MERCK FOUNDATION

Merck Alliance for Equity in Cancer Care

Call for Proposals

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1. Intent of Call for Proposals

In the United States, there are about 16.9 million people who have been diagnosed with cancer in their lifetime – an additional 1.9 million people are expected to be diagnosed in 2021.[1] Despite major advancements in cancer treatment modalities – which often result in more complex regimens – significant challenges remain in providing high-quality cancer care for all patients in the United States.

The burden of cancer falls disproportionately on some segments of the population, including racial and ethnic minority groups.[2,3] Though cancer incidence rates are similar between white and Black males and females in the United States, disparities persist in mortality rates.[4] In addition, inequitable access to care remains among underserved populations, including low-income individuals, rural populations and the uninsured.[5]

For people newly diagnosed with cancer, the health care system can be challenging and overwhelming. The delivery of cancer care is often fragmented and poorly coordinated, and patients often face barriers to receiving timely, patient-centered care.[6] A variety of complex interrelated social and economic factors influence timely access to high-quality cancer care, known collectively as the social determinants of health.[7,8] These factors include economic stability, the physical or built environment, level of education, social support and access to quality health care.

The COVID-19 pandemic has exacerbated access barriers related to the social determinants of health, such as lack of transportation, food insecurity and loss of health insurance. Additionally, critical support systems have been difficult to access or shut down completely, further delaying access to timely, high-quality cancer care for many patients living in underserved communities.[9]

In 2020, the American Society of Clinical Oncology (ASCO) released a statement focused on increasing equity in cancer care. The professional society calls for systems-level change with emphasis on meaningful engagement with communities to address the structural barriers patients face when seeking and receiving high-quality care.[10]

To help address persistent disparities across the cancer care continuum, the Merck Foundation (the Foundation) announces a new initiative, the *Merck Alliance for Equity in Cancer Care* (the Alliance). This initiative will work to advance health equity for underserved adult populations in the United States by improving timely access to community-focused, patient-centered, high-quality cancer care.

The Alliance aims to:

- Promote **evidence-informed, innovative, multi-level interventions** to improve key aspects of patient-centered care, including:
    - Coordination and integration of care from diagnosis through survivorship
    - Patient-provider communication
    - Patient engagement in treatment planning and decision making
    - Psychosocial services and other supportive care

- Build **sustainable community partnerships** between organizations inside and outside the health care system to address barriers related to the social determinants of health
- **Reduce disparities in access** to high-quality cancer care for underserved populations
- **Improve patient outcomes**, including satisfaction with care and quality of life
- Disseminate findings and program results to **improve the delivery of high-quality, culturally sensitive and respectful cancer care**

Through this Call for Proposals, the Foundation will select highly qualified organizations, informed by recommendations from an external expert review panel, to implement innovative, multi-level cancer care programs in communities across the United States. Through a learning collaborative and a comprehensive cross-site evaluation of the funded programs, the Alliance seeks to identify and promote best practices in patient-centered, community-focused cancer care that can improve patient outcomes and ensure equitable care.

2. 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 more than half of patients (55%) seek cancer care in their community,[11] eligible organizations must demonstrate active involvement in community-focused cancer care as well as meaningful collaboration with local community-based organizations (see **Section 5.7**). Eligible organizations may include the following:

- Health care organizations, including community cancer centers, integrated health systems, hospitals, oncology medical homes, community health centers and other health care organizations (Note: For academic medical or cancer centers, applicants must have affiliated community-based cancer center(s) and clearly demonstrate the active involvement of the community cancer center(s) in developing the application and proposed program)
- Community-based or nongovernmental organizations
- Units of state or local government

Organizations that are **not 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

3. Funding Availability and Expectations of Applicants

The Foundation may provide an organization with a maximum grant not to exceed $2 million over a 5-year period. Annual budgets for the proposed programs cannot exceed $400,000 in any single year.

The indirect rate for general administrative costs cannot exceed 15% of the total annual grant amount of up to $400,000. Any equipment should be specifically outlined in the budget – it is not considered a general administrative cost.

Grant funding cannot be used to displace existing support for ongoing programs or activities. The intent of the initiative is to build on or expand existing programs, or to create new ones. Additionally, grants are intended to support cancer care programs, not clinical research or other research studies.

To create a pathway toward program sustainability from the outset, organizations selected as grantees will be required to provide additional resources that are meaningful to them in support of their program – representing at least 15% of the total proposed project budget. Such funds may come from a variety of sources, including existing grants or new funding that the organization secures during the application process.

4. 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 local program evaluator
- 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 (depending on current public health guidelines for safe travel)
- Subcontracts (same allowable and unallowable uses of funds apply)

Grant funds may not be used for the following purposes:

- Direct clinical care (such as surgery, radiation therapy, or chemotherapy), support or social services, or other reimbursable services
- Medical screening or testing
- 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 specific approved subcontracting arrangements
- Programs that directly support marketing and/or sales objectives of Merck & Co., Inc., Kenilworth, NJ, USA

5. Expected Core Elements for Program Development

Core elements for program development are described below. Applicants should address all elements in their proposals.

5.1 Advance Equity in Cancer Care

Applicants should propose interventions in three areas critical to equitable, patient-centered care:

Program grantees will be expected to implement interventions that improve equitable, patient-centered cancer care as well as address access barriers related to the social determinants of health.

