive Director of the Center for Community Health Education Research and Service, Inc. (CCHERS, pronounced “cheers”), an academic/community partnership established in 1991 with a \$6 million grant from the WK Kellogg Foundation. CCHERS is a unique partnership among Northeastern University Bouvé College of Health Sciences, Boston Medical Center, Boston University School of Medicine, the Boston Public Health Commission and fifteen community health centers serving the diverse racial and ethnic underserved populations of the central city neighborhoods of Boston. CCHERS is a community based non-profit organization with a board of directors composed of representatives of its partner organizations and members of the communities they serve. Mr. Freeman has served in the community health center movement since 1973, first as a board member, then administrators in one health center, and finally the CEO for 17 years at another. His leadership of CCHERS, since 1997, has led to its recognition as a national model of an academic/community partnership promoting community-based participatory research (CBPR). CCHERS is organized as a primary care practice-based research network of community health centers.

Mr. Freeman is a recognized expert in the application of CBPR principles in partnerships with academic researchers to address disparities and inequalities in health and health care of underserved communities. He served on the “expert panel” for Agency for Healthcare Research and Quality Evidence Report No. 99, *Community-Based Participatory Research: Assessing the Evidence* and has served as an investigator on research funded by the National Institutes of Health, the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. His research areas of interest are the social, economic and political determinants of health status of minority populations; the impact of internalization of racism on the manifestation of health risk behaviors among oppressed groups; and incorporating evidence based practice in the management of chronic diseases in health center patient populations. He views research as essential to improving quality and health outcomes for at-risk populations and for promotion social and economic justice in vulnerable communities. CCHERS has established research partnerships with Harvard Medical School/Brigham and Women’s He is an advisory board member of the Tufts University Community Research Center and the Dana-Farber Cancer Institute Community Research Network, and he is a cofounder of the Community Health and Academic Medicine Partnership with Harvard Medical School and Brigham and Women’s Hospital, Tufts University/Tufts Medical Center, and Harvard School of Public Health. Mr. Freeman is involved nationally with Community-Campus Partnerships for Health, where he served as Board Chair, the American Public Health Association, and the National Association of Community Health Centers.

In 2007, Mr. Freeman was appointed to a four year term on the Council of Public Representatives, an advisory board to the Director of the National Institutes of Health, where he has an opportunity to help shape and inform policy as NIH begins to define “authentic” community engagement as part of its agenda to transform clinical and translational research and ensure a role for the public in NIH intra and extramural research.

LORETTA JONES, MA

Founder & Executive Director Healthy African American Families II Los Angeles, CA

Ms. Jones is the founder and Executive Director of Healthy African American Families II. As a "Community Gatekeeper," she has dedicated her entire life towards the hope and healing of community and society-at-large. Her career as a civil rights activist, health policy advocate, and social architect has spanned more than 30 years. In an effort to level the playing field for all people, Ms. Jones continues her unyielding commitment as a change agent against disparities in human health, development, and opportunity.

She is a co-investigator of the National Institute of Mental Health UCLA/RAND Center for Research on Quality in Managed Care, the National Institute on Aging UCLA Center for Health Improvement in Minority Elderly, the National Institutes of Health Drew/UCLA Project EXPORT, and Community Partners in Care, a Community Partnered Participatory Research Project that is based on a model she created, as well as a recipient of numerous CDC grants and contracts. She serves on the National Children's Study-Los Angeles Ventura County Study Center Committee. In addition, she is on both the Community Faculty and 4-year Medical School Planning Committees at Charles Drew University. She is also a member of the NIH National Institute of Child Health and Human Development (NICHD) Community Child Health Research Network, a member of the American Academy of Nursing Advisory Council, serves on the Advisory Board for the Los Angeles Best Babies Collaborative and UCLA Institutional Review Board (IRB) for protection of human subjects. She is the lead author on an article published in the Journal of the American Medical Association (Jones L, Wells K. Strategies for Academic and Clinician Engagement in Community Participatory Partnered Research, JAMA January 24, 2007). She served as a Commissioner for the Joint Center Health Policy Institution's Dellums Commission (2005-2006) and was a Family and Youth Stakeholder Member for the National Center for Children in Poverty in 2005. In addition, she served as a member of the Advisory Council planning NICHD's longitudinal health study and chaired its Social Justice Committee. In 2004, Ms. Jones was honored as the first recipient of the Centers for Disease Control and Prevention Award for National Contribution to Minority Health Programs, Research and Surveillance - Department of Reproductive Health.

