South Dakota Department of Health
Heart Disease and Stroke Prevention Program
Request for Applications (RFA)
Implementing Interventions to Improve the Health of South Dakotans Through Prevention and Management of Heart Disease

Heart disease is the leading cause of death in the U.S. and second leading cause of death in South Dakota (SD). Stroke is the fifth leading cause of death in the U.S and the sixth leading cause of death in SD.[1] Overall, cardiovascular disease (CVD) accounts for 27.5% of all deaths in SD. Similar to national data, approximately one in five (21.5%) of those who die from CVD in SD are less than 65 years old.[2] Risk factors for CVD include high blood pressure and high blood cholesterol. According to the 2015 Behavioral Risk Factor Surveillance Survey (BRFSS), 30% of SD adults are aware they have high blood pressure; however, only about half (54%) have their blood pressure under control according to national statistics. In addition, one-third of SD adults have been told they have high cholesterol, a risk factor for CVD.[3]

The South Dakota Department of Health (SD DOH) and the Heart Disease and Stroke Prevention Program (HDSPP) have entered into a cooperative agreement with the Centers for Disease Control and Prevention (CDC) as part of the funding opportunity DP18-1815 *Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke.* Therefore, HDSPP is soliciting applications from healthcare facilities to fulfill certain requirements of the agreement. The project HDSPP is seeking partnership regarding consists of four separate opportunities. Each applicant may select one or more of the objectives below:

Objectives	Information of importance and examples of eligible activities (not all-inclusive)
Strategy B.2 - Implement or expand the use of PopHealth, a population health data analysis tool	PopHealth is a specific population health data tool utilized by HDSPP. Other population health programs are not eligible for this activity. Awarded facilities would work with HealthPOINT (at no cost to facility) to export cardiovascular and diabetes related data from their electronic health record to the PopHealth program. Once successfully interfaced, this dashboard would then be used to develop quality improvement initiatives based on performance data.
Strategy B.2 - Implement policy and procedures around evidence-based quality measurement	Facility could: complete a workflow assessment and implement new procedure based on those findings (i.e. team huddles to review performance data, client reminder systems, etc.), develop and implement a quality improvement strategic plan, utilize dashboard measures to develop policy/procedure.
Strategy B.3 - Implement or improve upon an aspect of team-based care	Facility could: enroll in Medicaid Health Home program or become a Patient Centered Medical Home, develop referral system to mental health professional, nutritionist, physical therapist, etc., form teams consisting of non-physician members in addition to provider and nurse, implement policy to ensure all practitioners are working at the top of their scope of practice.
Strategy B.6 - Implement or improve upon a self-measured blood pressure (SMBP) monitoring program	Facility could: integrate Target: BP (https://targetbp.org/blood-pressure-improvement-program/patient-measured-bp/), Check. Change. Control (https://www.heart.org/en/health-topics/high-blood-pressure/find-high-blood-pressure-tools--resources/check-change-icontroli-community-partner-resources) or Million Hearts SMBP (https://millionhearts.hhs.gov/tools-protocols/smbp.html) into practice, add additional patients to current SMBP program or expand to additional providers or sites. Funding may not be used for purchase of blood pressure cuffs.

*All awarded initiatives would be developed and implemented with assistance from the 1815 team. 1815 team consists of experts from HealthPOINT, the Great Plains Quality Innovation Network, and SD Department of Health who have extensive knowledge and experience related to 1. electronic health records, 2. data, workflow, process analysis, 3. strategic plan development and implementation, 4. PDSA cycles, 5. policy and protocol development. Additional partners may be utilized for activities as needed. All team members are available to awarded facilities as a resource for accepted grant activities at no charge to the awardee.

Applicants may request up to $5,000 per objective (up to $20,000 if planning activities for all four objectives), as commensurate with the scope and impact of the project, within the request for grant application budget. Applicants must follow the attached grant application.

Staff will be available to answer questions, review grant applications and provide recommendations for revisions until **4pm CT** on **Wednesday, April 10, 2019**.