(1) coordination of cancer care, integration with primary care and other specialty care

(2) patient-centered communication and engagement in care

(3) psychosocial and other supportive care

5.2 Improve Access to High-Quality Cancer Care for Underserved Populations

Program grantees will design and implement interventions that improve access to high-quality care for underserved populations; that is, populations that face a disproportionate burden of disease and barriers to accessing high-quality care. Underserved populations may include racial and ethnic minorities; low-income individuals, people with limited access to health services based on geography, insurance coverage, or other factors; and patients with comorbidities, including disabilities, mental health issues, and substance use, among others.

Applicants can propose different strategies to improve equitable cancer care, including robust patient navigation services, interventions that are culturally sensitive and linguistically appropriate, collaborations with trusted community-based partner organizations that can help address the social determinants of health and the innovative use of digital tools to reduce barriers to care.

Applicants should clearly identify their focus population(s), based on the needs of their community; proposals should provide rationale for why the program will engage a specific population.

5.3 Expand and Strengthen Existing Efforts

The Alliance aims to build primarily on organizations' existing programs and activities, although the initiative may also support the development and implementation of new interventions.

Applicants should describe their current work with the focus population(s) as well as successes in improving access to equitable, patient-centered cancer care for underserved communities. If available, applicants should present existing evaluation findings or other documentation of program impact.

Further, applicants should demonstrate how they would use grant funds to build upon 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 new partners that can address patients' social needs, and/or (d) combining the components of their approaches in different ways.

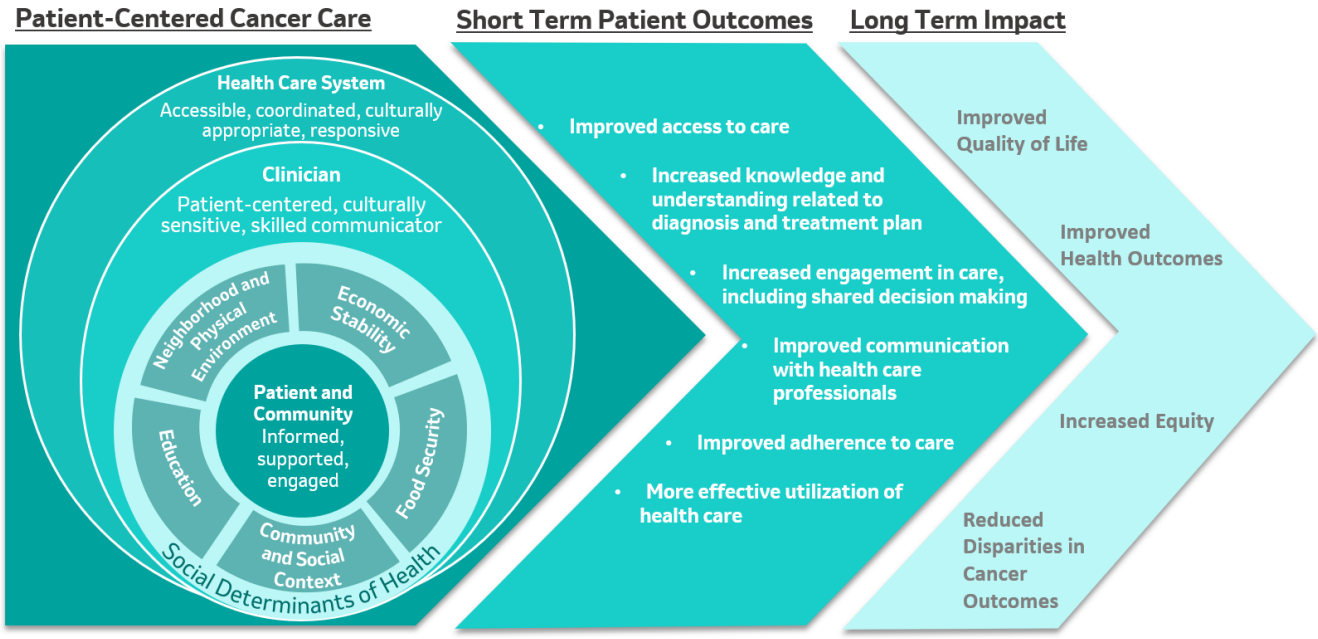
5.4 Implement Multi-Level Interventions that Address Multiple Cancer Types

Program grantees are expected to implement interventions that address multiple cancer types, rather than focus on a single cancer type. Additionally, interventions should have components that span different levels of the health care ecosystem, focused on: (1) patient, (2) health care provider/health care team and (3) health care system.

Applicants should propose interventions at each of these levels and demonstrate how each component will be integrated and mutually reinforcing to achieve meaningful impact and increase equity in care.

The framework below (Exhibit 1) illustrates how these interventions may connect across the health care ecosystem.

Exhibit 1: Framework for *Merck Alliance for Equity in Cancer Care* Programs



5.5 Use Evidence-Informed Approaches

Applicants should present evidence supporting proposed intervention approaches, such as published findings. If published findings are not available, applicants may refer to recognized best practices, recommendations and guidelines, or preliminary evaluation findings that support the effectiveness of proposed interventions. In developing their intervention(s), applicants should strive to balance innovation with existing evidence.

Program grantees are expected to implement interventions based on scientific evidence or, in cases of emerging approaches that have not yet been fully evaluated, on promising practices from the field.

