

**SD Department of Health Colorectal Cancer Control Program
Implementation Grants Request for Applications (RFA) #21CP0004**

**Purpose:** The SD Department of Health colorectal cancer program is seeking applications from primary care clinics interested in increasing colorectal cancer screening rates through the implementation of evidence-based interventions.

**Eligibility:**

Eligible applicants include primary care clinic(s) that serve primarily American Indians within South Dakota. Clinics should have a colorectal cancer screening rate below 60%. Clinics must be located in South Dakota. A health system may apply; however, the program is seeking active participation at the clinic level and requires identification of no more than four participating clinic locations within a health system.

**Available Funding:**

* Applicants may request up to $25,000 per project year. The project period will begin January 1, 2021. Subsequent year funding is contingent on awardee performance and availability of funds. Budget requests should be commensurate with the number of interventions selected and total number of individuals impacted.
* The total number of awards is dependent upon available funds and the number and scope of proposals submitted. 100% of this project will be funded by federal funds.
* Funding will be remitted on a reimbursement basis monthly or quarterly (depending on awardee preference).

**Funding Restrictions:**

* Funds can **not** cover any type of direct service (i.e. FIT kits, colorectal cancer screening tests, diagnostics, cancer treatment, or direct delivery of care). A limited amount of additional funds will be available to support reimbursement for follow-up colonoscopies for eligible patients screened at the participating clinics. *(This would be additional funding and should not be included in your budget request.)*
* Funds can **not** support patient incentives (i.e. gift cards for travel or screening completion).
* Funds may not be used for research activities, lobbying efforts at the local, state, or federal level or for the purchase of food, beverages, equipment, or client/patient/provider incentives.
* Numerous educational materials are available free of charge from the SD DOH at: [doh.sd.gov/catalog](https://apps.sd.gov/ph18publications/secure/puborder.aspx). Funds should not be used for the development or purchase of educational materials if an existing resource is available.
* Funds cannot be utilized to support costs associated with event booths or health fairs.
* Funding will be awarded to an organization only and not to an individual(s).
* Funds may not be used to replace dollars currently earmarked for cancer programs/projects.

**Funds CAN be used for items such as:**

* Staff time for informatics/data analysis, developing and implementing policies and workflows, implementing the listed evidence-based interventions.
* Development and mailing costs for reminders, automated reminder costs, mailing costs for FIT tests
* In-state travel to support intervention implementation (at state rates). Out-of-state travel requires pre-approval.
* Other eligible expenses. Please contact Lexi with any budgetary questions.

**Scoring Criteria:**

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

**Requirements for Awarded Applicant(s):**

* Implement at least two of the evidence-based intervention(s) listed.
* Participate in technical assistance sessions in-person quarterly and via conference call/webinar monthly to discuss project progress, successes, and challenges and/or receive technical assistance.
* Complete a baseline assessment and develop a project implementation plan.
* Comply with data reporting requirements.
* Identify a champion for colorectal cancer screening within the clinic.
* Provide referral options and patient navigation to support completion of follow-up colonoscopies after a positive or abnormal screening test.

**APPLICATIONS MUST BE SUBMITTED TO** **lexi.pugsley@state.sd.us** **NO LATER THAN 5:00 PM CENTRAL TIME ON NOVEMBER 12, 2020**

*Complete applications must be submitted by this deadline. Late or incomplete applications will not be considered for funding.*

**Application**

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| **Applicant Information** |

Entity’s Name (as listed in DUNS registration): Click or tap here to enter text.

Entity’s DUNS/unique entity identifier: Click or tap here to enter text.

Entity’s Address (as listed in DUNS registration): Click or tap here to enter text.

Entity’s City, State, Zip+4: Click or tap here to enter text.

