Collaborative for Equity in Cardiac Care

Call for Proposals

MERCK Foundation

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1. Overview

The Merck Foundation (the "Foundation") is pleased to announce the launch of the *Collaborative for Equity in Cardiac Care* (the "*Collaborative*"), a five-year national initiative to improve access to high-quality, culturally responsive care for people with heart conditions living in underserved communities across the United States.

Through this Call for Proposals, the Foundation will select eligible organizations to implement innovative, comprehensive programs for cardiovascular disease management. Eligible organizations must be designated as a qualified 501(c)(3) nonprofit organization in the United States. Please refer to Section 7 for a complete list of eligibility criteria.

Interested applicants should submit a Letter of Intent (LOI), of no more than 5 pages, by January 10, 2025 for consideration. Please see Section 11 for LOI submission instructions.

Following a review of LOIs, the Foundation will invite a select number of organizations to submit a full proposal. The Foundation anticipates announcing grant awards in the second quarter of 2025. Please see Section 10 for the application timeline.

2. Intent of the *Collaborative for Equity in Cardiac Care*

Inequities in Cardiovascular Disease

Cardiovascular disease (CVD), which includes but is not limited to heart disease, heart attack, stroke and heart failure, affects approximately half of all American adults.[1,2] Rates of CVD are continuing to rise, due in part to the growing prevalence of risk factors such as hypertension, high cholesterol, obesity and smoking.[2]

There are also significant disparities in the burden of CVD. Individuals with CVD who are from racial and ethnic minority groups, have a low income or have limited access to health care experience disproportionately worse health outcomes. These disparities are fueled by inequities in social drivers of health, such as access to health care, housing, transportation, education, job opportunities, nutritious foods and opportunities for physical activity.[3,4]

Racism, discrimination, violence and bias also play a significant role in general health outcomes. Individuals from racial and ethnic minority groups (for example, African Americans, Latinos, Native Americans, Asian subgroups) are less likely to receive the standard of care[5,6] and those with CVD also face barriers to timely diagnosis, receive poor quality care and experience worse health outcomes.[7]

Challenges with navigating the health care system also make it difficult for people living with CVD to access care. Fragmented and disorganized care across multiple health care practitioners and settings is associated with poor cardiovascular health outcomes, poor patient satisfaction, gaps in care coordination and failure of treatment.[8,9] Because CVD often

presents with other comorbidities, such as diabetes, it is especially important to coordinate and tailor care to an individual's needs.[10]

Complex interactions between the health care system and external societal factors contribute to inequities in cardiac care and the fact that people from underserved communities often confront greater hurdles in accessing the high-quality care that they need. The National Academies of Science, Engineering, and Medicine's recent report, *Ending Unequal Treatment: Strategies to Achieve Equitable Health Care and Optimal Health for All,* states that the U.S. has made little progress in advancing health care equity over the last 20 years. The report calls for greater investment in strategies that address both the medical and social needs of individuals as well as new models of integrated care.[11]

A New Initiative to Advance Equity in Cardiac Care

The *Collaborative* will help advance equitable access to high-quality, culturally responsive care for people with heart conditions living in underserved U.S. communities. The Foundation is committing $17 million over five years (2025-2030) to support this national, multi-site initiative.

The *Collaborative* aims to:

1. **Transform the delivery of primary care** by promoting person-centered approaches to meet the medical and social needs of people living with heart conditions;
2. **Build sustainable community partnerships** to address barriers to equitable cardiac care;
3. **Improve health outcomes and quality of life** for people living with heart conditions; and
4. **Disseminate key findings and lessons learned** to improve cardiac care delivery.

Program grantees will convene regularly to share best practices, challenges and lessons learned and participate in a variety of leadership, evaluation and data collection activities.

3. Expected Core Elements of Program Development

In working toward achieving the *Collaborative*'s goals, program grantees are expected to include the following elements in their proposed program.

3.1 Improve Access to High-Quality Cardiac Care for Underserved Populations

Program grantees are expected to implement interventions to address the needs of individuals living with **coronary artery disease, stroke, heart failure and hypertension**. These individuals may also be living with other comorbidities (e.g., diabetes).

The initiative will focus on underserved communities – those with a disproportionate burden of disease and barriers to accessing high-quality health care. Individuals from underserved communities may include those from racial and ethnic minority groups, those who have a low-income or those who have limited access to health care based on geography, insurance coverage, physician supply, limited health literacy or other factors.

Applicants should identify the population(s) in their local communities they will serve and provide a rationale.

3.2 Transform the Delivery of Primary Care

Program grantees are expected to implement two strategies to transform the delivery of primary care: person-centered and multidisciplinary, coordinated, team-based care.

Person-centered care ensures that health care services are integrated and delivered in a setting and manner that is responsive and tailored to an individual's goals, values and preferences and supports good communication between individuals and providers to make effective care plans together.[12] Person-centered care also involves tailoring care to an individual's risk level and comprehensive medical and social needs.[12,13]

Multidisciplinary, coordinated, team-based care ensures providers beyond primary and specialist teams – such as nurses, pharmacists, community health workers and social workers – are included in an individual's care and integrated across the health system.[14,15]

Applicants should describe their proposed approach to implementing person-centered and multidisciplinary, coordinated, team-based care as steps to foster the transformation of primary care. Section 4 provides additional guidance on related interventions.