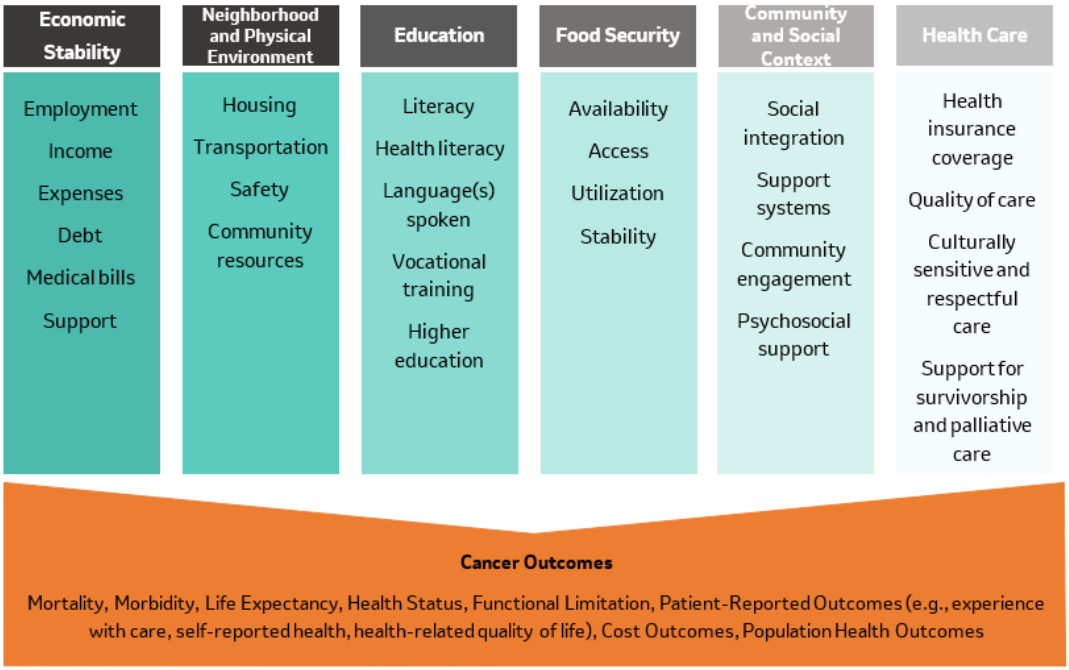
5.6 Create Cross-Sector Community Collaborations to Address Barriers Related to the Social Determinants of Health

Cross-sector collaboration will enable grantees to address barriers related to the social determinants of health, extend reach to underserved populations and increase capacity to expand or enhance the array of services offered. Collaborators may be nonprofit organizations, community groups, faith-based organizations, health departments, social service agencies, health-related organizations and others that offer services relevant to the proposed interventions or can facilitate outreach to and communication with the populations to be served by the program. Proposals will be strengthened by demonstrating how the program will foster broad cross-sector community collaboration that goes beyond the specific requirements.

Applicants are expected to establish or expand collaborations with community-based organizations in various sectors inside and outside health care, such as food, housing, education, transportation, public health and social services, to address the social determinants of health. Exhibit 2 describes how the social determinants of health impact access to high-quality cancer care.

Applicants should demonstrate how they will develop and maintain collaborations with organizations inside and outside the health care sector. Applicants should describe the collaborators' roles and responsibilities, any prior work with proposed partners and outcomes of the partnership. Note that partner organizations must meet the eligibility criteria described in Section 2 of this document.

Exhibit 2: Social Determinants of Cancer Risk, Care and Outcomes



Source: Heiman, H.J. & Artiga, S. (2015). Issue Brief. Beyond health care: The role of social determinants in promoting health and health equity. Melo Park, CA: The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation. Adapted with permission.

5.7 Engage the Community in Program Development and Implementation

All programs will begin with a 6-month planning period during which the grantee engages with members of the community and collaborating organizations (see Section 5.6). Involving the community from the outset will help ensure that the program is co-created to meet local needs, addresses the social determinants of health that present barriers to care and is respectful and responsive to the health beliefs, practices, cultural and linguistic needs of the focus population(s).[12]

Applicants should describe the process for engaging key local community stakeholders and partners – for example, through community advisory boards or other formal mechanisms for patient engagement and feedback – to obtain input for the program. Applicants should also describe how they will ensure meaningful ongoing participation and engagement of community partners in program implementation.

5.8 Plan for Sustainability and Potential Scalability of the Intervention

Program grantees are expected to implement interventions that can be sustained – and have the potential for scale – beyond the grant funding period.

Applicants should also describe their experience with sustainability planning and past success in sustaining interventions, and options for sustaining the program (or specific program elements) beyond the funding period based on the proposed intervention approach.

Applicants should present a realistic plan for sustainability; for example, a plan demonstrating how organizational infrastructure, staffing, and resources can support the interventions after grant funding ends; or how the applicant will aim to change organizational policy and practices to help ensure sustainability of the program.

Proposals should also include vision for and plan to explore scale up of the program, should the interventions have demonstrated impact at the local level.

5.9 Demonstrate the Feasibility of the Program

Applicants should demonstrate the feasibility of the proposed interventions, including how staff and resources will be allocated to implement the interventions effectively and in a timely manner. Applicants should also discuss potential challenges to implementing the proposed interventions and how the challenges will be addressed.