DETERMINING & NEGOTIATING AN INDIRECT COST RATE FOR A FEDERAL GRANT

This handout on indirect costs was prepared by the National Resource Center for the Compassion Capital Fund, <http://www.ccfbest.org/management/indirectcostrates.htm>

Additional information is available from the Division of Cost Allocation in the US Department of Health and Human Services at <http://rates.psc.gov/>

Question: How do you determine and negotiate an indirect cost rate (also known as a facility & administrative cost rate) for a federal grant?

Answer: In a multi-program organization, all costs can be divided into two different types: direct and indirect. Direct costs are those that are clearly and easily attributable to a specific program. For example, the cost of new basketballs is clearly related to the after-school athletics program. Similarly, it is easy to justify charging counselors salaries to the counseling program.

Indirect costs are those that are not easily identifiable with a specific program, but which are, nonetheless, necessary to the operation of the program. These costs are shared among programs and, in some cases, among functions (program, management and general, and fundraising). The executive director's salary is a common example of an expense that benefits all programs and functions. Other indirect, or shared, costs may include rent, telephone, postage, printing and other expenses that benefit all programs and functions of an organization.

Why Allocate Indirect Costs to the Programs? The full cost of a program rightfully includes a share of the overall costs of the organization. Knowing the full cost of a program sets a basis for financial analysis of the program, for pricing fee-based services, and for requesting reimbursement from funders for the full costs of providing services.

What Are the Methods for Allocating Indirect Costs? There are several methods for allocating indirect costs. The two most common are case-by-case allocation and developing an indirect cost rate.

Case-by-Case Allocation. One method of allocating indirect costs is to determine a rate of actual usage for each program. For example, you may decide to keep track of long distance telephone calls and charge them to the appropriate program when you pay the phone bill each month. Similarly, some organizations use a counter or log to track copying expenses for each program and/or function. Time sheets may form the basis for allocation of salaries for the executive director, accountant, and staff whose work benefits more than one program or activity. A different method can be adopted for each line item or case.

The advantage of this method is that it seems to "make sense." A major disadvantage, however, is that it often requires a great deal of time-consuming record-keeping. Even if you keep the records needed to precisely allocate shared expenses among programs, not all expenses will be covered. If, for example, the rent is allocated by square feet, how should you allocate the hallway and rest rooms? What about the local phone calls which cannot be tracked using a code? For those shared expenses which cannot easily be divided directly into programs and functions, an indirect cost rate is useful.

Developing an Indirect Cost Rate. The first step in determining an indirect cost rate is to separate all costs into two groups: **direct and indirect costs.** The indirect costs are aggregated into an indirect cost "pool" and then allocated to the programs based on a set proportion or rate. There are several measures used to determine the proportion of indirect costs to allocate (apply) to each program. The following simple example illustrates an indirect cost rate based on the relationship between total indirect costs and total direct costs:

Example 1-- The Tadpole League

The Tadpole League has a total budget of \$3,300. The budget is distributed as follows:

Program A has direct costs of \$1,000

Program B has direct costs of \$2,000

Indirect costs to run the programs is budgeted at \$300

Total costs are \$3,300

Since Program A's direct costs are one-third of the total direct costs of the agency (\$1,000 out of \$3,000), it should bear one-third of the indirect costs. Similarly, since Program B incurs two-thirds of the total direct costs of the agency, it should bear two-thirds of the indirect costs, as well.

The Tadpole League can create an indirect cost rate which will allow it to easily accomplish this allocation. An indirect cost rate (using direct costs as a base) is established by dividing the total indirect costs by the total direct costs. For the Tadpole League the indirect cost rate is:

Total Indirect Costs divided by Total Direct Costs = $\$300/\$3,000 = 10$ percent of total costs

Each program's share of indirect costs can be calculated as a proportion of its direct costs:

Program A Indirect Expenses: $\$1,000 \times 10\% = \100

Program B Indirect Expenses: $\$2,000 \times 10\% = \200

Total Indirect Expenses = \$300

After the indirect costs have been allocated to the programs, the budget now reads as follows:

Program A has direct costs of \$1,000, indirect costs of \$100 = \$1,100

Program B has direct costs of \$2,000, indirect costs of \$200 = \$2,200

Total costs are \$3,300

This illustrates that after Program A has picked up its fair share of indirect costs, the true cost of running Program A is \$1,100. As you can see from this example, using direct costs as a basis for your indirect cost rate will result in larger programs being charged with more of the indirect costs than smaller programs.

