Request for Proposal

National Colorectal Cancer Roundtable

REVISE & UPDATE: Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers

Request for Proposal Issue Date: June 18, 2020

Email Notification of Intent to Apply Due Date: July 8, 2020

Response Due Date: July 15, 2020

American Cancer Society

The American Cancer Society (ACS) is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from the disease.

Only ACS fights all cancers on all fronts: research, education, advocacy, and patient services. And only ACS has the organizational breadth, the grassroots volunteer capacity, and the wealth of public health experience necessary to dramatically improve the lives of millions of Americans facing cancer.

Cancer prevention is central to the mission and goals of ACS. As a community-based public health organization with local as well as national reach, ACS is uniquely positioned to address the goal of increasing cancer screening through numerous existing volunteer networks and partnerships. Its organizational structure enables staff and volunteers to disseminate, implement, and evaluate evidence-based strategies at the national, state, and local levels.

National Colorectal Cancer Roundtable

The National Colorectal Cancer Roundtable (NCCRT), established by ACS and the Centers for Disease Control and Prevention (CDC) in 1997, is a national coalition of more than 150 membership organizations, including public organizations, private organizations, voluntary organizations, and invited individuals, dedicated to reducing the incidence of and mortality from colorectal cancer (CRC) in the U.S., through coordinated leadership, strategic planning, and advocacy.

The ultimate goal of NCCRT is to increase the use of recommended CRC screening tests among the entire population for whom screening is appropriate. As part of this mission, the NCCRT has launched the 80% in Every Community initiative, which aims to ensure that CRC screening rates are reaching and exceeding 80% in communities and organizations across the nation. Since 2014, nearly 1800 organizations – including health plans, medical professional societies, academic centers, survivor groups, government agencies, cancer coalitions, cancer centers, and many others – have committed to make this goal a priority. Learn more about NCCRT and the 80% in Every Community initiative visit http://nccrt.org.

1.0 Overview – CRC Screening and Primary Care Practices

Colorectal cancer (CRC) is the third most commonly diagnosed cancer in both men and women and the second leading cause of cancer-related death in the U.S. when men and women are combined. In 2020, an estimated 147,950 new cases of CRC will be diagnosed and an estimated 53,200 deaths will occur due to CRC.

The real tragedy is that many CRC cases and deaths could be prevented if more people were offered and took advantage of CRC screening. CRC screening not only detects cancer early, it also prevents the cancer through the detection and removal of precancerous polyps. For those at average risk, it is important that screening begin by age 50. In fact, as trends are beginning to show colorectal cancer cases increasing in those younger than age 50, some leading public health organizations like the American Cancer Society now recommend starting screening at 45. Many evidence-based screening tests are available, including colonoscopy and non-colonoscopy options (e.g., stool-based tests, stool-DNA tests, and CT colonography). Despite the availability of these life-saving screening tests, about one in three adults between 50 and 75 years old are not getting screened as recommended. Screening rates are especially low among Hispanics, recent immigrants, and those with lower socioeconomic status, lower levels of education, and limited or no access to care.

Community health centers play a key and highly influential role in improving colorectal cancer screening rates in their communities and nationwide. In fact, throughout the NCCRT's 80% colorectal cancer screening campaigns, community health centers have proven to be optimal settings for promoting and recommending CRC screening to unscreened patient populations. According to the Uniform Data System (UDS), a national survey of Federally Qualified Health Centers, overall colorectal cancer screening rates in these centers have increased from 30 percent in 2012 to 44 percent in 2018. While this improvement is encouraging, screening rates in community health centers often still fall short of the national average (68.8 percent in 2018), thus suggesting enormous potential remains for community health centers to improve CRC screening rates. Moreover, due to the diverse patient populations served across the country, community health centers can support reductions in screening disparities that exist among different racial and ethnic communities as well as those communities that are more remote or socioeconomically challenged.

1.1 Project Overview

In 2014, the NCCRT's Community Health Centers Task Group developed a comprehensive toolkit entitled, *Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers (a.k.a. Steps Guide)*. The goal of this toolkit was to offer evidence-based, expert-endorsed recommendations for planning and implementing strategies in community health centers to improve CRC screening rates. The toolkit provided succinct steps-by-step instructions for community health center teams for implementing screening programs and policies along with guidance on evaluation and outcome tracking. Over its implementation period, the *Steps Guide* has been billed as a signature resource for NCCRT members and one of the most popular downloads in the NCCRT Resource Center. Moreover, while the document emphasizes community health centers, the *Steps Guide* offers a number of important steps that any primary care setting could consider when promoting CRC screening.