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.

6. Interventions

Program grantees will be required to implement interventions in three areas critical to improving patient-centered cancer care: coordination of care, patient-provider communication and patient engagement, and psychosocial care and other supportive services. Exhibit 3 provides examples of intervention strategies in each of these areas at the patient, provider and health systems levels.

6.1 Coordination of Cancer Care, Integration with Primary Care and Other Specialty Care

Two promising approaches to improving coordination of care are patient navigation and multidisciplinary team-based care. Integrated care teams that include diversity in disciplines focus on both a patient's care needs as well as their social needs beyond the clinic.[13,14] Patient navigators, including nurses, lay health advisors, and social workers, help patients and caregivers to overcome health care system barriers and receive timely access to high-quality care from diagnosis through survivorship.[12,15-16] Robust patient navigation services are particularly important for patients with comorbidities who need specialty care services to address not only their cancer care needs but also other health conditions. In addition to assessing the clinical needs of patients, navigators and other members of the care team can assess patients' social needs and provide referrals to community services that help address the social determinants of health.[17]

The complexity of cancer care requires interdisciplinary collaboration of health care professionals, including oncology specialists and primary care providers. Multidisciplinary team-based care can lead to improved coordination of care by encouraging health care professionals from different practices or specialties to follow standard practices and protocols for timely communication, information sharing, and timely follow-up care.[18]

Applicants are encouraged to consider the following characteristics of effective programs to improve coordination of care:

- **Patient navigation services that address multiple cancers and are initiated early in care following diagnosis and continue throughout treatment into survivorship. Trained navigators may be nurses, social workers, other clinicians, or lay navigators (e.g., community health workers).**
- **Closed-loop referral systems that link patients to community supportive services based on their social needs to address non-medical barriers to accessing and remaining in care.**
- **Multidisciplinary teams that incorporate patient navigators and ancillary care providers, such as nutritionists, mental health professionals, physical therapists, pain management specialists, social workers and rehabilitation specialists.**
- **Clear and timely treatment plans shared between oncology and primary care teams and other specialty providers. Treatment plans should be user friendly; for example, they should highlight summary information and follow-up/action steps and referrals to social support.**

6.2 Patient-Centered Communication and Engagement in Care

Effective communication between patients and clinicians, patient navigators, and others on the health care team is a key component of patient-centered cancer care. Clear, respectful communication can help patients handle the emotional impact of a cancer diagnosis, understand, and remember complex information about their treatment, and cope with the uncertainties of cancer care. Patient-clinician communication contributes directly or indirectly to intermediate outcomes, including access to care, therapeutic alliance (i.e., patient-clinician commitment to the relationship), patient knowledge and understanding, improved adherence to treatment, access to care and effective use of the health care system. Good patient-provider communication also influences patients' health-related quality of life, such as reducing anxiety, depression, and emotional distress.[19]

Applicants are encouraged to consider the following characteristics of effective programs to improve patient-provider communication and patient engagement:

- **Training for clinicians, patient navigators, and others on the health care team covers patient-centered communication and patient engagement. These skills include the following: fundamental communication and relationship skills, discussing prognosis and goals of treatment, assessing patient understanding of care, and driving towards shared decision-making. Training is most effective when it provides opportunities to practice skills with timely feedback.**
- **Implicit bias training for all members of the cancer care team to ensure they provide culturally sensitive and respectful care.**
- **Treatment planning with a patient-centered approach which involves engaging patients (and families, as appropriate) to develop a treatment plan using all available medical information appropriately while also considering the medical, social, and cultural needs and desires of the patient and their family.**
- **Educational tools and resources for patients that are culturally and linguistically appropriate and available in different formats.**
- **Interventions that use innovative digital approaches to support patient engagement (e.g., interactive mobile-based tools).**

6.3 Psychosocial Care and Other Supportive Services

A diagnosis of cancer is psychologically and emotionally challenging for many patients and family members. About 4 in 10 cancer patients report significant emotional distress.[20] The most common and distressing symptoms and side effects related to cancer and its treatment include pain, fatigue and emotional distress.[21] Key points of psychological and emotional vulnerability include the time of diagnosis, treatment endpoints and episodes of recurrence. Successful management of cancer-related symptoms is required to reduce burden and improve quality of life and treatment adherence.[22-24] Despite the importance of symptom management, cancer-related symptoms are often underassessed, underreported and undertreated.[25]

Applicants are encouraged to consider the following characteristics of effective programs to improve psychosocial care and other supportive services:

- **All patients are routinely screened for psychosocial distress – including depression and anxiety – and referred to appropriate services, such as support groups or counseling, and followed up with to ensure needs are met.**
- **Psychosocial support services may be offered within the cancer center/health care organization or through referral to community resources.**
- **All patients are routinely assessed for symptoms and side effects (e.g., pain, fatigue), referred to appropriate services (e.g., palliative care) and followed up with to ensure effective treatment of symptoms and side effects.**
- **Education is provided for patients (and families, as appropriate) about what to expect in terms of psychosocial concerns and symptoms and side effects as well as self-management of symptoms and side effects; information is provided about supportive services and resources available and how to access them.**

Examples of existing intervention tools and resources, such as training programs and assessment tools, are provided in Appendix A. Applicants may propose to use (or adapt) the tools and resources cited but are not required to do so. Applicants may propose to use alternative evidence-based or promising approaches and are encouraged to use innovative approaches to implement the interventions.

