Association of State and Territorial Health Officials

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REQUEST FOR PROPOSALS (RFP)

State Public Health Collaborative to Improve Cardiovascular Health Outcomes

I. Summary Information

Purpose: The Association of State and Territorial Health Officials (ASTHO), with the support of the Centers for Disease Control and Prevention's (CDC) Division of Heart Disease and Stroke, is offering this request for proposals to support 1-2 state health agencies to work with private payers and related entities to improve population-level blood pressure control through innovative, data-driven health care delivery and payment models. Successful implementation of these models statewide will ultimately improve cardiovascular health outcomes and reduce health care costs.

Proposal Due Date and Time: Friday, April 28, 2017, 5:00pm EDT
*A notice of intent to apply is also required of all potential applicants. By April 14, 2017, please send a short email to lshaull@astho.org with your intent to apply.

Selection Announcement Date: The week of **May 8, 2017.**

Monetary Assistance Available to Awardees: Awards of up to $125,000 each will be provided for 1-2 states in two phases:

- *Phase I*: States will be provided $20,000 to convene an initial stakeholder/core team meeting, develop an aim statement and initial plan to test selected strategies, develop a measurement plan to monitor and evaluate outcomes of selected strategies, and establish baseline measures/metrics.
- *Phase II*: States will be awarded an additional $105,000 to implement selected strategies identified in Phase I using the core team and partnerships that were developed.

Estimated Period of Performance and Final Report Date:

- *Phase I*: The project period is May 8, 2017 through June 30, 2017, with a Phase I Final Report and Phase II Scope of Work and Budget due June 30, 2017.
- *Phase II (contingent upon funding)*: The project period is July 1, 2017 through June 15, 2018, with final reports due June 30, 2018.

Eligibility: All states and territories in good standing with ASTHO are eligible to apply.

ASTHO Point of Contact: Elizabeth Romero (eromero@astho.org), Senior Director, Health Improvement. Applicants may also contact Lynn Shaull, Director, Health Promotion and Prevention, with questions (lshaull@astho.org).

Elizabeth Walker Romero
Senior Director, Health Improvement
ASTHO
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Lynn Shaull, MA
Director, Health Promotion and Disease Prevention
ASTHO
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II. Description of RFP

Purpose

The Association of State and Territorial Health Officials (ASTHO), with the support of the Centers for Disease Control and Prevention's (CDC) Division of Heart Disease and Stroke, is offering this request for proposals to support 1-2 state health agencies to work with private payers and related entities to improve population-level blood pressure control through innovative, data-driven health care delivery and payment models. Successful implementation of these models statewide will ultimately improve cardiovascular health outcomes and reduce health care costs.

Background

Despite uncertainty about the future direction of health care coverage and services provided through the Affordable Care Act, value-based delivery and payment models will likely continue to drive innovation in health care given the emphasis of improving patient outcomes and lowering cost. Engaging in partnerships that realize real improvements in performance measures such as the HEDIS hypertension measure and NQF 0018 is a critical opportunity for both health plans and public health agencies. Higher scores on these core measures not only communicate effectiveness and value to patients but also help plans identify high-performing providers, and increase reimbursement through incentive payments from Medicaid and Medicare. National incentive initiatives such as the National Committee for Quality Assurance (NCQA) recognition programs for heart disease and diabetes, Centers for Medicare and Medicaid Services (CMS) Star Ratings for pharmacies and Medicare Advantage plans, Leapfrog Hospital Ratings, Patient Centered Medical Homes, and others, continue to drive the shift toward value-based payment and encourage greater collaboration to reduce the challenges that result from fragmented care.

With this continued focus on improving patient outcomes, health plans are strongly incentivized to support health care delivery models that connect clinical care with community-based resources and services, such as through public health departments. Effectively connecting to these resources and services (such as public health nurses, community health workers, community-based care coordination services, lifestyle management programs, and services that address patient barriers to care such as lack of transportation, housing, and drug costs) ensures patients have access to the services they need to fully engage in their own care and manage their chronic conditions in a cost-effective manner. Determining the outcomes and monitoring performance of these models requires establishing robust health data sharing systems and engaging a broad range of stakeholders.

Public health agencies are important partners in establishing these collaborative models with payers. They are uniquely positioned to help bridge the gap between health care and community health to address the social, environmental and economic factors (such as housing, transportation, and economic barriers, sometimes called "social determinants of health"[1]) that impact a patient's ability to manage their condition and access care. Local public health agencies have intimate knowledge of the community, and have access to data that can help target initiatives to patients who are the highest risk, most underserved, and incur the

[1] Social determinants of health are conditions in the places where people live, learn, work, and play that can affect a wide range of health risks and outcomes. Five key areas that influence the social determinants of health include economic stability, education, social and community context, health and health care, and neighborhood and the built environment. Certain resources can enhance quality of life and have a significant influence on population health outcomes. Examples include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins. (CDC. "Social Determinants of Health: Know What Affects Health. Frequently Asked Questions." Available at https://www.cdc.gov/socialdeterminants/faqs/index.htm. Accessed 1/29/2017.)

highest health care spending. Strong, collaborative partnerships between payers and public health agencies can be powerful catalysts to creating robust systems of care that respond to the needs of the patients who are hardest to find and engage, but who are also the most vulnerable and costly from a health care system perspective.

This project provides an opportunity for state health agencies and payers to establish innovative partnerships that build upon existing successful models and initiatives. Awardees will test and develop care delivery and payment models and policies as well as the data systems to support these models for identifying and managing hypertension among the high risk and high cost populations. While the pilot models and initiatives developed through this learning community will initially be applied to improving hypertension control, they should also be able to be adapted to other costly and high burden conditions such as diabetes and stroke. Lessons learned from this learning community will also inform the work of other states and national initiatives through ASTHO and other partners and serve as models for public health agencies and payers interested in collaborating to address chronic conditions such as hypertension.

This project builds upon opportunities identified through ASTHO's Million Hearts Learning Collaborative. Lessons learned from the Learning Collaborative, and through key informant interviews with state health officials, payer leadership, and other key stakeholders identified a range of opportunities for state health agencies to partner with private and public payers, and related entities to improve hypertension identification and control. These opportunities are highlighted in an ASTHO white paper.

Project Activities

This RFP builds upon the opportunities identified through the ASTHO Million Hearts Learning Collaborative, and will support 1-2 states to select and test 1-3 of the strategies identified below. The number of strategies selected must be justified by the proposed budget and should include a plan to show measurable outcomes.

Project Strategies:

1. Identify high risk, high cost, and/or underserved ("hard-to-engage") populations with hypertension to target. Examples of possible target populations include individuals who are not currently being reached by the health care system, "high utilizers" of emergency departments or other costly health care services, those who were previously uninsured or underinsured, or individuals facing significant social or economic barriers to managing their conditions and accessing care (e.g., homeless populations).
2. Develop and test innovative payment mechanisms and/or health care delivery models and policies to support target populations in improving their blood pressure. These models may include expanding coverage for services or types of health care providers that support patient self-management (such as public health nurses, community health workers, community pharmacists, etc.), building connections between clinical, community, and public health services to identify and refer individuals to care, increasing use of evidence-based care delivery models such as team-based care and care coordination/case management, and others. Applicants may wish to refer to an ASTHO white paper highlighting additional possible approaches. This strategy may also involve looking at the range of opportunities to develop and/or strengthen policy (such as managed care contracts, state Medicaid authorities, and others). Models tested should be scalable to other communities across the state or in other states.
3. Strengthen statewide capacity to collect, access, share, and use data to identify and monitor individuals, monitor performance, and inform cost savings analysis. This strategy supports Strategies 1 and 2 by

facilitating timely data sharing through high functioning health information systems to support decision making and drive action among providers, health systems, health plans, and at the state level.

4. Analyze and communicate the value and potential cost savings of the prevention or care delivery models being tested. One example of this strategy is calculating the return on investment of shared performance measures or innovative care delivery models such as community team-based care or care coordination.

Systems Change: Applicants should describe how they will connect the work of this project with other initiatives within their state to inform and align efforts, and strengthen systems connecting public health, health care, and community resources. Applicants should also describe existing state-level initiatives that will inform and support spreading and sustaining these systems. Examples include: CMS State Innovation Model initiative and Comprehensive Primary Care Initiative; the CDC 6|18 Initiative; state health improvement plans or other state-level strategic plans; other federal funding from CDC, CMS, or other agencies; other payer innovation funding, etc.