RFA Schedule	Date
Request for grant application released and posted to http://healthysd.gov/fundingopportunities/ and http://goodandhealthysd.org/about/fundingopportunities/	February 13, 2019
Last day for questions and to request review of grant application	April 10, 2019
Application submission deadline	**4:00pm CT on Friday, April 12, 2019**
Notice of grant award issued (via email)	Week of May 6, 2019 *(tentative)*

Funding Parameters:

- The project period begins June 1, 2019 and ends May 31, 2020.
- Funding will not exceed $5,000 per objective (up to $20,000 if working on all four objectives).
- It is estimated that up to 8 applicants will be funded.
- Funding will be remitted on a reimbursement basis monthly. In the event the contractor lacks sufficient working capital to provide the services of the contract, an advance payment not to exceed half of the contract amount may be provided. Please indicate in your budget if advance payment is requested along with a justification.

Application Requirements:

- Applications should demonstrate a systems level change approach that impacts the permanent culture around heart disease prevention at the organizational level.
- Applications should demonstrate potential for sustained efforts and lasting impact that lead to improved heart disease prevention and management.
- Funds can **not** cover screening tests, diagnostics, treatment, or direct service items. Additional limitations are as listed in the "Grant Funding Restrictions" section below.

Eligibility:

- Interventions funded by this grant must be targeted towards patients whose primary residence is South Dakota or a South Dakota tribal community.
- Please direct any eligibility questions to Rachel at Rachel.Sehr@state.sd.us.

Scoring Criteria:

- Complete applications meeting RFA guidelines will be submitted for review by the grant review committee. Final award decisions will be determined by the SD Department of Health.

Grant Funding Restrictions:

- Interventions funded by this grant must be targeted towards South Dakota residents and/or tribal communities only.

- Funds may not be used to replace dollars currently earmarked for heart disease prevention and management programs/projects.
- Indirect/Administrative Costs: Funding can be requested to support indirect costs at a rate not to exceed 6.2% of the total grant award.
- Funds may not be used for any lobbying efforts at the local, state, or federal level, purchasing food, equipment, or client/patient/provider incentives, and research activities.

Award Requirements:

- Awardees must implement evidence-based interventions based on the objectives proposed in the application.
- Awardees will participate in periodic technical assistance sessions via conference call, webinar, or in-person to discuss project progress, successes, and challenges and/or receive technical assistance.
- Awardees will participate in periodic consultation with project evaluator(s) and grant staff.
- Awardees must utilize all funds; carryover will not be allowed.

Reporting Requirements:

- Quarterly reports are required of each funded applicant. Quarterly reports shall describe 1) qualitative and quantitative progress towards target outputs and outcomes, 2) progress made towards implementation of interventions, and 3) successes and/or barriers. Midterm and final budget reports will also be required.
- Technical assistance will be provided to funded sites to complete required reporting.
- Awardees must submit a success story using the success story template at the end of the project; the awardees give permission to share this story.
- Awardees will be required to submit data for the following performance measures (as appropriate):
    - Number and percentage of providers that use standardized quality measures to track differences in blood pressure control and cholesterol management in priority populations compared to overall populations.
    - Number and percentage of patients that are in health care systems that have policies or systems to encourage a multi-disciplinary approach to blood pressure control and cholesterol management.
    - Number and percentage of patients within health care systems with policies or systems to encourage self-monitoring of high blood pressure tied to clinical support.
    - Number of patients served within healthcare organizations with systems to identify people with prediabetes and refer them to the CDC-recognized lifestyle change programs.

Technical Assistance:

- Technical assistance will be provided to all interested applicants throughout the application period. Contact Rachel at Rachel.Sehr@state.sd.us or 605.367.5356 for assistance.
- Technical assistance will be provided to awardees throughout the grant period by the SD DOH staff and partner organizations.
- Evaluation support will be provided throughout the grant period by Spectrum.
- Brochures, posters, and other educational materials will be provided during the grant period, free of charge, by the SD Department of Health.