Exhibit 3: Examples of Multi-level Interventions

	Intervention Area		
Intervention Level	**Coordination and Integration of Care**	**Patient-Centered Communication and Patient Engagement**	**Psychosocial Care and Other Supportive Care**
Patient / Family	• Promotion of and education about patient navigation e.g., clinical and social services available, community resources, benefits to patient, how to use • Education that follows health literacy principles on multi-disciplinary team-based care e.g., benefits to patient • Digital tools to help coordinate care and supportive services	• Dissemination of information to support patient and family engagement e.g., educational materials, question prompt lists, decision support tools • Digital tools for patient education and communications with care team	• Education about psychosocial health and supportive services • Education about available assistance for symptoms and side effects e.g., palliative care
Health Care Provider / Care Team	• Education about patient navigation programs e.g., clinical and social services available, community resources, benefits to patient and provider, how to use • Time, infrastructure, and staffing support for multidisciplinary team-based care • Communications protocols for coordination with primary care providers and other specialists • Digital tools to coordinate care with multidisciplinary care team	• Skills training for clinicians and navigators e.g., communication, patient engagement, shared decision-making • Implicit, explicit and racial bias training for clinicians and navigators	• Training and tools to assess psychosocial needs e.g., assessment and management of distress, anxiety, depression • Training and tools to assess and manage symptoms and side effects e.g., nausea, fatigue, pain • Training and tools for assessment of social needs and referrals to community resources or services
Health Care System	• Policies, infrastructure, or staffing to support patient navigation programs, multidisciplinary team-based care and coordination between oncology and primary care teams e.g., initiated early in care, for multiple cancer types • Policies, infrastructure, or staffing to support assessment of social needs and closed-loop referrals to needed services	• Policies, infrastructure, or staffing to support clinician and navigator training in communication skills, patient engagement, shared decision-making • Policies, infrastructure, or staffing to support implicit and racial bias training	• Policies, infrastructure, or staffing to support timely assessment of psychosocial needs and provision of services e.g., counseling, support groups, peer-to-peer support • Policies, infrastructure, or staffing to support timely assessment and management of symptoms and side effects

7. Program Evaluation

To assess the impact of the Alliance, the Foundation will use a two-pronged approach to support evaluation of grantee programs. First, the Foundation will conduct a *cross-site evaluation* of all funded programs. **Grantees in the Alliance will be required to participate in the cross-site evaluation.** For this purpose, certain core outcomes (see Section 7.1) will be essential for all programs to assess as part of the cross-site evaluation. Second, grantees will be expected to implement a *local* evaluation and articulate what and how they aim to evaluate based on the specific intervention approaches they propose. Section 7.2 discusses this requirement in more detail.

7.1 Cross-Site Evaluation – Core Measures for Grantee Consideration and Refinement

Comprehensive and thoughtful program evaluation will allow the Foundation to understand *what* is working, *how* it is working and *why* it is or is not working. Although the Alliance's evaluation team will lead the cross-site evaluation design, implementation and analyses, grantees will be expected to actively participate in the design and site-specific data collection efforts.

During the **6-month planning period**, grantees will participate in developing the evaluation design and determining harmonized core measures and data collection methods. For example, it will be important to establish processes for collecting, aggregating and reporting required evaluation data, including how data will be obtained from collaborators. The cross-site evaluation will include both a process evaluation to examine how the interventions were implemented and an outcome evaluation to measure results.

The Foundation recognizes that a diverse set of methods, evaluation measures, analytic techniques, and statistical tests will be needed to yield a robust evaluation. It also recognizes that the cross-site evaluation will need to be tailored to the range of interventions funded. A set of harmonized core evaluation measures will need to be included in the cross-site evaluation. Sections 7.1.1 and 7.1.2 provide examples of measures that grantees will consider and refine for a robust evaluation.

7.1.1 Process Evaluation

Documenting and tracking the process of program implementation is key to understanding program implementation and reach.

The process evaluation will examine the following:

- How interventions were implemented
- Facilitators and barriers to implementation
- Fidelity of program implementation and reasons for any changes
- Organizational- or systems-level changes that occurred as a result of the initiative

- Community partnerships developed or enhanced as part of the initiative
- Implementation of sustainability plan and potential plan for scale
- Barriers and facilitators to sustainability and scalability

7.1.2 Outcome Evaluation

The outcome evaluation will examine the impact of the initiative across a number of agreed upon harmonized measures, which may include:

- **Clinical processes and health care utilization**
  - Timely access to care (e.g., time to first medical oncology appointment following diagnosis)
  - Timely assessment and management of distress and other symptoms and side effects
  - Overall health care utilization (such as emergency department visits, hospitalization rates)
- **Adherence to treatment plans**
  - Continuity of oncology, primary and other specialty care
- **Patient reported outcomes**
  - Patient experiences and engagement in care
  - Satisfaction with care
  - Provider trust and communication
  - Patient-reported physical and mental health
  - Quality of life
- **Social determinants of health**
  - Changes in access to services influenced by social determinants of health such as employment status, health insurance, housing instability, food insecurity, transportation needs, utility needs
  - Referrals to social support services based on social needs screening

Where possible, if data are available and accessible, the Foundation is interested in understanding the implementation context and potential population health outcomes that may result from the program. Examples include organizational-, system-, and/or population-level measures of the social determinants of health (e.g., poverty, unemployment) and health outcomes (e.g., cancer-related mortality).