Required activities: Funded states will use part of this funding to participate in the following activities:

Phase I:

- Week of May 15, 2017: Stakeholder Meeting 1 –Project Overview and Kickoff: State team stakeholders meet in person in-state and ASTHO joins virtually. Anticipated length = 2 hours.
- Early June 2017: Stakeholder Meeting 2/Site Visit: State team stakeholders meet in-person in-state for an ASTHO-facilitated planning meeting. Anticipated length = 5 hours. ASTHO will also visit key partner sites as appropriate. (Applicants should indicate in their proposal their preferences of date options provided in "Section IV: Required Proposal Content and Selection Criteria").
- May 30, 2017: Phase II Scope of Work and Budget due.
- June 30, 2017: Phase I project period ends and Phase I Final Report due.

Phase II (contingent upon funding availability):

- August/September 2017: Stakeholder Meeting 4: State team stakeholders meet in-person in-state and ASTHO joins virtually. States will present Phase II Scope of Work and progress since June meeting, revise scope and implementation plan as needed, and will have the opportunity to learn from the other grantee. Anticipated length = 2 hours.
- November/December 2017: Stakeholder Meeting 5: State team stakeholders meet in-person in-state and ASTHO joins virtually. States will present project updates and learn from other grantees. Anticipated length = 2 hours.
- February/March 2018: Stakeholder Meeting 6: State team stakeholders meet in-person in-state and ASTHO joins virtually. States will present project updates and learn from other grantees. Anticipated length = 2 hours.
- May 2018: Stakeholder Meeting 7: ASTHO convenes an in-person meeting of all funded states, as well as national partners. Anticipated length = 1.5 days.
- June 2018: Stakeholder Meeting 8: State team stakeholders meet in-person in-state and ASTHO joins virtually. States will present project updates and learn from other grantees. Anticipated length = 2 hours.
- June 15, 2018: Phase II project period ends.
- June 30, 2018: Final reports due to ASTHO.

State Team Members: Applicants should include a list of their proposed state team members, as well as those members' proposed roles and responsibilities. The state health official will collaborate with state health agency staff to identify an agency staff member programmatic lead and fiscal (contract and invoices) lead, and will engage at least one payer to convene an advisory group and an implementation team. The stakeholders involved in each group are listed below. Additional team members will depend on the project design, available partners, and other state-specific factors.

The advisory group will participate in the stakeholder meetings described above, and will provide input into the Phase I activities (Aim statement development, strategy selection, measurement plan development). The advisory group *should include*, at minimum:

1. State Health Agency Lead as identified by state health official, such as a Chronic Disease Director (This person will serve as ASTHO's primary programmatic contact and will be responsible for tasks such as coordinating in person sessions, reporting, participating in project lead calls, etc.), and a fiscal lead (this person will serve as ASTHO's primary contact for financial and invoicing matters).
2. A lead Deputy or Chief of Staff for the Agency (sometimes referred to as the Senior Deputy).
3. Any additional in-house expertise necessary to effectively plan the selected strategies. The staff with this expertise may include:
    a. Performance measurement/quality improvement
    b. Health information systems/health IT
    c. Health informatics/data management, analysis, and reporting (e.g., epidemiologist, data analyst)
    d. Other staff that play a role in developing and testing the care delivery models. These staff may work in areas that involve public health nursing, clinical community linkages, chronic disease prevention, and others.

4 . Key leadership from at least one private payer (additional private or public payers, such as the state Medicaid agency, are welcome in addition to a private payer partner). This leadership should include, at minimum:
    a . Executive leadership (e.g., CMO)
    b . Risk analysis (e.g., actuaries)

5 . Any additional in-house expertise necessary to effectively plan the selected strategies. The staff with this expertise may include:
    a . Performance measurement/quality improvement
    b . Health informatics/data governance
    c . Data management, analysis, and reporting
    d . Patient/community engagement
    e . Provider engagement
    f . In-house case management/care coordination
    g . Prevention and wellness

The implementation team will participate in all stakeholder meetings, and will provide input into the Phase I activities (Aim statement development, strategy selection, measurement plan development). In addition, the implementation team will be responsible for implementing and measuring outcomes of the selected strategies throughout Phase II. They should meet with the state team lead regularly between stakeholder meetings and submit data for monthly progress/data reports (described below). The implementation team should include, at minimum:

- State Health Agency Lead
- Any state health agency in-house expertise necessary to effectively implement and measure outcomes of the

selected strategies. The staff with this expertise may include:
    - Performance measurement/quality improvement
    - Health information systems/health IT
    - Health informatics/data management, analysis, and reporting (e.g., epidemiologist, data analyst)
    - Other staff that play a role in developing and testing the care delivery models. These staff may work in areas that involve public health nursing, clinical community linkages, chronic disease prevention, and others.
- Any payer in-house expertise necessary to effectively plan the selected strategies. The staff with this expertise may include:
    - Performance measurement/quality improvement
    - Health informatics/data governance
    - Data management, analysis, and reporting
    - Patient/community engagement
    - Provider engagement
    - In-house case management/care coordination
    - Prevention and wellness
- Based on the selected strategies, the implementation team should also include any state- or local-level stakeholders who will be involved in developing and testing the strategies. Examples of these stakeholders include:
    - Local health agency(ies)[2]
    - Clinical provider/Hospital system partner (e.g., federally qualified health center, local or regional health system, community health center, physician, clinical practice medical directors, practice facilitators, nurse managers, etc.)
    - Community partner (This might include but is not limited to: community health workers, public health nurses, public health care coordinators, community pharmacists, YMCA, EMS/fire personnel, faith-based organizations, etc.)
    - Health IT partner (e.g. health information/informatics experts, EHR vendors, etc.)
    - Regional healthcare and/or quality improvement partners (e.g. QIO, community health center network, health system, hospital service area or ACO)
    - Other partner (e.g., employers, academic institution, state professional associations, state licensing boards, etc)

Expected Outcomes

The goal of this project is to convene a wide variety of stakeholders to develop and test innovative, data-driven health care delivery and payment models that will improve population-level blood pressure control among high risk, high cost, and underserved populations. Successful implementation of these models statewide will ultimately improve cardiovascular health outcomes and reduce health care costs.

Deliverables, Products, and Results

[2] *Local health agency* refers to the local health departments run by local governments, or for centralized states, the component of the state health department that serves the local level. States in which the state health agency also functions as the local health agency (for instance, the District of Columbia and Delaware) are still eligible to participate in this opportunity, and we would not consider them to be two separate agencies.

Grantees are required to participate in/complete the project activities above (see Project Activities section). Grantees must invite stakeholder partners and identify a meeting space for these calls/meetings. ASTHO will provide meeting materials and facilitation assistance.

In addition, grantee will be required to submit:

1. Monthly invoices.
2. Monthly progress reports, including data to highlight project outcomes.
3. Presentations on virtual and in-person meetings.
4. Processes, best practices, tools, and resources developed through this project with team partners, leadership, ASTHO staff, and possibly the funder, national partners, and other stakeholders as appropriate.
5. Feedback and suggestions on project activities as requested via questionnaires and/or interviews with ASTHO staff.
6. Final report and final invoice.

Inclusion of Health Equity

ASTHO is committed to the promotion of health equity and the elimination of health inequities. Health inequities are reflected by disproportionately high rates of disease, premature death and a lower quality of life. Health inequities are avoidable and state, federal, and locally-funded activities play a key role in helping to solve this problem. Applicants are encouraged to address health inequities within the context of proposed activities.

Technical Support

ASTHO is available to provide information to the grantee at no additional cost to support grantees in meeting the expectations outlined above by:

- Providing tools and resources available through ASTHO's Tools for Change virtual library.
- Providing on-site technical assistance through site visits, in-person meetings, and virtual technical assistance through online convenings, webinars, conference calls, etc.
- Providing connections to national partner organizations and individuals, as needed.
- Supporting states in the development, implementation, and evaluation of their initiatives.

III. Requirements for Financial Award

Allowable Expenses

Funding can be used to support costs associated with participation in this project, including convening key partners, funding local health departments or clinics, data collection, consulting fees for national experts, and in-state travel associated with the project as outlined in the health agency's action plan. Grant funds can also be used for direct labor support, expert consultants, and dedicated staff to assure action steps are implemented, data collected, and outcomes are reported.

Funds may not be used for equipment purchases. Per HHS requirements, funds awarded under this RFP are prohibited from being used to pay the direct salary of an individual at a rate in excess of the federal Executive Schedule Level II (currently $187,000).