Objective Specific Requirements:

- Implement or expand the use of PopHealth, a population health data analysis tool
    - The grantee's proposed activity must align with the following DP18-1815 strategy: *Strategy B.2: Promote the adoption of evidence-based quality measurement at the provider level (e.g., use dashboard measures to monitor healthcare disparities and implement activities to eliminate healthcare disparities.)*
- Implement policy and procedure around evidence-based quality measurement

- The grantee's proposed activity must align with the following DP18-1815 strategy: *B.2: Promote the adoption of evidence-based quality measurement at the provider level (e.g., use dashboard measures to monitor healthcare disparities and implement activities to eliminate healthcare disparities.)*

- Implement or improve upon an aspect of team-based care
  - The grantee's proposed activity must align with the following DP18-1815 strategy: *B.3: Support engagement of non-physician team members (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers) in hypertension and cholesterol management in clinical settings.*
- Implement or improve upon a self-measured blood pressure (SMBP) monitoring program
  - The grantee's proposed activity must align with the following DP18-1815 strategy: *B.6: Facilitate use of self-measured blood pressure monitoring with clinical support among adults with hypertension.*

GRANT APPLICATION VIA ELECTRONIC SUBMISSION TO Rachel.Sehr@state.sd.us

DUE NO LATER THAN 4:00 PM CENTRAL TIME ON APRIL 12, 2019.

1. **Applicant Information:**

   Healthcare Facility Name:

   Mailing Address:

   City: Zip Code:

   Contact Person: Title:

   Email Address: Phone Number:

2. **Patient Demographics:** *Please answer to the best of your capability, considering patients seen within your facility within the past year.*

   Total number of patients served:

   Total number of patients diagnosed with hypertension:

   Total number of patients diagnosed with hypercholesterolemia:

   Total number of patients diagnosed with diabetes:

   Total number of patients diagnosed with pre-diabetes:

   Please indicate the number of patients within your facility for the following age, race, and insurance categories:

Demographic Category	Total Patients
Adults (20-24)	
Adults (25-39)	
Adults (40-49)	
Adults (50-64)	
Adults (65 & older)	
Male	
Female	
American Indian or Alaska Native	
African American or Black	
Asian	
Hispanic or Latino	
White, Not Hispanic or Latino	
Other Race Not Listed Above	
Medicare Recipient	
Medicaid Recipient	
Uninsured	
Underinsured	

3. **Population of Focus:** *Please describe the primary population(s) of focus for this grant. Be sure to include age and gender of the population that will be targeted. Additionally, if the target population will be different for each intervention, please specify that information below.*

4. **Quality Improvement Team:** *Please list the role, name, title, and email of the members who will be serving on your QI/Grant Team for this grant.*

Role	Name	Job Title	Email
Implementation Lead			

5. **Objectives:** *Please check the objective(s) your organization plans to address. Organizations may select one - four objectives to address simultaneously.*

☐ B.2 - Implement or expand the use of PopHealth, a population health data analysis tool
☐ B.2 - Implement policy and procedure around evidence-based quality measurement
☐ B.3 - Implement or improve upon an aspect of team-based care
☐ B.6 - Implement or improve upon a self-measured blood pressure (SMBP) monitoring program

6. **Objective Intervention Proposal:** *Please provide a thorough and thoughtful description of each proposed objective intervention, making sure to include the following:*
    a. *The staff that will be responsible for implementing, monitoring, and evaluating this project. Please include name/title and time that will be dedicated to this project.*
    b. *The process by which this intervention will be implemented, monitored, and evaluated.*
    c. *Capabilities of your electronic health record, organizational structure, etc. as it relates to the proposed intervention.*

7. **Sustainability Plan:** *Please describe the plan to sustain the project and related outcomes beyond the grant funding cycle.*

8. Budget Justification: *Applicants may request up to $5,000 per objective (up to $20,000 if all four objectives are worked on), as commensurate with the scope of the project and total number of individuals impacted.*

Category	**Implementation Grant Funding Requested**	**In-kind Contribution**
Supplies needed for this intervention Justification:	$	$
Itemized description:		
Staff Support for this intervention Justification:	$	$
Itemized description: *(Please include the duties that will be completed by the identified staff position(s). (Example: Jane Doe, RN, Clinical Coordinator $25 per hour x 60hrs = $1,500.)*		
Travel for this intervention Justification:	$	$
Itemized description:		
Other expenses Justification:	$	$
Itemized description:		
Indirect Costs *Indirect costs cannot exceed 6.2% of the total requested budget.*	$	$
Total request:	**Total: $**	**Total: $**

Budget Instructions

Allowable categories have been identified. If funding is requested for a category, a brief explanation or funding justification must be included. Be sure to identify the source of funds, any in-kind or cash contributions, etc.