7.2 Local Evaluation

Program grantees are also expected to conduct an evaluation of their own program. This local evaluation provides the opportunity to examine processes and outcomes specific to the local site, such as how intervention approaches were implemented and the overall impact on focus populations. While the ultimate goal of the initiative is to improve health outcomes, it may take more time than is available during the grant period to demonstrate changes.

Applicants should identify the evaluation team (if different from the program team) as part of the full proposal. The Foundation will give preference to applications with evaluation teams that demonstrate both a strong record of high-quality research and dissemination, such as peer-reviewed publications, and a history of successful collaboration with the intervention teams on prior projects.

Consequently, the local-level evaluation should identify and measure shorter term outcomes such as timely access to care and referrals to supportive services, and patient-reported outcomes such as patient experience with care and quality of life. Applicants invited to submit a full proposal should provide an overview of their local evaluation plan (instructions for the full proposal are presented in Section 9.2 of this document).

8. Dissemination of Findings

To help advance the field, grantees will share the findings and lessons learned from their programs throughout and at the end of the funding period. Potential approaches for disseminating findings include conference abstracts, peer-reviewed articles, op-eds or other editorial pieces and presentations to key stakeholders. Applicants should provide an overview of how project results will be shared widely to promote best practices in delivering patient-centered, equitable cancer care.

9. Project Timeline

Proposals will include a program timeline that outlines a 6-month planning period, program implementation, and evaluation activities. The timeline should also note potential points when the grantee plans to disseminate findings and any activities key to enacting the program's sustainability plan and promoting scalability.

10. 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 cancercareequity@rabinmartin.com.

10.1 Letter of Intent

The first step in the application process is to submit a letter of intent (LOI) by **November 19, 2021**, to cancercareequity@rabinmartin.com. The LOI should be no longer than five pages (single-spaced, minimum 10-point font size), excluding the cover page, and include:

Cover Page

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

Section 1: Project Plan

- Program goals and objectives
- Health challenge(s) to be addressed through the program
- Description of disparities in cancer care in the local community to be addressed through this program
- Potential impact on improving equitable cancer care and timely access to care for underserved populations
- Description of focus population(s) to be served, including age range, race or ethnicity, gender, gender identity, and socioeconomic status
- Geographic area for programs and population statistics for the area, specifically, total population of geographic area and population(s) to be served
- Overview of proposed multi-level intervention strategies
- Overview of proposed multisectoral community collaborations, including how they will address barriers to equitable cancer care related to the social determinants of health
- Discussion of how proposed interventions build on current programs and successes

Section 2: Capabilities and Experience

- Capabilities and experience of the organization, the project director, co-directors, and other key staff (e.g., evaluation staff)
- Qualifications of key staff in partner organizations and any subcontractors or consultants
- Experience of program partners related to improving health equity in their communities
- Evidence of prior collaboration with stakeholders, partners and community organizations beyond letters of support; evidence may include list of grant proposals, co-authored publications and documented program collaborations

Section 3: Evaluation

- Overview of the proposed local evaluation design

The Foundation will review the LOIs and invite selected applicants to submit a full proposal. All applicants will be notified whether or not they have been selected by **January 7, 2022**.

10.2 Invited Full Proposals

Invited applicants will submit a full proposal by **February 18, 2022**. The full proposal should include three volumes as separate documents:

- Volume I: (1) Cover Page, (2) Table of Contents, (3) Project Plan, (4) Local Evaluation Plan, (5) Organizational Capabilities and Experience, (6) Key Personnel and Staffing Plan (see Exhibit 4)
- Volume II: Appendices
- Volume III: Detailed Budget and Narrative Budget Justification

When we invite the full proposals, we will include instructions and the URL for uploading these documents in our online grants management system.

Exhibit 4: Overview of Volume I – Proposal 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 $2 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	• Limited to one page
3. Project plan	

3.1 Project goals and objectives	• Statement of overall goals and objectives of the proposed project
	• Discussion of how project will:
	  ○ Reduce disparities in access to high-quality, equitable cancer care for underserved populations
	  ○ Implement multi-level interventions to improve patient-centered care
	  ○ Build or expand community collaborations with organizations and stakeholders in the health care and non-health care sectors to address barriers related to the social determinants of health
	  ○ Disseminate important findings and program results to advance best practices for improving the delivery of high-quality, culturally sensitive and respectful cancer care
	• Anticipated impact of the program

3.2 Implementation Context	• Disparities in cancer care and outcomes in the local community to be addressed through the program
	• Barriers related to the social determinants of health that will be addressed through the program
	• Populations to be served, such as by race and ethnicity, age range, gender, gender identity, socioeconomic status
	  ○ Rationale for focusing on specific group(s) (e.g., disparities in morbidity, mortality, access to high-quality care)
	• Description of organization's access to and experience with identified population(s)
	• 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
	  ○ Rationale for focusing on specific geographic area(s)

