The Innovative Cardiovascular Health Program

CDC-RFA-DP23-0005

INFORMATIONAL CONFERENCE CALL
APRIL 12, 2023

Division for Heart Disease and Stroke Prevention
Program Development and Services Branch

AGENDA

- Introduction and Welcome
- General Overview of CDC-RFA-DP23-0005
- Application Content
- Application Requirements
- Website & Email
- Questions & Answers

GENERAL OVERVIEW OF DP23-0005

FUNDING

- $21 million for Year 1.
- CDC anticipates funding ~ 12 awards.
- Refer to the Funding Strategy in the NOFO for applicant funding criteria.
- Estimated award date: **08/30/2023.**
- Estimated start date: **09/30/2023.**

PURPOSE & FOCUS

- Identify and respond to health care disparities in cardiovascular disease.
- Improve outcomes for those with hypertension and high cholesterol.
- Address the disparities and inequities within priority populations with particular need for equity-focused health system interventions to prevent, control, and manage hypertension and high cholesterol.

GENERAL OVERVIEW OF DP23-0005

PRIORITY POPULATIONS

- Adults aged 18 and older, with a hypertension crude prevalence of 53% or higher, as shown by data specifically at the census tract level.

- Should include those affected disproportionately by hypertension and high cholesterol due to socioeconomic factors such as inadequate access or poor quality of care or low income.

GENERAL OVERVIEW OF DP23-0005

EMPHASIS

- Emphasis should be placed on achieving impact and reach across geographic locations where disparate populations can benefit from the strategies included in this NOFO.

- An applicant must offer a plan that prioritizes eliminating CVD health disparities and achieving health equity. The plan must describe the health equity challenges in these locations, detail proposals to address those challenges through various strategies, and show how progress will be measured.

- Applicants should also describe how they propose to engage communities in these locations, influence the environments, and empower individuals so that services are accessible and culturally appropriate.

- Organizations serving an approved population of focus, and representatives of the population, should be engaged in planning processes.

LEARNING COLLABORATIVES

THE CONCEPT

- The Learning Collaborative (LC) is defined as a group of public health leaders and partners with a common interest in a subject area that collaborates to achieve sustainable change and improvement.
- The Innovative Cardiovascular Health Program's LCs will have experience implementing evidence-based or evidence-informed practices for CVD prevention, detection, control, and management within approved priority populations.

THE OBJECTIVES

- LCs will facilitate communication and the exchange of ideas between health systems, community health organizations, and public health entities.
- They will leverage technical and financial resources to support programs to improve cardiovascular health outcomes for all persons but specifically focus on those with or at the highest risk of poorer health outcomes.

STRATEGIES/OUTCOMES

- 3 Overarching Strategies
- 8 Corresponding Strategies
- Outcomes

STRATEGY

STRATEGY 1

- Track and monitor clinical measures shown to improve health and wellness and, health care quality within approved populations of focus, with hypertension and high cholesterol.

CORRESPONDING STRATEGIES

- 1A. Advance the adoption and use of electronic health records (EHR) or health information technology (HIT).

- 1B. Promote the use of standardized processes or tools, such as GIS, to identify social services and support needs.

SHORT-TERM OUTCOMES: STRATEGY 1

THE GOALS:

- Increased use of EHRs or HIT to report, monitor, and track clinical data and social services and support needs within approved populations of focus.

- Increased use of standardized processes or tools, such as GIS, to identify, assess, track, and address social services and support needs within approved populations of focus.

STRATEGY

STRATEGY 2

- Implement team-based care to prevent, detect, control, and manage hypertension and high cholesterol within approved populations of focus.

CORRESPONDING STRATEGIES

- 2A. Advance the use of health information systems that support team-based care.
- 2B. Assemble or create multidisciplinary teams.
- 2C. Build and manage a coordinated network of multidisciplinary partnerships.

SHORT-TERM OUTCOMES: STRATEGY 2

THE GOALS:

- Increased use of health information systems to support communication and coordination among care team members to address HTN and high cholesterol within approved populations of focus.
- Increased use of multidisciplinary care teams adhering to evidence-based guidelines to support approved populations of focus.
- Increased multidisciplinary partnerships that address identified barriers to social services and support needs within approved populations of focus.

STRATEGY

STRATEGY 3

- Link community resources and clinical services that support comprehensive bidirectional referral and follow-up systems aimed at mitigating social services and support barriers for optimal health outcomes within approved populations of focus.

CORRESPONDING STRATEGIES

- 3A. Create and enhance community-clinical links to identify social determinants of health.
- 3B. Identify and deploy dedicated CHWs, or their equivalents, to provide a continuum of care and services.
- 3C. Promote the use of self-measured blood pressure monitoring (SMBP) with clinical support.