Period of Performance

- *Phase I*: The project period is May 8, 2017 through June 30, 2017, with a Phase I Final Report and Phase II Scope of Work and Budget due June 30, 2017.
- *Phase II (contingent upon funding)*: The project period is July 1, 2017 through June 15, 2018, with final reports due June 30, 2018.

Reporting Requirements

In addition to participating in the meetings highlighted above, grantee will be required to submit:

1. Monthly invoices
2. Monthly progress reports, including data to highlight project outcomes.
3. Presentations on virtual and in-person meetings.
4. Processes, best practices, tools, and resources developed through this project with team partners, leadership, ASTHO staff, and possibly the funder, national partners, and other stakeholders as appropriate.
5. Feedback and suggestions on project activities as requested via questionnaires and/or interviews with ASTHO staff.
6. Final report, final invoice, and final invoice narrative.

IV. Required Proposal Content and Selection Criteria

Proposals may not exceed 8 pages in length, excluding CVs, budget, and budget narrative, and should be single-spaced in 11-point font.

Required Sections:

A. Cover Letters:

- **Cover Letter from State Health Official *(NOTE: Applications without this will not be considered):*** Include the name of the lead programmatic contact person (please include the full name, job Position title, physical mailing address, e-mail, telephone number, and fax (if available), and agency's DUNS number or CAGE Code). The letter should address the following: vision describing how this initiative will connect and build upon other initiatives (e.g., SIM, 6|18, etc.); and agreement to attend in-state site visit meeting.
- **Cover Letter from the Grantee Fiscal Agent *(NOTE: Applications without this will not be considered)***: Include the name of the organization, entity, or agency that will serve as the grantee fiscal agent specifying a contract (please include the full name, job position title, physical mailing address, e-mail, telephone number, and fax (if available)).

B. Letters of Support from Key Stakeholders (10 points): Please provide letters of support from key stakeholders. A letter of support is **REQUIRED** from all payer partners (private and public) participating in the project. The letters should clearly state the entities' support; recognition of roles and responsibilities; resources and personnel; and alignment with their current work and willingness to undertake the project in collaboration with the applicant. In addition, the letters from payer partners should:

- Describe the stakeholder's existing capacity to access and analyze clinical, claims, public health, and/or social determinants of health-related data.

- Include a description of the specific parameters or data fields that will be used to define the initial target population for the proposed strategies. These parameters may include International Classification of Disease (ICD)-10 or Current Procedural Terminology (CPT) codes, specific places of service, or provider types.
- Be accompanied by a sample data pull using the aforementioned parameters that will be used to define the initial target population. Examples include: (1) A data report showing the number of members that have claims related to hypertension, such as elevated blood pressure without a diagnosis of hypertension (ICD-10-R03.0); or (2) A data report identifying members with a diagnosis of primary essential hypertension but with blood pressure still uncontrolled (ICD-9-401.9).

C. Proposed Approach (20 points): Provide a brief outline of the approach and 1-3 strategy(ies) described above upon which you will focus to accomplish the project goals. Detail a work plan which includes activities, timeline, goals, and milestones to achieve the deliverables and meet the expectations noted above. The proposed approach should explicitly include the following:

- Rationale for selecting the target priority population, including relevant health disparities.
- How current efforts in your state are not adequately serving this priority population.
- How the selected strategies in this proposal will serve this priority population by testing innovative approaches.
- Describe how you will work toward scaling the approach over time (including local, regional, and state-level infrastructure and systems in place to support scaling successful strategies statewide), and the number of individuals you expect to reach.
- A description of data system(s) (e.g., payer claims databases, EHR data, HIEs, etc.) that will be utilized and their potential to generate actionable data to identify and support the target population in controlling their blood pressure. <u>This description should include screenshots or sample data pulls of the data described to demonstrate ability to use the data sources to identify priority target population and monitor outcomes</u>.
- Date preferences for June 2017 Stakeholder Meeting/Site Visits: ASTHO will collaborate with your state agency to conduct an on-site learning session to engage stakeholders early in the process. In other projects, this process has been integral to gaining timely input and feedback. The site visit is developed in partnership with the agency and includes a 5-hour stakeholder engagement meeting and a visit with community partners at their sites to listen and learn. This may be structured depending upon the needs of the state. **Please RANK YOUR TOP THREE CHOICES from the following list for site visit dates that work best for you and your team:**

  _____June 1-2, 2017
  _____June 5-6, 2017
  _____June 7-8, 2017
  _____June 8-9, 2017
  _____June 12-13, 2017
  _____June 14-15, 2017

D. Existing and Proposed Partnerships (15 points): This section should include the following:

- A list of your partners, including names and contact information, their potential roles and responsibilities in the project, and how they will support the goals of the project. Please

refer to the "State Team Members" section (pp. 5-6) for the partners that are required and those that are optional.
- A description of how partners represent a multi-disciplinary cross-section of entities and issues within your state, particularly related to your selected issues and target population.

E. Prior Experience and Performance (10 points): This section should include the following points:
- Describe experience and quality of performance on recent work completed with similar scope.
- Include information about familiarity with and understanding of the topic.
- Describe ability to represent ASTHO well in interactions with state and territorial health agency staff and other governmental, private sector, and/or non-profit stakeholders.
- Past or current experience with sharing data across entities (state- or local-level) to measure and/or improve performance.
- Experience with public health and healthcare integration.
- Past or current experience partnering with payers on health care delivery and payment reform.

F. Organization Capacity (10 points): This section should include the following points:
- Sufficiency of financial resources and ability to perform the proposed project.
- Commitment of the state leadership in making this project a priority.
- Capacity of the state agency and/or stakeholders to collect and analyze data at either or both the population health and individual patient levels for the health indicators you propose to improve.
- Describe staff qualifications and provide a CV for key personnel/staff lead.
- Commitment to preparing and submitting monthly invoices and invoice narratives.

G. Plan for Scaling and Sustainability (10 points): This section should include the following points:
- Describe the infrastructure, systems, and other initiatives/funding that will be used to scale successful strategies to other communities across the state and sustain them beyond the end of the grant period.
- Describe how future target populations will be collaboratively identified and prioritized, and the process that will be used to scale and refine strategies to be applicable to other populations.
- Describe the number of people you plan to eventually reach when the tested strategies have been fully scaled.
- Describe how you plan to disseminate learnings from the project across the state and/or to other states.

H. Inclusion of Health Equity (5 points): Throughout the proposal, incorporate the following:
- Describe the extent to which health disparities are evident within the health focus of the application.
- Identify specific group(s) which experience a disproportionate burden of the health condition.
- Demonstrate how proposed activities address health inequities (this also includes identifying social and/or environmental conditions which are the root causes of health

disparities). The root causes of health inequities are sometimes referred to as social determinants of health. All information regarding health inequities must be supported with data.

I. **Budget & Budget Narrative (5 points)**: Provide a detailed cost-reimbursement budget, including detailed projected costs for the completion of Phase I of the project. Maximum total award is $125,000 ($20,000 in Phase I and $105,000 in Phase II). "Attachment A – Phases I & II" (please request these attachments as Excel spreadsheets by emailing lshaull@astho.org) outlines the general format in which the budget should be presented. Applicants may use Attachment A as a template or simply as a guide to inform development of the project budget. A budget narrative must accompany the budget and justify (or explain) the costs associated with each proposed activity.
    - The cost reimbursement budget should include salary, fringe benefits, consultant fees, travel expenses, other direct costs, and indirect costs, as appropriate. If indirect costs are included on your budget, please provide a copy of your approved Indirect Cost Rate (IDC) Agreement.

J. **Response to Draft Contract (*5* points)** ***(NOTE: Applications without this will not be considered)***: ASTHO and selected applicant(s) will enter into a sub-grant agreement. A draft agreement between ASTHO and the selected applicant is available in Attachment B. Review the agreement's terms and conditions with your contracts officer and confirm that if selected, you will enter into this agreement, or identify and include any proposed changes with your proposal application. ASTHO reserves the right to accept or decline any proposed changes to the terms and conditions. Significant proposed changes, which could affect the agreement's timely execution, may impact your selection as a successful applicant.

K. **Evaluation Plan (10 points)**: Please discuss capacity to identify/develop and monitor performance measures and an evaluation plan; and collect, analyze and submit data at both the population health and individual patient level. This evaluation plan should identify specific data sources that will be used to measures outcomes (for example, EHR data, claims data, etc.).