To support the 80% in Every Community campaign, the NCCRT Community Health Center Task Group has convened an ad-hoc advisory group to update, modernize, and improve the *Steps Guide*. This will

ensure the relevance of this tool for the current 80% in Every Community campaign and assist community health centers, **as well as other primary care settings**, in improving CRC screening rates. Further, the toolkit refresh will better equip these facilities with the latest in research, best practices, and other implementation recommendations. The evidence base has expanded regarding recommendations and best practices for CRC screening programs, including best practices for mailed fecal immunochemical test (FIT) programs as well as systems changes needed to facilitate timely response to abnormal results following a stool-based test. Therefore, in addition to making updates to existing content in the *Steps Guide*, the NCCRT also plans to add a new companion piece to the document: a brief that provides guidance on timely follow up to abnormal stool-based test results. Note, information specific to this brief is included within the scope of work for this proposal request (see section 4.3.3).

1.2 Strategic Objectives and Project Priorities

In March 2020, the NCCRT released the *80% in Every Community Strategic Plan*, which provides a focused, action-oriented roadmap for stakeholders, collaborators, and cross-sectored partners committed to achieving the shared goal of reaching colorectal cancer screening rates of 80% and higher. The plan provides a variety of recommended activities that all stakeholders can use to help define, prioritize, and accomplish their goals. From our strategic plan, we know the significant benefits that are realized when healthcare systems collaborate in their prioritization of CRC screening, including:

- A strengthened medical neighborhood that serves both the uninsured and the insured.
- Barriers to screening are overcome in both urban and remote/rural areas.
- Screening processes are optimized at the primary care setting.
- Technology, electronic health records (EHRs), and patient and provider reminders are leveraged to promote screening and follow up.
- Patient navigation approaches become a standard of care, are formalized, and optimized.

In addition to the 80% in Every Community Strategic Plan, the NCCRT has started soliciting input on what should be updated and newly included within the *Steps Guide*. The aim of these discussions is to identify the most appropriate learning objectives and outcomes for this guide. The expected strategic goals for this guide include:

- Develop a tool that is relevant to all primary care settings, with an emphasis on community health centers;
- Update, and modify where appropriate, the guide’s steps for developing and coming to an agreement on an office CRC screening strategy;
- Provide education on appropriate and high-quality screening;
- Improve uptake of screening among all age-eligible patients, including pre-Medicare age groups (i.e. ages 45-64 or 50-64);
- Recommend proven programs, interventions, and policies for the community health center setting;
- Advise on tracking and follow-up of screening and results; and
- Build networks between providers, health systems, and other key community stakeholders along the continuum of care.

2.0 Scope of Work and Project Priorities

The NCCRT seeks to select and engage a contractor via a competitive bid process to update, revise, and modernize the signature NCCRT resource, S*teps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers* (a.k.a. *The Steps Guide).* Our ultimate goal is to refresh the current *Steps Guide* and make its contents as successful and relevant to primary care practices engaged in the *80% in Every Community* campaign as its predecessor was to the practices engaged with the previous *80% by 2018* campaign.

More specific objectives and deliverables for this engagement are as follows:

- Revise, update, and improve the current iteration of the *Steps Guide* for further use within the 80% in Every Community campaign (including adding language and relevant links to promote the goals , priorities, and tools associated with the 80% in Every Community);
- Update and/or expand the literature, references, and contents to be more relevant and inclusive to all primary care settings, while still maintaining an emphasis on the unique barriers in the community health center setting;
- Update content related to national screening guidelines, specifically supporting organizations in the implementation of starting screening at both ages 45 or 50;
- Refresh and follow-up on any case studies used within the guide, and evaluate each case for continued use within the guide;
- Identify and conduct key informant interviews with a small set (2 to 4) of exemplary community health centers and experts in the field who have established best practices improving CRC screening (connections and outreach of exemplary case studies will be provided by the NCCRT);
- Review, update, retire, and/or replace current tools and templates within the guide's appendices;
- Improve in-text linkages to relevant NCCRT resources, particularly the addition of newer resources and tools created since publication; and,
- Utilizing the literature review, key informant interviews, and other identified resources, produce a 2020 update to the *Steps Guide*; and,
- Provide a new, supplemental brief (less than 10 pages) that provides guidance on how to follow-up after an abnormal stool-based screening test (note: a portion of materials and case stories will be provided to the contractor from previous NCCRT work in this area).