SHORT-TERM OUTCOMES: STRATEGY 3

THE GOALS:

- Increased community-clinical links to identify and respond to social services and support needs within approved populations of focus.
- Increased engagement of CHWs (or their equivalents) to provide a continuum of care for approved populations of focus.
- Increased use of SMBP with clinical support within approved populations of focus.

INTERMEDIATE OUTCOMES: ALL STRATEGIES

THE GOALS:

- Improved blood control among populations within partner health care and community settings.
- Reduced disparities in blood pressure control within partner health care and community settings.
- Increased utilization of social services and support within approved populations of focus.

LONG-TERM OUTCOMES: ALL STRATEGIES

THE GOALS:

- Improved cardiovascular health.
- Reduced disparities in cardiovascular health.

EVALUATION & PERFORMANCE MEASUREMENT

EVALUATION STRATEGY

- CDC-led comprehensive evaluation.
- Recipient-led evaluation.
- Performance measures.
- Applicants must provide a draft Evaluation and Performance Measurement Plan as part of their Project Narrative.

EVALUATION & PERFORMANCE MEASUREMENT PLAN

- Applicants must provide an Evaluation and Performance Measurement Plan that includes a Data Management Plan.
- The plan should describe how 15% of total funding is dedicated to evaluation activities, which is strongly encouraged in the NOFO.
- Within the first six months of the award, recipients are required to submit a detailed Evaluation and Performance Measurement plan.

PERFORMANCE MEASURES

- Recipients will be required to report all short-term and intermediate measures semi-annually to CDC. Long term measures are not required.

- Applicants are required to submit baselines, 6-month targets, and data sources for all performance measures as part of their workplans.

- Draft performance measure definitions will be provided after award and CDC will work with recipients to finalize measure definitions.

NOFO REQUIREMENTS & APPLICATION CONTENT

APPLICATION REQUIREMENTS & CONTENT

PROJECT NARRATIVE (20 page limit).

- Background.
- Approach.
- Evaluation and Performance Measurement Plan.
- Organizational Capacity.

WORK PLAN (not included in Projective Narrative page limit)

- Must address all corresponding strategies to achieve the NOFO's outcomes.
- Delineates specific applicant activity plans by corresponding strategy to achieve the period of performance outcomes.

DEVELOPING WORK PLAN ACTIVITIES

Well-written activities <u>are:</u>

- Directly related to the performance measures for the strategy/intervention (i.e., *engaging in these activities will contribute to "moving the needle" on the relevant performance measures*).

- Inclusive of major milestones, including the milestones or deliverables contractors and partner organizations will accomplish to support the strategy/intervention.
- Inclusive of key actions that will be completed to achieve progress toward performance measure targets.

- Written clearly so that an external audience is able to understand what will be accomplished.
- Specific and concise.

DEVELOPING WORK PLAN ACTIVITIES

THINK:

- **S** Specific.
- **M** Measurable.
- **A** Attainable.
- **R** Relevant.
- **T** Time-Bound.
- **I** Inclusive.
- **E** Equitable.

APPLICATION CONTENT

BUDGET NARRATIVE

- Applicants must submit an itemized budget narrative.
- Should include justification for proposed activities.
- Proposed budget in the project narrative must be reasonable and consistent with the purpose, outcomes, and program strategy.
- The budget narrative is *not* included in the 20 page Project Narrative limit.
- Guidance on the budget narrative is provided in the NOFO.

BEST PRACTICES: BUDGETING

IN ADDITION TO THE FISCAL PRINCIPLES SPECIFIC TO DP23-0004, GOOD BUDGETING PRACTICES ARE ESSENTIAL.

- Refer to CDC's Budget Preparation Guidelines available at: http://www.cdc.gov/grants/interestedinapplying/applicationresources.html

- Applicants should follow these guidelines to ensure that budgets are accurate and contain the necessary information required by CDC.

SUMMARY OF APPLICATION REQUIREMENTS

Registration:	All organizations must be registered with Grants.gov and SAM.gov before applying.
Letter of Intent Due Date:	April 24, 2023
Application Due Date:	No later than **May 23, 2023** **by 11:59 p.m., US Eastern Daylight Time.**
Submission:	Only PDFs submitted electronically will be accepted.

WEBSITE & EMAIL

- WEBSITE:

  https://www.cdc.gov/dhdsp/funding-opps/index.htm

The email address listed on the slide should be used when submitting questions related to the NOFO.

- EMAIL:

  InnovativeCVH@CDC.gov

We encourage you to review the full NOFO, as well as the FAQs already posted on the Web site.

THANK YOU!

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