3.3 Implement Multi-Level Health Care Interventions

Inequities in health care can have multiple, interrelated causes. Multi-level interventions address inequities by targeting at least three levels of influence within the health care system.[16] Levels include the individual, the individual's family and support system, health care provider(s) or team(s), the health care organization or system and health care policy. Multi-level interventions, while complex, may be most effective at addressing health care inequities because they address multiple drivers of health.[16]

Applicants should propose interventions that address three or more levels in the health care sector and at least one of these levels must involve organizations or systems that deliver health services. Additional guidance on multi-level health care interventions can be found in Section 4.

3.4 Collaborate with Organizations Outside the Health Care Sector to Address Social Care Needs

Cross-sectoral collaborations will enable program grantees to address barriers to care related to the social drivers of health, extend reach to underserved populations and increase capacity to enhance the array of services offered to people living with heart conditions.

Program grantees are expected to collaborate with organizations in various sectors outside of health care – such as food, housing, recreation/parks districts, education, public health and social services – to develop and implement effective and sustainable interventions that meet the needs of underserved populations.

Applicants should demonstrate how they will develop and maintain collaborations with other sectors, including how they will define roles and responsibilities and how the collaboration will address relevant social drivers of health for the selected population(s). Additional guidance on cross-sectoral collaborations can be found in Section 4.3.

Note: Collaborating organizations must meet the eligibility criteria described in Section 7.

3.5 Engage the Community in Program Development and Implementation

Programs will begin with a 6-month planning period during which program grantees are expected to engage members of their community and collaborating organizations in program development. Involving the community from the outset and throughout program implementation helps ensure that the program is tailored to local needs, addresses the social drivers of health that present barriers to care and is respectful and responsive to the health beliefs, practices and cultural and linguistic needs of the focus population(s).

Program grantees should implement activities that create authentic and equitable opportunities for community participation. Appendix A provides resources for approaches to encourage community input in program development.

Applicants should describe the process for engaging community members and/or organizations – for example, via community advisory councils and/or focus groups – to obtain input for the program.

Applicants should demonstrate how they will develop and maintain partnerships and ensure meaningful and ongoing participation and engagement with community members and/or organizations. Organizations must meet the eligibility criteria described in Section 7.

3.6 Expand and Strengthen Existing Efforts

The *Collaborative* aims to build on applicants' prior successes in implementing cardiovascular health interventions among underserved communities, although the Foundation may also support the development and implementation of new interventions. Applicants should present evaluation findings or other documentation of program successes (see Section 3.7).

Applicants should describe how they will use grant funding to build on previous efforts. For example, applicants may propose to expand successful approaches by (a) extending them to additional populations or settings, (b) adding intervention components, (c) enhancing collaborations with current partners, (d) collaborating with new partners or (e) combining components of their approaches in various ways.

Applicants should describe their current work relevant to this initiative, including (a) work to improve health care delivery and health outcomes in cardiovascular health for underserved communities and (b) cross-sectoral collaborations to address social drivers of health.

3.7 Use Evidence-Informed Approaches to Meet Local Needs

Program grantees are expected to implement interventions based on scientific evidence or, in cases of newer approaches that have not yet been fully evaluated, based on promising practices from the field that are relevant to their local communities. In developing their intervention(s), program grantees should strive to balance local innovation and knowledge with existing evidence to meet the needs of the focus population(s).

Applicants should present evidence supporting proposed intervention approaches, such as published findings, recognized best practices, recommendations and guidelines, or preliminary evaluation findings that support the effectiveness of the proposed interventions. In developing their interventions, applicants should aim to balance innovation with existing evidence.

3.8 Demonstrate Feasibility

Program grantees are expected to implement interventions that are feasible within the parameters of the grant (e.g., time frame, funding available) and the existing infrastructure of the applicant organization and its partners (e.g., staff capacity, resources).

Applicants should demonstrate the feasibility of the proposed program, including how staff and other resources will be allocated to implement the program effectively and in a timely manner. Applicants should acknowledge potential challenges to implementing the proposed program and offer potential solutions to how those challenges will be addressed.

3.9 Engage Public and/or Private Payers

While efforts to expand insurance coverage have improved access to primary care for some, many individuals continue to face challenges accessing care. There are few alternative payment models that address long-term management of cardiovascular disease.[17] Some recent progress includes experimentation with innovative payment models that recognize quality care that addresses both the medical and social needs of individuals – as opposed to volume of care. New statewide health policy reforms are demonstrating positive effects on health care spending and service use, such as unplanned readmissions to hospitals and rehabilitation centers, preventable admissions and timely follow-up by health care providers.[18]

Program grantees are expected to involve public and/or private payers (such as health plans or State Medicaid programs) as key stakeholders in their program because they play an important role in helping ensure sustainable improvements in health care delivery and outcomes. Payers' involvement may take a variety of forms, including material or in-kind support, financial reimbursement for services to support cardiovascular health management (e.g., support per member/per monthly payments or coverage for non-medical services), implementation of models that lower risk for and enable successful participation of primary care providers and safety net providers or funding to support infrastructure development or implementation. [18,19]

Applicants should describe plans to engage third party payers in innovative models to address relevant payment reform challenges in their communities. Strong applicants will provide detailed information about their partnerships with third party payers.