Additional Selection Considerations

Selection will also include consideration of diverse representation of state [and territorial, if applicable] health agencies such as agency structure (i.e., centralized versus decentralized), geography, and organizational structure within government.

V. Submission Information

Application Procedure

The application deadline is Friday, April 28th, 2017, 3:00pm EDT/12:00pm PST**.** Please submit an electronic copy of the application via email to Elizabeth Walker Romero (email: eromero@astho.org) and Lynn Shaull (email: lshaull@astho.org).

Incomplete applications or applications received after the deadline will not be considered.

Timeline

- April 14, 2017: Deadline for submitting notice of intent to apply
- April 28, 2017 at 5:00pm EDT: Deadline for submission of grant proposals
- Week of May 8, 2017: Contract award announced
- May 15, 2017: Contract period commences
- June 30, 2017: Phase I Ends
- June 30, 2017: Final invoice and invoice narrative due

Applicant Questions and Guidance
ASTHO will support interested applicants to offer guidance and address specific questions about the RFP.

Disclaimer Notice:
This RFP is not binding on ASTHO, nor does it constitute a contractual offer. Without limiting the foregoing, ASTHO reserves the right, in its sole discretion, to reject any or all proposals; to modify, supplement, or cancel the RFP; to waive any deviation from the RFP; to negotiate regarding any proposal; and to negotiate final terms and conditions that may differ from those stated in the RFP. Under no circumstances shall ASTHO be liable for any costs incurred by any person in connection with the preparation and submission of a response to this RFP.

ATTACHMENT B: DRAFT SUBRECIPIENT AGREEMENT

This Agreement, entered into as of this 8th day of May, 2017 by and between the Association of State and Territorial Health Officials (hereinafter referred to as "ASTHO") and "SUBRECIPIENT'S NAME" (hereinafter referred to as "Contractor").

WHEREAS, ASTHO desires to engage the Contractor to serve as a demonstration state and enhance their state public health and public and private payer collaboration around a specific initiative to improve population health, in connection with an undertaking or project titled, "*State Public Health Collaborative to Improve Cardiovascular Health Outcomes*" funded wholly or in part by the U.S. Department of Health and Human Services (hereinafter referred to as the "Project"); and

WHEREAS, the Contractor desires to render such services in connection with the Project,

NOW, THEREFORE, in consideration of the above, and the mutual covenants and agreements hereinafter contained, the parties hereto agree as follows:

1. **Engagement**. ASTHO hereby engages the Contractor, and the Contractor hereby accepts the engagement, to perform the work set forth in the attached Scope of Work, which is incorporated by reference and made a part of this Agreement.

2. **Term**. This Agreement shall commence August 1, 2016 and shall continue until June 30, 2017 unless earlier terminated as allowed pursuant to the General Terms and Conditions. Work under this Agreement shall be completed within the time schedule set forth in the attached Scope of Work.

3. **Compensation**. The Contractor shall be compensated for the work to be performed under this Agreement as detailed in the attached Scope of Work. In no event will the total compensation to be paid to the Contractor exceed the sum of **$20,000.**

4. **Terms and Conditions**. The "General Terms and Conditions" and any Addendums, all of which are attached hereto, are incorporated by reference and made a part of this Agreement. The Contractor must return an executed copy of this Agreement to ASTHO within 10 business days of receipt or the contract will be cancelled. ASTHO reserves the right to accept or decline any proposed changes to the terms and conditions.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date set forth below.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS	**SUBRECIPIENT ENTITY NAME**
_____	_____
Signature	Signature
John Mericsko, Chief Operating Officer	_____
Name and Title	Name and Title
Date: _____	Date: _____

CONTRACTUAL CONTACT INFORMATION

ASTHO Contacts	Contracting Party Contacts
For programmatic issues & invoice submission Elizabeth Walker Romero Senior Director, Health Improvement Association of State and Territorial Health Officials 2231 Crystal Drive, Suite 450 Arlington, VA 22202 Email: eromero@astho.org Phone: 571-527-3170	***For programmatic issues*** Name: Full Name of Programmatic Lead Title: Full Position Title Organization: Full Organization/Entity name Address: Full physical mailing address City, State, Zip code: Email: Phone:
For contract and financial issues Evangeline Crawford Director, Grants and Contracts Association of State and Territorial Health Officials 2231 Crystal Drive, Suite 450 Arlington, VA 22202 Email: ecrawford@astho.org Phone: 571-527-3178	***For contract and financial issues*** Name: Full Name of Fiscal/Contracting Lead Title: Full Position Title Organization: Full Organization/Entity name Address: Full physical mailing address City, State, Zip code: Email: Phone:

Attachments incorporated as part of this Agreement:

X General Terms and Conditions

___ Special Terms and Conditions

X Scope of Work

X Travel Policies

X Style Guidelines

X Debarment Certification

X Sub-recipient Addendum

X Other: Subrecipient's Proposal, Budget, and Budget Narrative

GENERAL TERMS AND CONDITIONS

1. Definitions
A. *Agreement* shall mean the Master Agreement entered into between Contractor and ASTHO, including the Scope of Work, these General Terms and Conditions, and any other Addendums, attachments and exhibits.

B. *Services* shall mean those services Contractor is to provide pursuant to the Agreement, including any Scope of Work.

C. *Work* shall mean all work, deliverables, documents, data, goods, and other materials produced, developed, collected, or authored by Contractor pursuant to the Agreement.

D. *Concerned Funding Agency* means the U.S. Department of Health and Human Services or any other governmental entity providing funding, in whole or in part, related to the Agreement.

2. Relationship
The Contractor is an independent contractor, and the relationship between ASTHO and the Contractor shall be solely contractual and not in the nature of a partnership, joint venture, or general agency. Neither party may speak nor act on behalf of the other, nor legally commit the other.

3. Ownership Rights
The services provided by the Contractor pursuant to the Agreement shall be "work for hire" and therefore all Work shall be sole and exclusive property of ASTHO. To the extent that the Services, or any part of them, may not constitute work for hire under the law, Contractor hereby transfers to ASTHO all right, title, and interest in and to the Work.

Notwithstanding the foregoing, should the Work incorporate pre-existing materials owned by Contractor, Contractor shall retain all ownership rights to those materials, and ASTHO shall have a perpetual, irrevocable, royalty-free license to utilize the pre-existing materials as incorporated in the Work.

Without limiting the foregoing, ASTHO shall have access to the Work at any time during the term of the Agreement.

4. Warranties and Representations
The Contractor warrants and represents that: (a) the Services shall conform to the Scope of Work in all respects; (b) the Work shall be original to the Contractor and shall not infringe the copyright or other rights of any party; (c) the Contractor possesses, and shall employ, the resources necessary to perform the Services in conformance with the Agreement; (d) the Services shall be performed, and the Work produced, in accordance with high standards of expertise, quality, diligence, professionalism, integrity, and timeliness; and (e) the Contractor has no interest, relationship, or bias that could present a financial, philosophical, business, or other conflict with the performance of the Work or create a perception of a conflict or a lack of independence or objectivity in performing the Work.

5. Time of the Essence
Time is of the essence in respect of the Services to be performed and Work to be produced by the Contractor.

6. Compliance with the Law
The Contractor shall at all times act in accordance with all applicable governmental laws and regulations.

7. Key Personnel
Any personnel identified in the Scope of Work as individuals who will be performing the Services or producing the Work may not be changed without the written approval of ASTHO.

8. Publicity and Media
The Contractor shall not make any public statements or communications relating to the existence or performance of the Agreement, including the Services and the Work, or conduct any interviews or respond to any inquiries,

concerning the same, without the express written consent of ASTHO. All media inquiries shall be directed to the ASTHO Office of Communications.

9. Assignment and Subcontracting
The Contractor shall not assign or subcontract any portion of the Agreement, or its obligations or rights thereunder, without the prior written consent of ASTHO. Any attempted assignment or subcontracting in violation of this provision shall be void.

10. Review and Coordination
To ensure adequate review and evaluation of the Services and Work, and proper coordination among interested parties, ASTHO shall be kept fully informed concerning the progress of the Work and Services to be performed hereunder, and, further, ASTHO may require the Contractor to meet with designated officials of ASTHO from time to time to review the same.

11. Inspection of Work
The Contractor shall comply with any request to make the Work available, in its then current status, to authorized representatives of ASTHO and/or of any Concerned Funding Agency for inspection and review in order to assess compliance with, and progress toward completion of, the Agreement. The Contractor shall fully cooperate in any such inspection and review.