3.3 Intervention strategies	• Description of proposed multi-level interventions (patient, provider, health system levels) and how they will improve access to patient-centered cancer care • 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 proposed interventions will help to achieve the Alliance's goals and local program goals and objective(s) • Description of any anticipated challenges and proposed solutions • Completed program logic model
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 ○ Overview of any prior work with proposed collaborators and the outcomes of the partnership • Roles and responsibilities of collaborating organizations • Description of how the collaborations will be developed and maintained • Description of how the collaborations will enable the program to address barriers related to the social determinants of health • Source(s) of funding for partner organization activities • Rationale for partnering; how partnerships will contribute to success • Documentation of proposed collaborating organizations' commitment and evidence of prior collaboration beyond letters of support – may include list of grant proposals, coauthored publications, and documented program collaborations • Discussion of how patients and community members will be meaningfully engaged during the program planning period and implementation (e.g., through a community advisory board)
3.5 Sustainability plan and potential scalability	• Demonstration of experience with sustainability planning • Description of past success in sustaining interventions • Description of options to sustain 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 strategies for addressing them • Overview of possible opportunities to explore project scale • Identification of potential challenges to scalability of the program and strategies for addressing them
3.6 Dissemination of findings	• Description of how lessons learned will be communicated with the field • Identification of potential approaches to share findings and program results
3.7 Overall project timeline	• Project planning and implementation timeline with specific milestones, including 6-month planning period

4. Local program evaluation plan	
4.1 Evaluation design	• Proposed process and outcome evaluation questions • Overview of evaluation design • Proposed metrics to assess program impact
4.2 Data collection methods	• Proposed data collection methods, including how data will be collected from collaborating organization(s) • Proposed data collection instruments
4.3 Evaluation timeline	• Evaluation timeline with specific milestones, including 6-month planning period
5. Organization capabilities and experience	• Existing programs, activities, staffing, and resources in the areas of the proposed project ○ Detailed information for any subcontractor(s) • Capabilities to implement evaluation activities (may be through arrangement with external evaluation organization), including to collect patient outcomes and track health care utilization • Ability to obtain data for evaluation from an electronic health record • Previously and currently funded projects related to patient-centered care, disparities in cancer care, or other relevant areas: brief description of projects and accomplishments and, if appropriate, how ongoing projects will be integrated with the currently proposed project • Past and current collaborations focused on community cancer care and improving health equity and any relationship to the proposed project • Pending funding (including potential funding sources and amounts) for projects similar to the proposed project • Key accomplishments, evaluation findings, and lessons learned from previously and currently funded relevant projects
6. Key personnel and staffing plan (for project and local evaluation)	• Titles, affiliations, experience, and qualifications of project director, co-directors, project manager, and other key staff • Roles and responsibilities for project director, co-directors and other key staff – include organizational chart • Percentage of time on project anticipated for project director, co-directors, and other key staff • Role of subcontractor(s) staff, if any

10.2.1 Volume I

The specifications for this volume should include a running header comprising the name of the project director and consecutive page numbers covering all of Volume I. Together the cover page, table of contents, Project Plan, and Evaluation Plan should not exceed 25 pages. Please use 1-inch margins, type font no smaller than Arial 11 point, and set for one-sided printing.

10.2.2 Volume II

Proposals may include a limited number of appendices:

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

10.2.3 Volume III

The budget should include sufficient detail on labor and other costs for reviewers to assess how project 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 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, data processing.
- **Indirect costs.** Indirect rates must not exceed 15%.
- **Additional financial support or matching funds for the project:** These contributions must be at least 15% of the total budget from sources outside the proposed grant from the Merck Foundation.

A detailed narrative budget justification should be prepared in Microsoft Word that addresses the following:

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

11. Full Proposal Review and Evaluation Criteria

11.1 Proposal Review

The Foundation will review invited proposals, with input from a panel of external experts in cancer care and health equity, using the review criteria outlined below. The Foundation cannot return proposals or provide individual technical critiques.

11.2 Review Criteria

Proposal review criteria include the following (see Exhibit 5 for the technical evaluation weights for invited full proposals):

- **Potential impact of the program**, including the significance of the project goals as they relate to addressing critical issues in cancer care in the local community, improving patient-centered care and timely access to care, reducing disparities and increasing equity in cancer care among the population(s) to be served. Impact will also be assessed based on the scale and reach of the interventions.
- **Evidence-based innovation**, including interventions that build on the scientific evidence and offer innovative approaches to improve patient-centered care and promote equitable cancer care for underserved populations.
- **Multisectoral collaboration and community engagement**, including the diversity of organizations and how collaborations will expand the reach and effectiveness of the program and address barriers related to the social determinants of health.
- **Qualifications and experience** of the organization, project director, co-directors and other key staff.
- **Sustainability plan** for proposed interventions and multisectoral community collaborations as well as plans for potential program scale up if it is determined that interventions are effective.
- **Evaluation plan and evaluation capabilities**, including the local evaluation plan and demonstrated capabilities to contribute to the cross-site evaluation.

Proposals will be strengthened by the inclusion of one or more of the following elements:

- **Demonstration** of how the project will foster broad and sustainable community collaboration that goes beyond the specific requirements of the project (e.g., proposed collaboration with local government or payors).
- **Financial or in-kind contributions** from applicant and/or collaborating organizations beyond the required 15% of total budget.