3.10 Plan for Sustainability and Scale

Program grantees will implement interventions that have the potential to be sustained and scaled beyond the grant funding period. Sustainability may be achieved through activities such as:

- Engaging with local, regional or national policy makers*
- Engaging payers to develop innovative cost-sharing or payment reform models
- Experimenting with revenue-generating models so that programs can self-sustain
- Securing opportunities to unlock additional funding from other funders to scale programs

**Although Foundation funds cannot be used to support legislative advocacy, we recognize the importance of engaging with policy stakeholders to identify avenues for program sustainability and communicate strategic goals of the Collaborative.*

With respect to scale, program grantees may consider collaborating with each other or with organizations outside their communities to share lessons learned and promote program adaptation and/or replication in new geographies with similar population demographics and barriers to care.

Applicants should present a realistic plan for sustainability and/or scalability of the program considering the local context and capacity. Plans should demonstrate how organizational infrastructure, staffing and resources can support the intervention after the grant funding ends.

4. Interventions

Program grantees will be required to implement interventions in three areas critical to improving the health of people living with heart conditions:

- Primary care transformation
- Multi-level health care interventions addressing at least three levels of the health care sector – individual, providers or health care team, health care organization or system or health policy[16]
- Cross-sectoral collaborations that address the social drivers of health

4.1 Primary Care Transformation

Core elements of primary care transformation that must be implemented include:

- **Person-centered care** strategies can occur at multiple levels of the health care system, should be tailored to an individual's medical needs and may involve different health care approaches based on a patient's risk level (risk stratification).[20] Person-centered care may include, but is not limited to:
    - Supporting a workforce committed to providing person-centered care;
    - Creating structures to measure and monitor person-centered care, such as through patient-reported outcomes; or
    - Supporting health care providers to cultivate effective communication with patients, including practicing respectful and compassionate care, engaging patients in managing their care and providing integrated care.

  Person-centered care also includes providing culturally responsive care, defined as care that respects diversity in the patient population and respects cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes and behaviors.[13]

- **Coordinated, team-based care** operates through a multidisciplinary team of health care providers. Team-based care models have shown to be effective at improving cardiovascular health, especially when pharmacists and nurses are included in the team.[15] Successful team-based models to improve cardiovascular health also include involving Indigenous community health workers, dieticians and social workers.[15,21]

4.2 Multi-Level Health Care Interventions

Within the health care sector, the levels for interventions are as follows:

- **Individuals:** Support people living with heart conditions by providing comprehensive care tailored to meet their needs
    - *Examples: Health coaching and self-management education; family engagement in care; and psychosocial support*
- **Health care providers or teams:** Equip health care providers and teams to deliver culturally responsive and respectful care
    - *Examples: Training on communications skills, shared decision-making, addressing implicit bias and/or cultural sensitivity*
- **Health care organization or system:** Reorganize health care teams within facilities and coordinate with community partners to provide more holistic care
    - *Examples: Engaging community health workers, faith-based leaders or Indigenous and Native leaders in care; deploying performance feedback/scorecards; convening community advisory councils; implementing closed-loop referral systems*
- **Health policy:** Efforts to increase access to affordable medical and social care that involves providers, clinics, administrators and third-party payers, among others
    - *Examples: Cost-sharing models to reimburse medical and/or social care services (e.g., community health worker services)*

4.3 Cross-sectoral collaborations

The initiative requires collaboration with organizations outside the health care sector to address the health-related social needs of underserved populations. Program grantees should establish or strengthen partnerships with groups that are addressing the social drivers of health that are most relevant to their focus population(s). Collaborators may include nonprofit organizations, community groups, faith-based organizations, health departments, social service agencies and other organizations that offer services relevant to the proposed interventions or can facilitate outreach to and communication with the communities that program grantees will serve.

Cross-sectoral collaborations should address underlying issues that lead to health inequities. Examples of interventions that aim to address social drivers of health related to cardiovascular health care include:

- Interventions that increase access to heart-healthy foods through partnerships with local grocery stores, farmers' markets or food pantries;
- Partnerships that support access to temporary housing to improve access to health services;
- Collaborations with urban planners or community stakeholders to support the creation of walkable communities or safe spaces for physical activity; or
- Partnerships with community-based organization to support enrollment in social or health benefits programs.

Applicants should propose interventions at three (or more) levels of the health care sector; one level must be the organization or system level. Interventions that engage multiple collaborators are encouraged.

Applicants should tailor their proposed interventions to the specific context of the focus population and avoid a one-size-fits-all approach.

5. Monitoring & Evaluation

5.1 Cross-Site Program Evaluation

To assess the impact of the *Collaborative*, the Foundation will support a cross-site evaluation involving all funded programs. The evaluation will provide evidence of the initiative's impact and support grantees' efforts to achieve sustainability and scale. The evaluation will assess improvements in cardiac care delivery and cardiac-related health outcomes.

The *Collaborative's* evaluation team will lead the cross-site evaluation and engage program grantees in a 6-month planning period to develop the evaluation plan, core outcomes for each program to measure and standard data collection methods and instruments. Program grantees are expected to actively participate in evaluation design, including harmonization of cross-site metrics, and site-specific data collection efforts. Program grantees will be responsible for collecting and reporting on data using the selected data collection instruments.

The evaluation will include both a process evaluation to examine how the interventions were implemented and an outcome evaluation to measure results.