12. Confidential Information
Any information regarding ASTHO that is not generally publicly known or available, whether or not such information would constitute a trade secret under statutory or common law, that is disclosed to or discovered by the Contractor during the course of the Agreement (hereinafter, "Confidential Information") shall be considered confidential and proprietary to ASTHO, and the Contractor shall maintain all Confidential Information in confidence; shall employ reasonable efforts to ensure the security of the Confidential Information; and shall not disclose the Confidential Information to any third party or use the Confidential Information except as necessary to perform the Services or produce the Work.

Should the Contractor receive a subpoena directing disclosure of any Confidential Information, the Contractor shall immediately inform ASTHO and cooperate fully with ASTHO in responding to the subpoena.

13. Financial Record Keeping and Inspection
The Contractor warrants that it shall, during the term of the Agreement and for a period of three (3) years following the date of submission of the final expenditure report, maintain accurate and complete financial records, including accounts, books, and other records related to charges, costs, disbursements, and expenses, in accordance with generally accepted accounting principles and practices, consistently applied. ASTHO, directly or through its authorized agents, auditors or other independent accounting firm, at its own expense, and the Concerned Funding Agency directly or through its duly authorized representatives, shall have the right, from time to time, upon at least ten (10) days' notice, to audit, inspect, and copy the Contractor's records. The Contractor shall fully cooperate, including by making available such of its personnel, records and facilities as are reasonably requested by ASTHO or the Concerned Funding Agency. This Section shall remain in force during the term of the Agreement and for the three (3) years following the termination or expiration of the Agreement. If an audit, litigation, or other action involving the records is started before the end of the three (3) year period, Contractor agrees to maintain the records until the end of the three (3) year period or until the audit, litigation, or other action is completed, whichever is later.

The Contractor further acknowledges and agrees that in the event the Contractor s has expenditures of $750,000 or more in total federal awards, including this Agreement, Contractor shall be subject to audit by the federal government as provided for under OMB Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Omni Circular"). Contractor further agrees to cooperate and to promptly furnish any requested information in the course of any audit of ASTHO by the federal government under the Omni Circular.

14. Remedies
The Contractor acknowledges that monetary damages alone will not adequately compensate ASTHO in the event of a breach by the Contractor of the restrictions imposed and set forth in Sections paragraph 12 and 13, and therefore the Contractor hereby agrees that in addition to all remedies available to ASTHO at law or in equity, including, any

applicable State trade secrets law, ASTHO shall be entitled to interim restraints and permanent injunctive relief for enforcement thereof, and to an accounting and payment of all receipts realized by the Contractor as a result of such breach.

15. Allowable Costs
Allowable costs shall be determined in accordance with the OMB Circular as well as by the terms of the agreement between ASTHO and the Concerned Funding Agency, and any rules of, or guidelines issued by, the Concerned Funding Agency. The Contractor is responsible for reimbursing ASTHO in a timely and prompt manner for any payment made under this subcontract which is subsequently determined to be unallowable by ASTHO, the Concerned Funding Agency, or other appropriate Federal or State officials.

16. Concerned Funding Agency
The Contractor shall comply with all rules, regulations, policies, and requirements of the Concerned Funding Agency applicable to agreements such as this Agreement. Without limiting the foregoing, when the Concerned Federal Agency is HHS, these shall include in particular: the HHS Grants Policy Statement; **the salary rate limitation prohibiting HHS funds from being used to pay the direct salary of an individual at a rate in excess of the federal Executive Schedule Level II (see table below**); and the prohibition on utilizing HHS funds in connection with federal lobbying activity funds (45 CFR Part 93).

Executive Level II Salary Rates	
October 1, 2012 - January 11, 2014	$179,700
January 12, 2014 - January 10, 2015	$181,500
January 11, 2015 - January 9, 2016	$183,300
January 10, 2016 - September 30, 2016	$185,100
January 8, 2017 - September 30, 2017	$187,000

Contractor confirms that it has disclosed to the Concerned Funding Agency in writing and on a timely basis (a) any potential conflict of interest in accordance with applicable Agency policy; and (2) all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award.

This Agreement is subject to the terms of any agreement between ASTHO and a Concerned Funding Agency and in particular may be terminated by ASTHO without penalty or further obligation if the Concerned Funding Agency terminates, suspends or materially reduces its funding for any reason. Additionally, the payment obligations of ASTHO under this Agreement are subject to the timely fulfillment by Concerned Funding Agency of its funding obligations to ASTHO.

17. Flowdown Provisions
The Contractor agrees to assume, as to ASTHO, the same obligations and responsibilities that ASTHO assumes toward the Concerned Funding Agency under those Federal Acquisition Regulations (FAR), if any, and applicable Concerned Funding Agency acquisition regulations, if any, that are mandated by their own terms or other law or regulation to flowdown to subcontractors or subgrantees, and therefore the Agreement incorporates by reference, and the Contractor is subject to, all such mandatory flowdown clauses. Such clauses, however, shall not be construed as bestowing any rights or privileges on the Contractor beyond what is allowed by or provided for in the Agreement, or as limiting any rights or privileges of ASTHO otherwise allowed by or provided for in the Agreement. The Contractor also agrees to flowdown these same provisions to any lower-tier subcontractors.

18. Term and Termination
The Agreement shall be for such term as is set forth in the Agreement. The Agreement may be terminated by ASTHO prior to the end of any term on fifteen (15) days written notice.

In addition, this Agreement may be terminated by either party on written notice should the other party: (a) fail to cure a material breach within ten (10) days of delivery of written notice; (b) become insolvent; (c) be the subject of a bankruptcy filing; or (d) cease doing business.

Upon termination, the Contractor shall deliver to ASTHO: all Work, whether in final or draft form, that has been produced as of the date of termination; all Confidential Information; and any materials or items previously provided

to the Contractor by ASTHO. Upon receipt thereof by ASTHO, the Contractor shall be paid for work performed through the date of termination.

In all instances of terminations, the Contractor shall use best efforts to not incur new costs and expenses after the notice of termination, and shall cancel as many outstanding obligations as possible.

19. Indemnification
Should one party (the "Indemnified Party") incur or suffer any liability, damage, or expense, including reasonable attorney's fees, in connection with the defense of a legal proceeding brought by a third party arising out of the negligent or other wrongful actions of the other party (the "Indemnifying Party"), then the Indemnifying Party shall indemnify and hold harmless the Indemnified Party for such liability, damage, or expense. Notwithstanding the foregoing, **in the event the Contractor is prohibited by law** from contractually obligating itself to provide indemnification, this Section shall be void.

20. Special Damages
Neither party shall be liable to the other for consequential or indirect damages, including lost profits, or for punitive damages, arising from breach of the Agreement.

21. Limitation of Liability
Notwithstanding any other provision of the Agreement, under no circumstances shall the liability of ASTHO to the Contractor exceed the total amount of compensation to be paid to the Contractor.

22. Insurance
The Contractor shall effect and maintain with a reputable insurance company a policy or policies of insurance providing an adequate level of coverage in respect of all risks which may be incurred by the Contractor, arising out of the Contractor's performance of the Agreement, in respect of death or personal injury, or loss of or damage to property. The Contractor shall produce to ASTHO, on request, copies of all insurance policies referred to in this condition or other evidence confirming the existence and extent of the coverage given by those policies, together with receipts or other evidence of payment of the latest premiums due under those policies. Notwithstanding the foregoing, **in the event the Contractor is prohibited by law** from contractually obligating itself to obtain insurance coverage as required above, this Section shall be void.

23. Governing Law; Forum Selection.
This contract is deemed made in the Commonwealth of Virginia and shall be governed by, subject to, and construed in accordance with the laws of the Commonwealth of Virginia (without giving effect to its conflict of law rules). All actions, suits or proceedings between the parties hereto with respect to the Agreement shall be litigated in the State or federal courts located in the Commonwealth of Virginia. Notwithstanding the foregoing, **in the event the Contractor is prohibited by law** from contractually designating the law of any other State as being controlling, then this Agreement shall be governed by, subject to, and construed in accordance with the laws of the State of residence of the Contractor, and the forum selection provision shall be void.

24. Waiver
No failure or delay by either party to exercise any right, power or remedy will operate as a waiver of the same, nor will any partial exercise preclude any further exercise of the same or some other right, power or remedy.