Exhibit 5. Technical Evaluation Weights for Invited Full Proposals

Review Criteria	Points
Potential impact of the program, significance of project goals as they relate to improving patient-centered cancer care and increasing equity in cancer care	20
Evidence-based innovation, multi-level intervention strategies, and integration of program components	20
Multisectoral collaborations and community engagement to address the social determinants of health	15
Qualifications and experience of the organization, project director, and other key staff	15
Sustainability plan and potential plans for program scale	15
Evaluation plan and evaluation capabilities	15
Total	***100***

Appendix A: Resources to Inform Development of Multi-Level Interventions

1. Coordination of Care

Patient Navigation Programs

- The Association of Community Cancer Centers (ACCC) provides resources and tools for patient navigation programs, which address the following patient navigation roles: (1) ensure the patient, family members, and other caregivers move through the complexities of the system in a timely fashion; (2) provide psychosocial services to patients, families, and caregivers or refer them to an oncology social worker for psychosocial care; (3) link patients, families, and caregivers with appropriate community resources (e.g., financial, transportation, translation services, and hospice); and (4) provide education to the patient, families, and caregivers throughout the continuum of care.[26]
- The George Washington Cancer Institute has defined core competences for patient navigators that can be used as a guide for training and monitoring. Core competencies include interpersonal communication skills, interprofessional collaboration, and patient-centered care that is compassionate, appropriate, and effective for the treatment of cancer and the promotion of health.[27]
- The Academy of Oncology Nurse & Patient Navigators and the American Cancer Society developed a Navigation Metrics Toolkit that includes Core Navigation Metrics: 1) Navigator Competencies, 2) Navigation Caseload, 3) Barriers to Care, 4) Psychosocial Distress Screening, 5) Interventions.

Multidisciplinary Team-Based Care

- Team-based care interventions should align with the principles for effective teamwork identified as part of the National Cancer Institute and American Society of Clinical Oncology (ASCO) joint initiative called Teams in Cancer Care Delivery, which includes team leadership, team orientation, shared problem-solving and decision-making, conflict resolution/management, planning, goal setting, and role definition, and team composition/diversity.[28] The ACCC also provides guidelines for multidisciplinary team-based care to ensure that patients' needs are identified, interventions are planned, treatments are coordinated, and care is monitored and evaluated.[29]

2. Patient-Clinician Communication and Patient Engagement

Skills Training for Providers and Navigators

- Various communication skills training programs for providers have been developed and evaluated. The most effective programs are carried out over time (versus providing one-time training), use multiple pedagogical approaches, include opportunities to practice communication skills, provide timely feedback, and allow clinicians to work in groups with skilled facilitators.[30,31]

- Another important area for skills training is coaching, which helps patients play an active role in their care. One tool frequently used in coaching is a "question prompt list" designed to help patients prepare for the clinical encounter (e.g., helps them to consider their agenda and priorities for the appointment and to articulate their questions).[32]
- Implicit bias training is necessary to ensure health care providers are delivering culturally sensitive and respectful care. Patient-clinician relationships and health care decisions can be affected by implicit bias, which is the unconscious collection of attitudes and stereotypes one holds towards certain groups of people.[33] Harvard University's Project Implicit measures unconscious bias and can be a tool to identify blind spots, while the University of California Los Angeles has a series of Implicit Bias Videos to inform about how behavior is influenced by bias and learn countermeasures. Another useful tool is the National Research Mentoring Network (NRMN) Unconscious Bias Course, which is designed to help address disparity in medicine and health care.

Tools and Resources for Patients

- In addition to question prompt lists (see above), resources for patients can include videos, educational materials, and decision aids. The American Cancer Society offers a series of "questions to ask your doctor" for patients with different types of cancer.[34] The Agency for Health care Research and Quality's Questions Are the Answer campaign—though not cancer specific—has resources to enhance patient engagement, including videos featuring patients and clinicians discussing why it is important to ask questions and offering ways that patients can ask questions and get their health care needs met. It also includes a question builder tool that helps patients identify questions to ask in a clinical encounter.[35] Other organizations that offer patient/family resources to navigate cancer care include NavigateHealth, the LIVESTRONG Foundation, the Cancer Support Community, and the American Cancer Society.

3. Psychosocial and Other Supportive Care

Training and Tools for Assessment and Management of Psychosocial Needs

- Protocols for managing side effects and symptoms call for routine assessment and referral to specialists (e.g., palliative care providers, nutritionists) as appropriate. Telephone-based programs that allow patients and families access to clinicians at all times have been effective in managing symptoms and side effects.[36]
- ASCO, ACCC, the National Comprehensive Cancer Network (NCCN), and other groups have tools and resources for assessing and managing anxiety, depression, and other psychosocial issues. Assessment tools include the NCCN distress thermometer, the Psychosocial Screen for Cancer, and the ASCO screening guideline.[37-39]
- Timely provision of appropriate support services, including individual counseling, support groups, and other peer-to-peer support programs (e.g., buddy programs that link newly diagnosed patients with cancer survivors) can reduce distress and improve quality of life.[40,41] Attention to culturally appropriate services also is important.

Training and Tools for Assessment and Management of Symptoms and Side Effects

- ASCO, NCCN, and other groups provide tools for assessing and managing patients' symptoms and side effects, including pain, fatigue, sleep disturbance, and nausea. Tools include the ASCO fatigue assessment instrument and treatment and care map.[42] and the Cancer Care Ontario's toolkits, which has symptom assessment tools and management guidelines for pain, nausea, fatigue, sleep disturbances, and other symptoms and side effects.[43]

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