The process evaluation will examine the following:

- How interventions were implemented
- Facilitators and barriers to implementation

- Fidelity of program implementation and reasons for changes (if any)
- Systems-level changes that occurred as a result of the initiative
- Partnerships developed or enhanced as part of the initiative, including with public and/or private payers
- Implementation of the sustainability plan, including barriers and facilitators to sustainability

The outcome evaluation will examine the impact of the initiative based on the following types of outcomes, which are illustrative and will be finalized with program grantees:

- **Clinical outcomes:** changes in blood pressure, cholesterol, triglycerides, body mass index (BMI) or physical activity
- **Patient-reported outcomes:** experience with care, such as satisfaction with care, provider trust and improved communication, patient-reported health and quality of life
- **Patient knowledge, attitudes, and behaviors:** patient knowledge about heart conditions, self-efficacy and self-management skills and behaviors, shared decision-making between individuals and providers, participation in the development of care plans and adherence to care plans (such as medication and lifestyle change adherence)
- **Health care utilization:** improved resource utilization, such as fewer emergency department admissions related to cardiovascular events; reduced hospital re-admission related to cardiovascular events; improved coordination and integration of primary, specialty and other care; and improved collaboration and/or referrals to social care teams
- **Cost outcomes:** assessment of the basic costs of program implementation and operations, costs savings for health care organizations/systems and individuals as a result of the program

The examples above are illustrative. Applicants should describe evaluation measures that are most relevant and applicable to their local communities. Appendix A. includes a list of resources that applicants may – but are not required to - reference in the development of their proposals.

5.2 Program Grantee-Level Data Collection and Monitoring Requirements

Program grantees are expected to develop and implement data collection plans to monitor and assess implementation of their interventions. Monitoring plans should aim to identify program implementation challenges and necessary course corrections and measure program impact.

Program grantees are also expected to provide routine reports to the Foundation on progress, challenges and successes with program implementation.

In addition to the cross-site, harmonized measures, program grantees should identify additional data needed to monitor and assess implementation of the proposed program. These may include shorter-term health outcomes, including patient-reported health outcomes and experiences with care, health care utilization and clinical health outcomes.

Applicants invited to submit a full proposal will be required to include a programmatic logic model as part of their proposal. The logic model should outline planned inputs, activities, short-term outcomes and long-term outcomes aligned with the goals of the Collaborative. Further instructions on the logic model are presented in Section 11.2.1.

6. Dissemination of Findings

To help advance the field, program grantees will share the findings and lessons learned from their programs throughout the five-year initiative and at the end of the funding period. Potential approaches for disseminating findings include conference abstracts, peer-reviewed articles, op-eds or other articles and presentations to key stakeholders.

Applicants should provide an overview of how program results will be shared widely to promote best practices in transforming primary care to improve access to timely, high-quality, culturally responsive care for people with heart conditions living in underserved communities.

7. Eligible Organizations

An eligible organization is one that the United States Internal Revenue Service has designated as a qualified 501 (c) (3) nonprofit organization in the United States. Given that the *Collaborative* aims to meet both the medical and social needs of individual living with heart conditions in underserved communities, applicants must demonstrate active involvement in community-focused cardiovascular health and /or meaningful collaboration with local community-based organizations.

Eligible organizations may include the following:

- Health care organizations, including, but not limited to, Federally Qualified Health Centers, community health centers or clinics, integrated health systems, hospitals and other health care organizations (Note: For academic medical centers, applicants must have affiliated community-based health center(s) and clearly demonstrate active involvement of community-based health centers in the development of the application and proposed program)
- Academic institutions
- Community-based or nongovernmental organizations
- Units of state or local government

Organizations that are <u>not</u> eligible for support through this initiative include the following:

- For-profit entities or organizations
- Political organizations
- Fraternal, labor, or veterans' organizations and activities
- Religious organizations or groups whose activities are primarily sectarian in purpose
- Organizations that discriminate on the basis of race, color, gender, sexual orientation, gender identity, marital status, religion, age, national origin, veteran's status or disability

Program grantees are encouraged to partner with other organizations in their geographic area to develop and implement locally relevant and community-informed programs and may identify additional partners as sub-contractors. Sub-contractors must meet the eligibility criteria outlined above.

8. Funding Available

The Foundation may provide an organization with a maximum grant not to exceed **$1,750,000** over a 5-year period. Annual budgets for the proposed programs cannot exceed **$350,000** in any single year. Grant funds cannot be used to displace existing funding for ongoing programs.

The indirect rate for general administrative costs cannot exceed 15% of the total annual grant amount of up to **$350,000**. Any equipment should be specifically outlined in the budget – it is not considered a general administrative cost.

Note: Grants are intended to support cardiac care programs, not clinical research or other research studies.

9. Allowable and Unallowable Use of Funds

Grant funds may be used for the following purposes:

- Project staff salaries and fringe benefits (Note: Grant funding is not expected to provide full staff support)
- Project consultants, such as a data collection or communications support
- Other essential direct costs, including educational and training materials, limited equipment, general office materials and supplies, printing and copying, telephone and computer costs, postage and delivery and data processing
- Travel to program activities, including an annual program grantee meeting
- Subcontracts (same allowable and unallowable use of funds apply)

Grant funds may <u>not</u> be used for the following purposes:

- Direct clinical care, social services or other reimbursable services, such as medical care, food or housing
- Medical screening or testing, except as part of the program evaluation
- Purchase of or discounts on medications, vaccines, medical devices or biologics
- Basic or clinical research projects, including epidemiological studies, clinical trials, outcomes research or other pharmaceutical studies
- Unrestricted general operating support
- Financial support for political candidates, lobbying or legislative advocacy
- Fellowship/tuition support intended for a specific individual or institution
- Endowments, including for academic chairs
- Media products that are not an integral part of the program
- Meetings, conferences or symposia that are not integral parts of the program
- Fundraising events
- Capital or building campaigns, including new construction or renovation of facilities or health information technology installation or improvement
- Grants to one organization to be passed to another, except under specified approved subcontracting arrangements
- Programs that directly support marketing and/or sales objectives of Merck & Co., Inc., Rahway, NJ, USA