25. Entire Agreement
The Agreement constitutes the entire agreement between the parties relating to the subject matter of the contract. The Agreement supersedes all prior negotiations, representations and undertakings, whether written or oral.

26. Modification
The Agreement may not be modified except by further written agreement signed by the parties. The parties may enter into a change letter that modifies any aspect of the Agreement or any Addendum or Attachment, including the Scope or Services, rather than issuing a new version of the affected document.

27. Severability
If for any reason any part of the Agreement is held to be unenforceable, illegal or invalid, that unenforceability,

illegality or invalidity will not affect any other provisions, which will continue in full force and effect.

28. Successors and Assigns
The Agreement shall be binding on the parties' respective successors, heirs, and permitted assigns.

29. Survival
Those provisions that logically would survive termination or that impose requirements beyond the stated term, and this Section 29, shall survive termination of this the Agreement.

30. Contractor Employee Whistleblower Rights and Requirement to Inform Employees of Whistleblower Rights.

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908. Specifically, no employee of Contractor may be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing to those federal employees and other persons listed in 41 U.S.C. 4712(a)(2) information that the employee reasonably believes is evidence of gross mismanagement of a Federal contract or grant, a gross waste of Federal funds, an abuse of authority relating to a Federal contract or grant, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a Federal contract (including the competition for or negotiation of a contract) or grant.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation (FAR).

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold (currently $150,000) as described in section 2.101 of FAR.

SCOPE OF WORK

A. General Description of Engagement

ASTHO will provide funding to one state health agency to be a demonstration state and enhance their state public health and public and private payer collaboration around a specific initiative to improve population health. Their required activities will be informed by the issues for consideration and strategies that come from the round table meeting.

- The demonstration state will implement activities outlined in their application. It will report on progress through progress reports prior to each learning session meeting and through a final report.
- ASTHO will support the state with funding and targeted TA through a combination of in-person and virtual learning session meetings, including 2-3 virtual meetings and 2 in-person meetings.
- ASTHO will develop a case study outlining its work with the demonstration state, highlighting successes, challenges, and lessons learned. The case study will inform future work with this state, and that of potential others.

B. Textual Description of Key Tasks

Sub-recipient is expected to participate in the learning collaborative to enhance their state public health and payer collaborations through virtual and in-person meetings, calls, and webinars. This includes presentations to and discussions with public and private payer leaders on systems changes, best practices, successes, and how to overcome barriers and challenges.

The required learning collaborative activities include:

1. Participate in Virtual Kick-Off Call.
2. Participate and engage with stakeholders at an in-person site visit facilitated by ASTHO.
3. Participate in an additional two virtual meetings at which sub-recipient will present project updates.
4. Submit evaluation data reports bimonthly
5. Participate and engage with stakeholders during a final in-person state visit facilitated by ASTHO,
6. Submit a final report to ASTHO on June 30, 2017.
7. Submit progress report and invoice to ASTHO monthly.

See attached Proposal, budget, and budget narrative for additional details.

C. Summary Table of Tasks, Deliverables, and Due Dates

TASK	DELIVERABLE	DUE DATE
1	Participate in Virtual Kick-Off Call.	06/01/17
2	Participate and engage with stakeholders at an in-person site visit facilitated by ASTHO.	06/01/17
3	Participate in an additional two virtual meetings at which sub-recipients will present project updates.	06/01/17

4	Submit evaluation data reports bimonthly	6/01/17
5	Participate and engage with stakeholders during a final in-person state visit facilitated by ASTHO.	6/01/17
6	Submit a final report to ASTHO	6/30/17
7	Submit progress report and invoice to ASTHO monthly	Ongoing

D. Compensation and Reporting Requirements

Contractor shall be compensated on a cost reimbursement basis according to the financial budget prepared by Contractor, approved by ASTHO, and attached to this Agreement. The total reimbursable amount may not exceed **$20,000.** Reallocations of less than 10% of a line item or $500 between budgeted line items are allowed but the ASTHO programmatic and financial contacts must be notified within thirty days. Reallocations of more than these amounts may be allowed but must be approved in advance by ASTHO. All incurred costs must be reasonable and conform to any provision of this Agreement regarding Allowable Costs.

Per Section 9 of the General Terms and Conditions, subcontractors require prior written consent of the ASTHO. Approval of the attached budget does not constitute this consent. Once a subcontractor has been determined, the Contractor must request written approval from ASTHO to subcontract. Use of subcontractors does not relieve Contractor of its obligations under this Agreement, and Contractor shall at all times remain responsible for the performance of, and payment for work performed by, its Subcontractors. Contractor shall enter into a written subcontract with each of its Subcontractors that (a) makes the terms and conditions of this Agreement binding on the Subcontractor to the same extent such provisions are binding on the Contractor, and (b) states that the Subcontractor is without privity of contract to ASTHO and by entering into the subcontract the Subcontractor does not acquire any rights against ASTHO.

Contractor must submit invoices to the program contact listed on page two of this agreement and **send an electronic copy to PreventionInvoice@astho.org to receive payment**. Contractor shall render an invoice to ASTHO on a monthly basis on or before the last day of the subsequent month in which expenses were incurred. A narrative report describing activities conducted during the period must accompany each invoice. Upon Contractor's presentation of an invoice, ASTHO will review the invoice and pay Contractor for work that has been judged acceptable for any approved invoice. The invoice must detail current period expenditures and cumulative expenditures versus the approved budget. Payment of the final invoice will not be made until all work has been completed and has been judged acceptable by ASTHO. Contractor must submit final invoice within 30 days of contract end date**, no later than 5 p.m. (EST) July 30, 2017,** to receive payment. Invoice(s) will be paid within 30 days of receipt at ASTHO. The Contractor shall return to ASTHO all overpayments, such as those due to actual rates or costs being less than estimated or provisional rates, or due to any other cause, in a timely and prompt manner.

Reporting Requirements:

Contractor is required to participate in meetings, calls, and learning sessions and report on the project during each session. The awardees will report on their progress through presentations and progress reports at the following intervals: initial kick-off call; in-person meetings; virtual meetings; data submissions every other month; and a final report. The awardees will also be responsible for submitting monthly progress report and invoice to ASTHO.

Contractor must also:

- Implement activities outlined in their application and will report on progress through progress reports prior to each learning session meeting and through a final report.
- Participate in an additional two virtual meetings at which sub-recipient will present project updates.

- May 30, 2017: Phase II (contingent on funding availability) Scope of Work and Budget due.
- Early June 2017: Participate in Stakeholder Meeting 2/Site Visit.
- Participate and engage with stakeholders during a final in-person state visit facilitated by ASTHO.
- Submit a final report to ASTHO on June 30, 2017.
- Submit progress report, including data to highlight project outcomes, and invoice to ASTHO monthly.
- Submit final invoice and final invoice narrative by June 30, 2017.
- Participate in, and complete the project activities above (see Project Activities section of the RFP). Contractor must invite stakeholder partners and identify a meeting space for these calls/meetings.
- Submit processes, experiences/best practices, tools, and resources developed through this project with state team partners, state leadership, ASTHO staff, and possibly the funder, national partners, and other stakeholders as appropriate.
- Feedback and suggestions on project activities as requested via questionnaires and/or interviews with ASTHO staff.

E. Key Personnel

The active participation of the following person(s) is a material condition of this agreement:

1. State Health Agency Lead as identified by state health official
2. A lead Deputy or Chief of Staff for the Agency
3. Any additional in-house expertise necessary to effectively plan the selected strategies.
4. Key leadership from at least one private payer
5. Any additional in-house expertise necessary to effectively plan the selected strategies.