Is There More Than One Way to Calculate an Indirect Cost Rate? The Office of Management and Budget Circular A-122, Cost Principles for Nonprofit Organizations, describes the method of developing a federal indirect cost rate, using these same principles.

<http://www.whitehouse.gov/omb/circulars/a122/a122.html>

However, even within these guidelines, indirect cost rates for the same organization may vary from federal agency to federal agency. Organizations may allocate indirect costs based on how many people are served in each of their programs, how large each of their sites is, or other logical methods.

What Is the Standard for Allowable Indirect Costs? There is little agreement in the nonprofit or funding community about how to calculate the rate, what to include, and how much is fair. There are no across-the-board standards or maximum levels for indirect costs. Some foundations have informal, unwritten guidelines for a maximum level. Under federal guidelines, allowable indirect costs range from 3 percent to 70 percent, varying from agency to agency.

Contrary to popular belief, indirect costs are not an easy measure of an organization's efficiency or stewardship. For example, imagine a multi-service agency where each program has its own bookkeeper, purchases its own supplies, and has all its own equipment. Such an organization would have no indirect costs at all, but would be clearly less efficient than if the programs shared bookkeeping costs, supplies and equipment.

Final Comments. Because the presentation of financial information influences the way the federal government assesses an agency's finances, the selection of indirect costing methods and accounting procedures has an important impact on decision-making. Several urgent and perhaps conflicting demands are made of the indirect costing process: to attribute indirect costs in the fairest way possible, to attribute the most indirect costs to the programs that can best afford them, to eliminate as many indirect costs as possible by having each program buy its own supplies, etc. Finding a balance among these demands that clears confusion and informs decision-makers is a responsibility of all participants in the nonprofit sector.

What is the NIH eRA Commons?

NIH has developed a system to facilitate the discrete exchange of essential information between NIH and applicant organizations. The “Commons” is a Web interface where NIH and the grantee community are able to conduct their extramural research administration business electronically.

An institution must be registered in the NIH eRA Commons before faculty and staff can take advantage of electronic submission and retrieval of grant information. Only an individual with signatory authority for the institution in grant-related matters can register an institution. To register in the NIH eRA Commons, open the [NIH eRA Commons homepage \(https://commons.era.nih.gov/commons/\)](https://commons.era.nih.gov/commons/) and click on the Grantee Organization Registration link. Follow the step-by-step instructions. The institution is registered when the information is completed, submitted (by pressing the Submit button) and confirmed by the NIH.

Only **Signing Officials** can register their institutions with the NIH. An **SO, or Signing Official**, has institutional authority to legally bind the institution in grants administration matters. The individual fulfilling this role may have any number of titles in the grantee organization. The label "Signing Official" is used in conjunction with the NIH eRA Commons. The SO can register the institution, and create and modify the institutional profile and user accounts. The SO also can view all grants within the institution, including status and award information. An SO can create additional SO accounts as well as accounts with any other role or combination of roles.

Follow these directions to register your institution.

1. Complete the online Institution Registration Form and click Submit. A screen appears with information about NIH registration and the institution data entered in the Registration form.
2. Print the registration page, make any corrections and affix your signature as designated.
3. Fax the registration page to the number at the top of the page. NIH will validate the information your institution submitted for approval and send a verification email to the Signing Official (SO).
4. Reply to the verification e-mail. Upon receipt of the verification email, the NIH sets up your institution account, and sends an email to the SO with a link to a page showing their NIH institution name and associated information.
5. Verify that all information is correct.
6. Send confirmation response to this information and proceed.
7. Receive email notification of registered SO account (userid/password) from the NIH.
8. Create and maintain additional accounts for your institution staff.

Federal Wide Assurance (FWA)

Answers to Frequently Asked Questions about FWA

<http://www.hhs.gov/ohrp/FWAfaq.html>

Steps to File a Domestic FWA

http://www.hhs.gov/ohrp/assurances/assurances_index.html#domestic