Note: *Program grantees can use funds to catalyze change at local, state or regional levels, with the aim of producing results that improve population health. However, program grantees cannot use funds to advocate for legislation at any level; to pay for direct or other reimbursable services, such as medical care, food or housing; or to supplant existing funding sources for programming.*

10. Timelines

10.1 Application Timeline

Deadline	Application Activity
Jan 10, 2025	Deadline for eligible organizations submit a LOI
March 7, 2025	Applicants are notified whether they are invited to submit a full proposal
April 17, 2025	Deadline for invited applicants to submit full proposals
Q2 2025	Anticipate that awards will be announced

10.2 Project Timeline

Proposals will include a project timeline that outlines a 6-month planning period and program implementation activities across the 5-year grant period. The timeline should also note potential points when the program grantee plans to disseminate program updates or impact and any activities key to executing the programs' sustainability plan and/or promoting scalability of the program.

11. How To Apply

Instructions for submitting a proposal through the two-step application process are outlined below. All questions regarding the application process can be directed to cardiaccareequity@rabinmartin.com.

11.1 Letter of Intent

The first step in the application process is to submit a letter of intent (LOI) by **January 10, 2025** to cardiaccareequity@rabinmartin.com. The LOI should be no longer than five pages (1.5 line-spaced, minimum 10-point font size, excluding the cover page) and include:

Cover Page

- Program director information (name, title, affiliation, mailing/shipping address, telephone number and e-mail address)
- Contact person's information (if different from project director)
- Communications contact person's information

Section I: Program focus (approximately 0.5 page)

- Program goals and objectives
- Description of inequities in cardiovascular health in the local community to be addressed through this program, including:
    - Description of focus population(s) to be served, including age range, race or ethnicity, gender, gender identity and socioeconomic status
    - Geographic area for proposed program as well as populations statistics for selected geographic areas including total population

Section II: Proposed program (approximately 3.5 pages)

- Overview of program interventions focused on transforming primary care through person-centered and coordinated, team-based care. Interventions should include multi-level health care interventions addressing at least three levels of the health care sector and cross-sectoral collaborations. Applicant should describe how the program will address barriers to equitable cardiac care related to the social drivers of health.
- Discussion of how the proposed interventions build on current programs and successes in the field and/or in the community

- Overview of proposed plan to monitor successful program implementation
- Potential impact on improving access to timely, high-quality, culturally responsive care for people with heart conditions living in underserved communities
- **Note: LOIs should not reference any medicines manufactured by Merck or any other company.**

Section III: Capabilities and Experience (approximately 1 pages)

- Capabilities and experience of the applicant organization, the program director, co-directors and other key staff (e.g., data manager, communications staff) as they relate to the program goals and interventions
- Qualifications of key staff in partner organizations and any sub-contractors or consultants
- Experience of program partners related to advancing health equity in their communities
- Evidence of authentic community engagement through prior or current collaborations with community stakeholders, partners and organizations beyond letters of support; evidence may include joint grant proposals, co-authored publications and documented program collaborations with previous or current partners.

The Foundation will review the LOIs and invite select applicants to submit a full proposal. All applicants will be notified whether they have been selected by **March 7, 2025**.

11.2 Invited Full Proposals

Invited applicants will submit a full proposal by **April 17, 2025**.The full proposal should include three sections as separate documents:

- **Section I:** Proposal narrative including Cover Page, Table of Contents, Program Plans, Data Collection Plans, Organizational Capabilities and Experience and Key Personnel and Staffing Plan (see Exhibit B.)
- **Section II:** Appendices
- **Section III:** Detailed budget and narrative budget justification

Invitations for full proposals will include instructions and the URL for uploading proposal documents to the Foundation's online grants management system.

11.2.1 Section I

The specifications for this section should include a header on each page that details the name of the program director and consecutive page numbers covering all of Section I. Section I should not exceed 20 pages. Please use 1-inch margins, type font no smaller than Arial 11 point and set for one-sided printing. **Note: Proposals should not reference any medicines manufactured by Merck or any other company.**

Exhibit A.: Overview of Section I – Proposal narrative sections and content

1. Cover page	• Project title • Project director information (name, title, affiliations and contact information) • Contact person, if different than the project director • Person responsible for grant and budget administration, if different than the project director • Proposed grant period • Total amount of funding requested (not to exceed $1,750,000 million over 5 years) • 1-2 sentence overview of the program that may be used in internal or external communications should the organization be selected for a grant
2. Table of Contents	• Limit to one page
3. Program Plan	

3.1 Program goals and objectives	• Statement of overall goals and objectives of the proposed program
	• Discussion of how the program will transform the delivery of primary care by promoting person-centered approaches to meet the medical and social needs of people living with heart conditions through:
	  ○ Tailored and culturally responsive care
	  ○ Multi-disciplinary, coordinated, team-based care
	  ○ Cross-sector collaboration with community-based organizations
	• Anticipated impact of the program