Supplies

Estimate the unit cost for each item and the total number of items needed. (Example: 250 client reminder postcards X $0.64 = $160.)

Staff Support

SD DOH partners with multiple entities to enhance efforts related to prevention and management of heart disease throughout the state. In certain cases, a project may require an extraordinary amount of staff time – over and above what is normally requested of partners. If this is the case, applying collaborations may request funds for key personnel. Funds should not be requested to supplant existing job responsibilities. The position title must be included plus the rate per hour times the total number of hours estimated for the project period. Benefits can either be calculated in the rate per hour or itemized separately. In the itemized description section, please include the duties that will be completed by the identified staff position(s). (Example: Jane Doe, RN, Clinical Coordinator $25 per hour x 60hrs = $1,500.)

Travel

Travel essential to the proposed project may be funded under this proposal. Travel reimbursement is allowed at the following rates: $0.42/mile, $6.00/breakfast, $11.00/lunch and $15.00/dinner; lodging maximum is $55 plus taxes per night.

Other

Include additional requests not addressed in the budget categories provided. Be sure to provide a thorough itemized description.

Indirect (Administrative) Costs

Funding can be requested to support indirect costs at a rate not to exceed 6.2% of the total grant award. Indirect costs represent the expenses of doing business that are not readily identified within the budget submission but are necessary for the general operation of the organization of the activities required.

Restrictions and Guidelines: Certain restrictions apply to the use of implementation grant funds, including:

- Grant dollars may not be used for any lobbying efforts at the local, state or federal level.
- Grant dollars may not be used for purchasing food.
- Grant dollars may not be used for screening procedures or any type of direct service.
- Grant dollars may not purchase equipment.
- Activities must target residents and/or tribal communities within South Dakota.
- Funding will be awarded to an organization only not to an individual(s).
- Materials produced with implementation funds must be pre-approved prior to printing, inclusion of program logos may be required.

Appendix A: Scoring Criteria

Complete applications meeting RFA guidelines will be submitted for review by the grant review committee.

Scoring Criteria

1. Applicant Information = 1 point
2. Patient Demographics = 8 points
3. Population of Focus = 8 points
4. Quality Improvement Team = 5 points
5. Objectives = 8 points
6. Objective Intervention Proposal = 40 points
7. Sustainability Plan = 15 points
8. Budget Justification = 15 points

Appendix B: Helpful Resources/Links

1. Best Practices Guide for Cardiovascular Disease Prevention Programs: A Guide to Effective Health Care System Interventions and Community Programs Linked to Clinics Services: https://www.cdc.gov/dhdsp/pubs/docs/Best-Practices-Guide-508.pdf
2. The Cardiovascular Collaborative Team-Based Care Toolkit: https://doh.sd.gov/diseases/chronic/heartdisease/teambasedcareguide
3. The Cardiovascular Collaborative Quality Improvement Resource Guide: https://doh.sd.gov/diseases/chronic/heartdisease/qitoolkit
4. American Heart Association: https://www.heart.org/
5. Million Hearts: https://millionhearts.hhs.gov/index.html
6. Great Plains Quality Innovation Network: https://greatplainsqin.org/
7. Community HealthCare Association of the Dakotas: https://www.communityhealthcare.net/
8. South Dakota Association of Healthcare Organizations: https://www.communityhealthcare.net/
9. HealthPOINT**:** https://healthpoint.dsu.edu/

Appendix C: References

1. United States Census Bureau. (2017). City and Town Population Totals: 2010-2017. Retrieved from https://www.census.gov/programs-surveys/popest/data/tables.html.
2. South Dakota Department of Health, Office of Health Statistics. (2016). 2016 South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators, Mortality. Retrieved from https://doh.sd.gov/statistics/2016Vital/Mortality.pdf.
3. South Dakota Department of Health, Office of Health Statistics. (2016). The Health Behaviors of South Dakotans 2015, Hypertension and Cholesterol. Retrieved from https://doh.sd.gov/statistics/2015BRFSS/Hypertension.pdf.