CONTRACT BUDGET TEMPLATE

I. CONTRACT INFORMATION

Sub Awardee Name	ENTITY / ORGANIZATION NAME	*ASTHO Lead Staff*	Elizabeth Walker Romero, Lynn Shaull
Project Name	State Public Health Collaborative to Improve Cardiovascular Health Outcomes (Phase I)	*Period of Performance*	05/08/17 - 06/30/17
Project Code	83-10194	*Payment Method*	Cost Reimbursement
Date Submitted	3/15/2017	*Total Budget Amount*	$ 20,000.00

II. DIRECT LABOR

Project Task	Personnel	Duration (Months)	% FTE	Salary ($)	Total Cost
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
SUBTOTAL DIRECT LABOR					$ -
FRINGE BENEFITS (%)					$ -
SUBTOTAL DIRECT LABOR + FRINGE					$ -

III. CONSULTANTS/CONTRACTORS (e.g. a temp agency, subcontract, etc.)

Consultant/Contractor Name	Rate	# of Hours	Total Cost
			$ -
			$ -
			$ -
			$ -
			$ -
SUBTOTAL CONSULTANTS/CONTRACTORS			$ -

IV. MATERIALS/SUPPLIES

Item	Cost/Unit	# of Units	Total Cost
			$ -
			$ -
			$ -
			$ -
			$ -
SUBTOTAL DIRECT MATERIALS			$ -

V. TRAVEL

Travel Expense	Total Cost
SUBTOTAL TRAVEL	$ -

VI. OTHER EXPENSES

Item	Total Cost
SUBTOTAL OTHER EXPENSES	$ -

VII. TOTAL DIRECT COSTS

SUBTOTAL TOTAL DIRECT COSTS	$ -

VIII. INDIRECT COSTS

G&A/Indirect Costs	Percentage %	Cost	Total Cost
Indirect Cost Rate/G&A			$ -
Indirect Costs			$ -
SUBTOTAL INDIRECT COSTS			$ -
TOTAL REQUESTED BUDGET AMOUNT			$ -

BUDGET NARRATIVE

Instructions: Please use this section to provide details and explain the line items requested within the contract budget and why each is needed to accomplish the scope of work. Relevant experience and skills should be described for all personnel listed. Costs must prove to be reasonable, allowable, and allocable. If using a fixed price payment method, please identify payment schedule as it relates to the completion of each task within the justification section.

II. DIRECT LABOR		
Project Task	Personnel	Justification
0	0	
0	0	
0	0	
0	0	
0	0	
0	0	
0	0	
0	0	
0	0	
0	0	

FRINGE BENEFITS (%)	Justification
0%	

III. CONSULTANTS/CONTRACTORS (e.g. a temp agency, subcontract, etc.)	
Consultant/Contractor Name	Justification
0	
0	
0	
0	
0	

IV. MATERIALS/SUPPLIES	
Item	Justification
0	
0	
0	
0	
0	

V. TRAVEL	
Travel Expense	Justification
0	
0	
0	
0	
0	

VI. OTHER EXPENSES	
Item	Justification
0	
0	
0	
0	
0	

VIII. INDIRECT COSTS		
G&A/Indirect Costs	Percentage/Cost	Justification
Indirect Cost Rate/G&A	0%	
Indirect Costs	0	

Association Of State And Territorial Health Officials
2231 Crystal Drive, Suite 450 | Arlington, Virginia 22202
(202) 371-9090 | www.astho.org

ASTHO Travel and Reimbursement Procedures
CONTRACTORS

- ***Airfare***: Is allowed and should be on "American" carriers, unless doing so would be disadvantageous to ASTHO. Costs in excess of the lowest available commercial discount fare or standard coach fare are unallowable, except for the following: Would require circuitous route, add lengthy delays that affects the traveler's ability to reasonably meet other work-related obligations, or does not provide for medical needs of the traveler. Travelers must justify the use of a fare greater than lowest available fare. ASTHO requires pre-approval of any airfare greater than $500.00. ASTHO will pay airfare to/from the traveler's nearest airport to/from meeting location airport or within 25 miles of such airport if more than one is available. The cost of canceling and rebooking ticket is not reimbursable, unless it can be shown that it was necessary or required for legitimate business reasons. In addition, ASTHO will pay for check baggage as follows: 1 bag for expected stay of 5 days or less; 2 bags for expected stay of 5 days or more. ASTHO will not reimburse for excess or overweight baggage.

- ***Rail Transportation***: Is an allowed transportation expenses and can be used when either flying or driving is not feasible or for health or other approved reasons. Approval is required for rail services when the associated cost of flying is lower than rail service by more than $75.00. Rail service should be in coach class.

- ***Lodging***: Is allowed and cannot exceed the GSA lodging per diem for the location in which ASTHO business is being conducted. If lodging cannot be found within the GSA rate, prior approval from the CFO is required. Local or long distance phone calls directly from the hotel room will not reimbursed.

- ***Personal Vehicle Transportation***: Travelers using personal automobiles on ASTHO business will be reimbursed at a per mile rate, based on the IRS rate at the time of travel. At no time will ASTHO reimburse more than the cost that would have been incurred had rail or air transportation been used. Any expected mileage over $300.00 requires prior approval. Use of the personal vehicles is permitted provided the traveler has a valid driver's license and has adequate insurance protection as required by state law in which the vehicle is registered. Automobile liability, bodily injury and property and physical damage insurance while on ASTHO travel is the responsibility of the traveler. ASTHO will reimburse travelers for travel from/to their home/place of business to/from the airport.

- ***Meals***: Travelers will be reimbursed according to the GSA meals and incidentals per diem rate (currently $69/day for Arlington, VA). The first day of travel is paid at 75% of the full per diem rate. Deductions from the per diem amount will be made when the

meeting or conference included that particular meal, except for documented dietary restrictions not able to be accommodated by the conference restaurant or caterer.

- ***Rental Vehicle Transportation***: Rental vehicles are an allowed expense when the total expected costs to be incurred, including parking, fuel, and GPS, are less than using other modes of transportation such as taxis or shuttles. If a rented vehicle is used, the most economical vehicle adequate for business requirement must be used. There must be a clear advantage to justify the use of a rented vehicle. Travelers should refuel rental vehicles prior to return to the vendor if not the traveler is responsible for the difference in pricing between the average gas price and that charged by the rental agency including surcharges.

- ***Taxi & Shuttle Transportation***: Travelers will be reimbursed for transportation to/from airport to/from hotel. In addition, any taxi & shuttle services to related events or gatherings will be reimbursed. When possible travelers should share taxis and shuttles to minimize costs.

Reimbursement Process

- ***Receipts***: Receipts are required regardless of amount for air/rail transportation, lodging expenses, and car rentals. Detailed, itemized receipts are required for all expenditures over $75.00 except for the meals & incidentals per diem; any expenditure without a receipt will only be paid up to the $75.00 maximum. Original copy of receipts are not required.

Style Guidelines

ASTHO often works with outside experts and writers when developing publications. The following style guidelines must be followed in any work developed by an outside contractor. If you have questions about the guidelines below, please contact the ASTHO Communications team at communications@astho.org.

ASTHO publications undergo an internal review process before publication. Please be aware that that review process may generate questions for you. We appreciate your assistance in resolving any questions that arise prior to the publication of your document.

General Guidelines

- Use one space after an exclamation point, period, question mark, or colon.
- Documents should be single-spaced with a 10 pt. space after paragraph breaks.
- ASTHO uses serial commas (e.g., "bread, milk, and cheese" not "bread, milk and cheese").
- Use active voice ("The agency conducted a survey," not "A survey was conducted by the agency").
- ASTHO requires an executive summary on any document longer than six pages. Executive summaries are particularly important for documents aimed at a state or territorial health official audience.
    - Executive summaries are usually proportional in length to the larger work they summarize. Most executive summaries are one or two paragraphs, and all executive summaries should be no more than a page.

Abbreviations and Acronyms

- You may use the following acronyms on first use without needing to write out the full name: APHA, APSR, CDC, EPA, FDA, FEMA, HHS, HRSA, NACCHO, NGA, and USDA.
- In all other cases, do not list an organization's name abbreviation unless the abbreviation will be used again in the place of the organization's full, proper name.
- Try to keep use of abbreviations to a minimum by spelling out the full name of any organization that is referenced infrequently in your document. While abbreviations save space, too many abbreviations can be difficult for a reader to keep track of.
- Do not put a "the" before acronyms or abbreviations.

Lists

- Ensure parallel construction. If the first bullet starts with a declarative sentence in the present tense, the rest need to do the same.

- Begin list items with a capital letter. End list items with a period unless they are very short (i.e., one or two words). Do not use semicolons in lists. No *and* is needed before the last bullet.
- Use only one line space between a paragraph and a list.

Graphics

- Label all figures, charts, and graphs in sequence, using "Figure 1," "Figure 2," etc.
- Do not use graphics without referencing them in the text. Conversely, do not use graphics and then repeat the same information in text. Reference the table rather than repeating it.
- Graphic language, color, format, etc. should be as consistent as possible throughout your document.
- If a document will be professionally designed and printed, graphs/charts must either be provided as separate image files in high-resolution format (not embedded in a Word document), or the original data must be provided so the designer can recreate the figure.
- If using figures from other organizations, ASTHO must have written permission from that organization to use the figure in question, unless it is from a federal agency or otherwise in the public domain. (This includes state health agencies—state agencies' work is not public domain as a federal agency's work would be.)