3.2 Program context	• Health inequities in cardiovascular health care and outcomes in the local community to be addressed through the program • Barriers related to the social drivers of health that will be addressed through the program • Geographic area for the program and population level statistics for the area, specifically: total population of geographic area and population(s) to be served by the program (including race and ethnicity, age range, gender, gender identity, socioeconomic status and rationale for focusing on a specific group(s) and or geographic area(s) (e.g. inequities in morbidity, mortality, access to high-quality care) • Description of the organization's access to and experience with the identified population(s)
3.3 Intervention approaches	• Description of the proposed multi-level interventions (individual, providers/ health care teams, health systems/organizations and health policy)

	• Description of cross-sectoral collaborations and how they will address medical and social needs to transform primary health care through person-centered and coordinated, team-based cardiac care • Description of options for partnering with private and/or public payers in identifying opportunities to implement innovative payment models • Evidence to support proposed intervention strategies • Description of how the proposed intervention strategies will build on, strengthen, and expand existing programs, and prior successes • Description of how the proposed interventions will help to achieve the initiative's goals and the local program goals and objectives • Description of anticipated challenges and proposed mitigation strategies
3.4 Collaboration with community partners and stakeholders	• Description of community and cross-sector collaborator(s), including type of organization, mission, populations served and relevant capabilities • Description of how the collaborations will enable the program to address barriers related to the social drivers of health • Discussion of how people living with heart conditions and community members will be meaningfully engaged during the program planning period and implementation (e.g., through a community advisory board) and how community involvement will be developed and maintained • Roles and responsibilities of collaborating organizations
3.5 Feasibility of program	• Description of how staff and resources, including collaborating organizations, will be allocated within the budget and timeframe of the initiative • Description of potential challenges with program implementation and solutions to address them
3.6 Sustainability plan and potential scalability	• Description of options to sustain and scale the program or specific elements beyond the grant period, including how staffing and other program costs will be supported • Identification of potential challenges to program sustainability and scalability and strategies for addressing them
3.7 Project timeline	• Project planning and implementation timeline with specific milestones, including 6-month planning period
4. Data collection	
4.1 Program logic model and impact metrics (1 page)	• Logic model outlining the key components of the proposed program and relationship between the outcomes expected in the short-, intermediate- and long-term and the proposed inputs and activities, including illustrative programmatic metrics to assess impact. More details can be found in Appendix B.

4.2 Data collection	• Proposed data collection strategy and methods, including how data will be collected from collaborating organization(s) • Description of local program monitoring plan
5. Dissemination of findings	• Identification of potential approaches to share findings and program results
6. Organizational capabilities and experience	• Existing programs, activities, staffing and resources in the areas of the proposed project • Key accomplishments, evaluation findings, and lessons learned from previously and currently funded relevant projects, and, if appropriate, how ongoing projects will be integrated with the currently proposed project • Overview of any past or current collaborations focused on community health and improving health equity, outcomes of partnerships and any relationship to the proposed project • Capabilities related to evaluation, routine program monitoring and data collection activities • Description of experience and past success with sustainability and scalability planning • Description of prior experience participating in a multi-site initiative and convening with peers as part of a cohort to share best practices, challenges and lessons learned • Pending funding (including potential funding sources and amounts) for projects similar to the proposed project • Detailed information for any subcontractor(s) and source(s) of funding for partner organization activities including documentation of proposed collaborating organizations' commitment and evidence of any prior collaboration (not required) beyond letters of support – may include list of grant proposals, coauthored publications, and documented program collaborations.
7. Key personnel and staffing plan	• Titles, affiliations, experience and qualifications of program director, co-directors, program manager and other key staff • Roles and responsibilities for program director, co-directors and other key staff • Percentage of time on program anticipated for program director, co-directors and other key staff • Role of subcontractor(s) staff, if any

11.2.2 Section II

Proposals may include a limited number of appendices:

- Resumes for the program director and other key staff (limited to two pages each)
- Publications (up to three publications directly relevant to the proposed program)
- Samples of training, educational, assessment or other materials that would be used as part of the interventions or local evaluation (up to 5 pages total)

11.2.3 Section III

The budget should include sufficient detail on labor and other costs for reviewers to assess how program activities will be supported and the adequacy of proposed staffing. The budget should be submitted in Excel format with (1) a summary worksheet for all 5 years, and (2) separate summary worksheets for each year of funding requested. Summary worksheets should present the following information:

- **Salary and fringe benefits:** List personnel individually by title. Include annual salary, percentage of time on the project and fringe benefits in accordance with applicant's personnel policies.
- **Travel and transportation:** State the number of trips and specify the origin and destination for proposed trips, mode and duration of travel and number of individuals traveling. Travel expenses should be based on the applicant's standard travel policies.
- **Equipment:** Include a breakdown of equipment by type, including unit cost and quantity.
- **Training or workshops:** Breakdown by type of training or workshop, including proposed number of participants and days.
- **Subcontracts:** List any goods and services procured through a contract mechanism, including subgrants and consultants. Show each contract separately and provide a breakdown of costs included, such as daily rate and number of days for consultants.
- **Other direct costs:** Include costs associated with communications, printing, report preparation, telephone and computer and data processing.
- **Indirect costs:** Indirect rates must not exceed 15%.
- **In-kind contributions:** Includes in-kind support from applicant and/or collaborating organizations for the project.