1. Please provide a description of your health system. Include how many primary care sites/clinics deliver services within your health system in SD.
2. Based on your health system’s experience and knowledge, what are the barriers to colorectal cancer screening? Barriers might include access to care, cultural, financial, health literacy, housing, insurance, language, transportation, etc.
3. Do you have an Electronic Health Record (EHR) system? If yes, include the name of your EHR vendor and how long your health system has used this EHR.
4. Do you plan to switch to a different EHR vendor? If yes, please specify when you plan to switch and the new proposed vendor.
5. Does your EHR system have the ability to produce reports (i.e. registries, screening rates, etc.)?
6. Please outline your patient population by race and ethnicity:

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| --- | --- |
| Hispanic/Latino Patients  | %  |
| Non-Hispanic White Patients | %  |
| Asian Patients | %  |
| Native Hawaiian/Other Pacific Islander Patients | %  |
| Black/African American Patients | %  |
| American Indian/Alaska Native Patients | %  |
| More than one race | %  |

1. Approximately what percent of all patients at your health system are insured by:

|  |  |
| --- | --- |
| Medicaid  | %  |
| Medicare  | %  |
| Private Insurance  | %  |
| IHS or Tribal Contract Health  | %  |
| Veteran’s Administration  | %  |
| Uninsured  | %  |
| Other –specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | %  |
| Total | 100% |

1. Is there a known champion for colorectal cancer screening in your health system?

[ ]  Yes: If yes, please note name and title:

[ ]  No: If no, please identify who (name and title) will serve as the CRC screening champion for this project if selected.

1. Please list the role, name, title, and email of the members who will be serving on your grant and/or quality improvement team for this project.

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| **Role** | **Name** | **Job Title** | **Email** |
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1. Does your health system have a written colorectal cancer screening policy, protocol, or workflow in place? If yes, please submit.
2. What national screening guideline(s) does your health system follow for colorectal cancer screening?
3. Select the evidence-based interventions (EBIs) your health system currently utilizes for colorectal cancer screening as well as those you would like to expand or begin to implement in the future. *(Please note: If selected, we will work with your health system to complete a detailed clinic assessment to determine and finalize EBIs and develop an implementation plan.)*

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| **EBI** | **Currently Implementing** | **Interested in Implementing/Expanding As Part of the CRC Project** |
| **Client/Patient Reminders:** System to remind patients when they are due or overdue for colorectal screening, such as with letters, postcards, emails, texts, patient portal, and/or phone calls, etc. Client reminders should be tailored with the intent to reach one specific person based on characteristics unique to that person, related to the outcome of interest, and derived from an individual assessment. | [ ]  | [ ]  |
| *If currently implementing, please describe current efforts:* | *If currently implementing and you have an interest in expanding as part of this project, please briefly describe how you would expand efforts:* |
| **Provider Reminders:**Reminders inform health care providers it is time for a client’s cancer screening test (called a “reminder”) or that a client is overdue for screening (called a “recall”). | [ ]  | [ ]  |
| *If currently implementing, please describe current efforts:* | *If currently implementing and you have an interest in expanding as part of this project, please briefly describe how you would expand efforts:* |
| **Provider Assessment and Feedback:**Interventions that evaluate provider performance in delivering or offering screening to patients (assessment) and presentation of information to providers about their performance in providing screening services (feedback). | [ ]  | [ ]  |
| *If currently implementing, please describe current efforts:* | *If currently implementing and you have an interest in expanding as part of this project, please describe how you would expand efforts:* |
| **Reducing Structural Barriers:** Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening. Possible interventions include provision of FIT tests for eligible patients via mail, expanded service delivery (provision of FIT tests at a worksite), extended service hours, patient navigation, addressing transportation barriers, and providing translation services. Grant funds can not pay for FIT tests.  | [ ]  | [ ]  |
| *If currently implementing, please describe current efforts:* | *If currently implementing and you have an interest in expanding as part of this project, please describe how you would expand efforts:* |

1. Health systems may choose between up to four primary care sites/clinics to implement project efforts in year one.

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| **Clinic Name, Address, and Brief Description** | **Total number of adults aged 50-75 years who have had at least one medical visit to the clinic in the last calendar year (2019)** | **Description of Target Populations Served**  |
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1. Please indicate the colorectal cancer screening rate for your health system and each proposed participating clinic.