Citations and Explanatory Footnotes

- Use **endnotes** for references or citations. Endnotes should use Arabic numerals (even though Word often defaults to Roman numerals).
- Use **footnotes** when you want to provide additional information, explanation, or comments about the text without interrupting the document's flow. Insert a Roman numeral or asterisk immediately after the section you want to explain (Roman numerals/asterisks allow footnotes to remain separate from any endnotes in the document, to avoid confusion).
- When appearing at the end of a sentence citation numbers should be outside of any punctuation marks. Example: This sentence has a citation number at the end of it.[1]
- There should not be any spaces between the superscript numeral/asterisk and the word or punctuation mark preceding it.
- You can substitute *ibid* for a citation if you are citing the same source consecutively. Use ibid only when citing the identical source as the immediately preceding citation.
- Citations should be numbered consecutively, rather than re-using citation numbers. (Exceptions can be made when there are space constraints or specific funder requests.)
- All citations **must** follow ASTHO citation style; examples are given in the chart below. If you are citing a document type not listed below, default to the format for website/web page.

Type of Entry	Example
Book—single author.	Shepard TH. *Catalog of Teratogenic Agents*. 7th ed. Baltimore, MD: Johns Hopkins Press. 1992.

Book—more than one author. (List all authors if three or less, otherwise list first three followed by "*et al*.")	Baselt RC, Cravey RH. *Disposition of Toxic Drugs and Chemicals in Man*. 4th ed. Foster City, CA: Chemical Toxicology Institute. 1995.
Book—with editors.	Armitage JO, Antman KH, (eds.) *High-dose Cancer Therapy: Pharmacology, Hematopoietins, Stem Cells*. Baltimore, MD: Williams & Wilkins. 1995.
Chapter from a book.	Degner LF, McWilliams ME. "Challenges in conducting cross-national nursing research." In: *Fitzpatrick JJ, Stevenson JS, Polis NS, (eds.) Nursing Research and Its Utilization: International State of the Science*. New York, NY: Springer. 1994. 211-215.
Article from journal—single author.	Moldofsky H. "Sleep, neuroimmune and neuroendocrine functions in fibromyalgia and chronic fatigue syndrome." *Adv Neuroimmunol*. 1995. 5:39-56. Available at www.ncbi.nlm.nih.gov/pubmed/7795892. Accessed 7-25-2013.
Article from journal—more than one author. (List all authors if three or less, otherwise list first three followed by "*et al*.")	Raux H, Coulon P, Lafay F, *et al*. "Monoclonal antibodies which recognize the acidic configuration of the rabies glycoprotein at the surface of the virion can be neutralizing." *Virology*. 1995. 210:400-408. Available at http://www.ncbi.nlm.nih.gov/pubmed/7542418. Accessed 7-25-2013.
Conference presentation.	Moldofsky H. "Sleep, neuroimmune and neuroendocrine functions in fibromyalgia and chronic fatigue syndrome." Presented at American Public Health Association Annual Meeting. 2013. Available at http://www.ncbi.nlm.nih.gov/pubmed/7795892. Accessed 7-25-2013.
Monographic series.	Davidoff RA. *Migraine: Manifestations, Pathogenesis, and Management*. Philadelphia, PA: FA Davis. 1995. Contemporary Neurology Series, No. 42.
Online journals with volume and page information.	Simon JA, Hudes ES. "Relationship of ascorbic acid to blood lead levels." *Journal of the American Medical Association* [serial online]. 1999. 281:2289-2293. Available from American Medical Association, Chicago, IL. Available at http://jama.jamanetwork.com/article.aspx?articleid=190540. Accessed 7-25-2013.

Online journals without volume and page information	Gordon GF. "Bypassing heart surgery." *Alternative Medicine* [serial online]. 1999. Issue 30. Accessed 9-30-2004.
Personal e-mail. (Citation is written into the text, not cited in the reference list.)	Chafez LA (personal communication, Jan. 28, 1997).
Website/web page.	CDC. "Protect Your Family from Rabies." Available at http://www.cdc.gov/Features/RabiesSafeFamily/. Accessed 7-25-2013.
News article.	Parker-Pope T. "Black-White Divide Persists in Breast Cancer." *New York Times*. July 23, 2013: A10. Available http://well.blogs.nytimes.com/2013/07/23/black-white-divide-persists-in-breast-cancer/?ref=health. Accessed 7-24-2013.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION

This form must be signed and submitted along with the signed contract.

In accordance with Executive Order 12549 and Executive Order 12689, entitled Debarment and Suspension, and any applicable implementing regulations, this certification must be completed by the Contractor and any subcontractors.

1. Under penalty of perjury, except as noted below, all persons or firms or any person associated therewith in the capacity of owner, partner, director, officer, or manager:

   a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency;

   b) Have not, within the three (3) year period preceding this certification, been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction, violation of Federal or state antitrust statutes, or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

   c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses listed in subparagraph (1)(b) of this certification; and

   d) Have not, within the three (3) year period preceding this certification, had one or more public transactions (Federal, state, or local) terminated for cause or default.

2. If such persons or firms later become aware of any information contradicting the statements of paragraph (1), they will promptly provide that information to ASTHO.

Name of Contractor: _____

Signature: _____ Date: _____

Printed Name and Title of Signer: _____

FEDERAL SUBRECIPIENT ADDENDUM

The Contractor's status as a "Sub-recipient" as that term is defined in the Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards, 2 CFR Part 200 ("Omni Circular") imposes additional disclosure and reporting requirements on both ASTHO and the Contractor.

1. General Information:

A) CFDA Title: PPHF 2013: OSTLTS Partnerships – CBA of the Public Health System
B) CFDA Number: 93.424

C) DUNS Number (9 digits): _____ (Contractor to Complete)
D) NAICS Code: _____ (Contractor to complete)
E) Zip + 4 of address where work will be completed _____ (Contractor to complete)
F) Congressional district: _____ (Contractor to complete)

G) Award Name: State Public Health Collaborative to Improve Cardiovascular Health Outcomes
H) Award Number: 6 NU38OT000161-04-02 (Formerly: 3U38OT000161-03S4)
I) Award Date: 08/19/2016
J) Federal Agency Name: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
K) Awarding Official Contact Information: Ralph U Robinson (inp2@cdc.gov)
L) Period of Performance: 07/01/2016 – 06/30/2017
M) Sub-recipient Name: ENTITY / ORGANIZATION'S NAME
N) Pass-Through Entity: Association of State and Territorial Health Officials (ASTHO)

O) Amount of Federal Funds Obligated: $1,696,532
P) Total Amount of Federal Funds Obligated to Sub-recipient: $20,000 (Phase I)
Q) Total Amount of Federal Award: $17,906,742
R) R&D ___ [Y] __X[N]
S) Indirect Cost Rate: 31.70%

2. The following requirements must be complied with:

A) Federal Laws and Regulations: US Department of Health and Human Services Grants Policy Statement; Office of Management and Budget Omni Circular; 45 CFR Part 92 – Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local and Tribal Governments; 48 CFR Part 352-- Contract Clauses; 48 CFR §331.101-70 – Salary rate limitation; 45 CFR Part 93 – Restrictions on lobbying; the Federal Funding Accountability and Transparency Act and Federal statutes generally applicable to public contracts, including with respect to equal opportunity and civil rights.

B) Contract or Grant Agreement

3. Contractor shall have an active System for Award Management (SAM) registration, formerly Central Contractor Registry (CCR).

4. Contractor shall allow ASTHO to monitor activities to ensure use of the funds complies with the authorized purposes in compliance with Federal laws, regulations and the provisions of contracts or grant agreements and that performance goals are achieved.

5. Contractor shall meet the Omni Circular audit requirements within 120 days of Contractor's fiscal year.

6. If Contractor, in its preceding completed fiscal year, received (a) 80 percent or more of its annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (b) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements, then Contractor hereby reports the names and compensation of its five most highly compensated officers below. [Note: This compensation information need not be reported here if it is otherwise publicly available through periodic reports filed under the Securities Exchange Act (15 U.S.C.§78m(a), §78o(d)) or the Internal Revenue Code (26 U.S.C. §6104). If that is the case, please check here: _____.]

Name:	Compensation:
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____