A detailed narrative budget justification should be prepared in Microsoft Word to address the following:

- Amount and duration of requested funding
- Explanation and justification for all budget line items

12. Full Proposal Review and Evaluation Criteria

The Foundation will review invited proposals, with input from a panel of external experts in cardiovascular health and health equity, using the review criteria outlined below. The Foundation cannot return proposals or provide individual technical critiques. Proposal review criteria and technical evaluation weights include the following:

Exhibit B. Technical evaluation weights for invited full proposals

Review Criteria	Points
Potential impact of the program, significance of program goals as they relate to transforming primary health care through person-centered and coordinated, team-based care for cardiac health. Impact will also be assessed based on the proposed program logic model and potential scale and reach of the interventions.	20
Evidence-informed innovation and strength of intervention approaches that build on scientific evidence and offer innovative, multi-level, integrated and locally adapted approaches.	20
Cross-sectoral collaborations, including the diversity of organizations and how collaborations will expand the reach and effectiveness of the program and address barriers related to the social drivers of health.	15
Qualifications and experience of the organization, program director and other key staff	20
Sustainability plan for proposed interventions and cross-sectoral community collaborations, as well as plans for potential program scale up if it is determined that interventions are effective.	15
Data collection plans and capabilities, including demonstrated capabilities to contribute to the cross-site evaluation.	10
Total	**100**

Appendix A | Additional Resources for Applicants

Primary Care Transformation

Person-Centered Care

- Person-centered care, *Centers for Medicare & Medicaid Services* (https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care)

- How to practice person-centred care: A conceptual framework, *Health Expectations* (https://onlinelibrary.wiley.com/doi/full/10.1111/hex.12640)

- When the patient is the expert: measuring patient experience and satisfaction with care, *World Health Organization* (https://iris.who.int/handle/10665/326274)

Coordinated, Team-Based Care

- Heart Disease and Stroke Prevention: Team-based Care to Improve Blood Pressure Control, *Centers for Disease Control and Prevention* (https://www.thecommunityguide.org/findings/heart-disease-stroke-prevention-team-based-care-improve-blood-pressure-control.html)

- Building and Optimizing the Interdisciplinary Heart Team, *Journal of the Society for Cardiovascular Angiography & Interventions* (https://www.jscai.org/action/showPdf?pii=S2772-9303%2823%2900558-6)

- Hearts: Technical Package for Cardiovascular Disease Management in Primary Health Care – Team-Based Care, *World Health Organization* (https://iris.who.int/bitstream/handle/10665/260424/WHO-NMH-NVI-18.4-eng.pdf?sequence=1)

Multi-Level Health Care Interventions

Individual

- Engaging Families in Adult Cardiovascular Care: A Scientific Statement from the *American Heart Association* (https://www.ahajournals.org/doi/10.1161/JAHA.122.025859)

- The Effectiveness of Health Coaching, *Department of Veterans Affairs* (https://www.hsrd.research.va.gov/publications/esp/health-coaching.pdf)

Provider

- Culturally Sensitivity: The Importance of Cultural Sensitivity in Providing Effective Care for Diverse Populations (Position Paper), *American Academy of Family Physicians (AAFP)*

(https://www.aafp.org/about/policies/all/cultural-proficiency-position-paper.html)

Health care teams

- A Public Health Framework to Improve Population Health Through Health Care and Community Clinical Linkages: The ASTHO/CDC Heart Disease and Stroke Prevention Learning Collaborative, *Center for Disease Control and Prevention* (https://www.cdc.gov/pcd/issues/2019/19_0065.htm)

- Community-Clinical Linkages for the Prevention and Control of Chronic Diseases: A Practitioner's Guide, Division for Heart Disease and Stroke Prevention (DHDSP) of the *Centers for Disease Control and Prevention* (https://www.cdc.gov/high-blood-pressure/docs/CCL-Practitioners-Guide.pdf)

Health care organizations/systems

- Building a Health Equity Focus into Value-Based Payment Design: Approaches for Medicaid Payers, *Center for Healthcare Strategies* (https://www.chcs.org/resource/building-a-health-equity-focus-into-value-based-payment-design-approaches-for-medicaid-payers)

- Advancing Health Equity Through Value-Based Care: CMS Innovation Center Update, *Health Affairs* (https://www.healthaffairs.org/content/forefront/advancing-health-equity-through-value-based-care-cms-innovation-center-update)

- Developing Primary Care Population-Based Payment Models in Medicaid: A Primer For States, *Center for Healthcare Strategies* (https://www.chcs.org/resource/developing-primary-care-population-based-payment-models-in-medicaid-a-primer-for-states/?utm_source=CHCS+Email+Updates&utm_campaign=fdcb481ff8-CHCS-Monthly-News_May_05%2F30%2F24&utm_medium=email&utm_term=0_-fdcb481ff8-%5BLIST_EMAIL_ID%5D)

- Maryland Total Cost of Care Model: Evaluation of the First Four Years (2019 – 2022), *Center for Medicare & Medicaid Innovation* (https://www.cms.gov/priorities/innovation/data-and-reports/2024/md-tcoc-1st-progress-rpt-aag)

Cross-Sectoral Collaborations and Interventions

- Life's Essential 8: Updating and Enhancing the American Heart Association Construct of Cardiovascular Health: A Presidential Advisory from the American Heart Association, *American Heart Association* (https://www.ahajournals.org/doi/10.1161/CIR.0000000000001078)

Community Engagement in Program Development, Implementation, and Evaluation

- Community-Based Participatory Research to Improve Cardiovascular Health Among US Racial and Ethnic Minority Groups, *Current Epidemiology Reports* (https://link.springer.com/article/10.1007/s40471-022-00298-5)