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| **Colorectal Cancer Screening Rate** | Measure (Examples: NQF0034, UDS, Other) | **2018 Baseline** (Jan. 1, 2018 – Dec. 31, 2018) | **2019 Baseline** (Jan. 1, 2019 – Dec. 31, 2019) | **Target During Year One Project Period**(Jan. 1, 2021– Dec. 31, 2021) |
| Health System |  | Numerator:Denominator: Percentage: | Numerator:Denominator: Percentage: | Percentage: |
| Clinic #1: (Insert Name) |  | Numerator:Denominator: Percentage: | Numerator:Denominator: Percentage: | Percentage: |
| Clinic #2: (Insert Name) |  | Numerator:Denominator: Percentage: | Numerator:Denominator: Percentage: | Percentage: |
| Clinic #3: (Insert Name) |  | Numerator:Denominator: Percentage: | Numerator:Denominator: Percentage: | Percentage: |
| Clinic #4: (Insert Name) |  | Numerator:Denominator: Percentage: | Numerator:Denominator: Percentage: | Percentage: |

1. How confident are you in the accuracy of your colorectal cancer screening rates? Please describe any quality or data validation processes utilized by your health system.
2. What colorectal cancer screening and diagnostic related services does your organization offer directly to your patient population or offer through a referral relationship? Please indicate referral sites.
3. In addition to the funding provided to your health system to implement the evidence-based interventions, a limited amount of additional funds may be available to support reimbursement for follow-up colonoscopies for eligible patients screened at the participating clinics. To be eligible, patients must be asymptomatic, uninsured or underinsured, age 50-75, and screened for colorectal cancer at a participating clinic site. Funds may not support colonoscopies to evaluate or diagnose symptomatic patients. Reimbursement may not exceed the Medicare rate. Please complete the table below to estimate your follow-up colonoscopy need. \**If you aren’t able to provide your estimated annual colonoscopy need, we will assist with the determination based on the numbers provided in this chart.*

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|  | **Number of patients with a positive or abnormal screening test in 2019** | **% Uninsured** | **Estimated Annual Colonoscopy Need\***  | **Justification for how the Estimated Colonoscopy Need was Calculated** | **Colonoscopy Referral Site Name(s) and Location(s)** | **How will your clinic facilitate linkage to follow-up colonoscopy**  | **How will your clinic facilitate linkage to treatment services for patients diagnosed with cancer** |
| Clinic #1: (Insert Name) |  |  |  |  |  |  |  |
| Clinic #2: (Insert Name) |  |  |  |  |  |  |  |
| Clinic #3: (Insert Name) |  |  |  |  |  |  |  |
| Clinic #4: (Insert Name) |  |  |  |  |  |  |  |

1. If selected, are you able to report the following data at a clinic level for the participating clinic sites?

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| **Data Indicator** | **Yes** | **No***If no, please describe limitations* |
| The number of patients given a FIT or FOBT kit |  |  |
| The percentage of patients that returned a kit to the clinic |  |  |
| The number of patients with a positive or abnormal screening test |  |  |
| The percentage that completed a follow-up colonoscopy |  |  |
| Final results of colonoscopies paid for with South Dakota Colorectal Cancer Program funds (in aggregate, the number of colonoscopies provided) |  |  |
| Final results [cancer, adenomatous polyp, non-adenomatous polyp, other abnormal finding, or normal] of colonoscopies paid for with South Dakota Colorectal Cancer Program funds |  |  |
| The total number of patients diagnosed with colorectal cancer (for those who had their colonoscopy paid for with South Dakota Colorectal Cancer Program funds) |  |  |
| The percent of patients who were diagnosed with colorectal cancer starting treatment (for those who had their colonoscopy paid for with South Dakota Colorectal Cancer Program funds) |  |  |

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| **Budget Justification:**Please indicate how funding will be utilized to implement the project goals. Funding up to $25,000 may be requested for Year 1. |

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| **Category** | **Funding Requested** |
| **Supplies:** | $ |
| Itemized description:*List all supplies and support services below.*  |
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| Justification: |
| **Personnel:**  | $ |
| Itemized description: *Please list the following information for each staff member. Include salary and fringe benefits in the total amount.* *Name, Title, Grant Role, Number of Hours*  |
|
| Justification: |
| **Travel:** | $ |
| Itemized description: *List all travel.*  |
|
| Justification: |
| **Other expenses:** *Funding can be requested to support indirect costs at a rate not to exceed 6.1% of the total grant award.* | $ |