- Rethinking, Reimagining, and Reigniting Community-Engaged Research to Promote Cardiovascular Health Equity, Cardiovascular Quality and Outcomes, *American Heart Association* (https://www.ahajournals.org/doi/full/10.1161/CIRCOUTCOMES.122.009519)

- A Blueprint for Promoting Equitable Health and Health Care through Community-Led Initiatives, *Urban Institute* (https://www.urban.org/research/publication/blueprint-promoting-equitable-health-and-health-care-through-community-led)

Appendix B | Program Logic Model Template

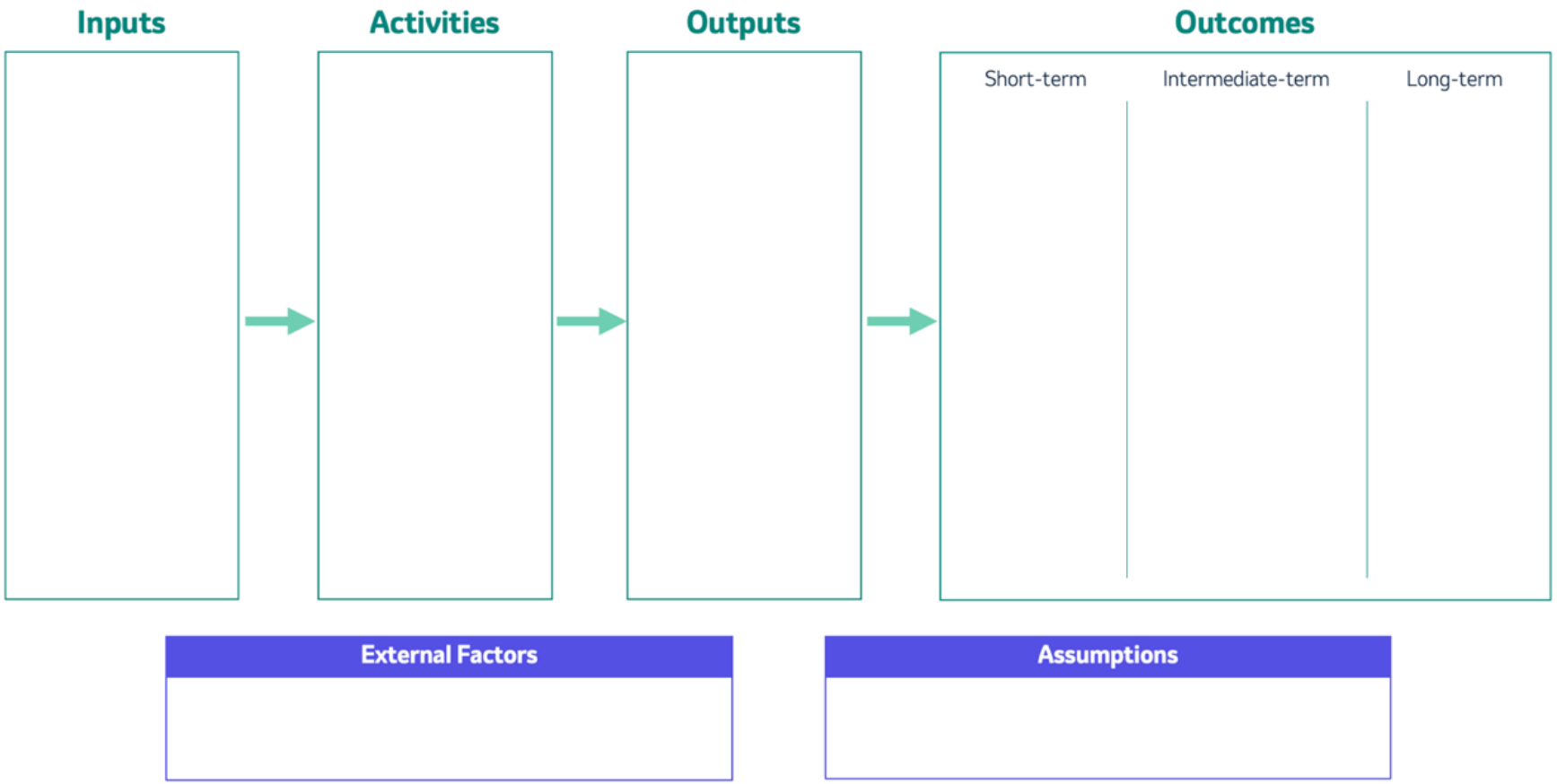
Applicants invited to submit a full proposal are required to submit a logic model outlining the key components of the proposed program and relationship between the outcomes expected in the short-, intermediate-, and long-term and the proposed inputs and activities.

A logic model template is provided on the next page. Applicants should develop their own logic models in Microsoft Word and include it in the appendices of the full proposal submission.

Applicants are welcome to approach the logic model as they see fit, but we recommend including the below elements:

- **Inputs:** The resources (e.g., financial, human, and technological) required to conduct the activities proposed
- **Activities:** The specific changes or action that will occur to produce the outputs and outcomes proposed
- **Outputs:** The quantifiable deliverables that are a result of the proposed activities taken place
- **Outcomes:** The impact you expect the inputs, activities, and outputs will have for the focus population and wider community
- **External Factors:** The elements outside of one's control that can affect the success of the program or intervention (e.g., economic environment, climate, and conflict).
- **Assumptions:** The aspects, situations, or components that may help or hinder the success of the intervention or program

Program Logic Model Template:



Appendix C | References

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