3.0 Instructions/Process for RFP

3.1 Questions Regarding the RFP

If you have questions pertaining to this RFP, please email NCCRT Director – Programs & Partnerships, Caleb Levell (**caleb.levell@cancer.org**) by July 8, 2020. Be sure to include relevant contact information, and specifically reference the section(s) of the RFP in question. All questions must be in writing. Questions and answers may be given to all applicants to avoid any unfair advantage. These guidelines for communications have been established to ensure a fair and equitable evaluation process for all respondents. Any attempt to bypass the above lines of communication may be perceived as establishing an unfair or biased process and could lead to your disqualification as a potential contractor.

3.2 Response Due Date and Delivery

Please submit a letter of intent by July 8, 2020 and an electronic copy of your proposal by July 15, 2020 to Caleb Levell (caleb.levell@cancer.org) via email.

3.3 Response Costs

All costs associated with the preparation of a Proposal shall be borne by the applicant.

3.4 Confidentiality

This RFP and any information supplied in connection with the preparation of a Proposal is confidential and must not be disclosed, reproduced, or used in any way, except for the sole purpose of responding to this RFP.

3.5 Selection Process

The evaluation team members will evaluate each proposal based upon how it satisfies ACS and NCCRT requirements. While the evaluation methodology is confidential, at a high level, the major areas of considerations are:

- Delivery of a strong and realistic project plan following the specifications in the RFP;
- Ability to meet the proposed deadline;
- Familiarity with the latest research, published literature, and general issues surrounding practice improvement and systems change, CRC screening, CRC screening barriers, and primary care systems;
- Experience with conducting qualitative interviews;
- Ability to conduct a robust interview process;
- Ability to translate the lessons learned into concrete and useful recommended next steps;
- Industry experience and strong references;
- Quality assurance commitment and high performance standards;
- Willingness to work closely and receive input from NCCRT and Advisory Group members, while also exercising independent judgment and creative thinking;
- Strong analytical, written, and oral communication skills;
- Budget and fee proposal.

While cost is always an important decision factor, the quality, level of service, and operating efficiencies are also important and are critical aspects that will be examined by ACS and NCCRT. Please be sure to include all essential data in the proposal to ensure ACS and NCCRT have a full and complete understanding of your (the Contractor) capabilities and experience. See Section 4.4 for information about the budget and available funds.

3.6 Schedule of Events

Please observe the following schedule:

- RFP Issue Date: June 18, 2020
- Bidders Indicate Intention to Respond: July 8, 2020
- Proposal Due Date: July 15, 2020 (5:00 p.m. EST)
- Contractor Selected: Week of July 20, 2020 (approximately)

- Kick off Call: Week of July 27, 2020 (approximately)
- Target Project Start Date: August 10, 2020
- Deliverables Check-in #1: September 29, 2020
- Final Deliverables: December 30, 2020

4.0 Proposal Deliverables

The proposal must follow the structure outlined in this section, using the numbering of sections specified. The proposal text for each section should begin by repeating the section question or statement followed by your response. In cases where the question/statement for a section does not apply, or you are unable to respond, reference the question, and then follow with a response of "N/A" (Not Applicable), including a brief explanation of the reason for not responding. Applicant may add items not listed within this section by placing them at the end of the proposal.

4.1 Contractor Profile

4.1.1 Company Name:
4.1.2 Mailing Address:
4.1.3 Street Address:
4.1.4 Tax Payer ID:
4.1.5 Dun & Bradstreet Number (DUNS):
4.1.6 Key Contact (Name, Title, Phone, Fax, and E-Mail):
4.1.7 Minority business status, if applicable.
4.1.9 Provide the location(s) of your corporate facilities.
4.1.10 Has your firm filed for bankruptcy within the past five years? If yes, provide details.
4.1.11 List any services or products that you have provided to the American Cancer Society in the past 5 years.
4.1.12 List your top 5 major clients, including not-for-profit clients, for whom you have performed similar work (i.e. work related to colorectal cancer, cancer screening, cancer prevention and early detection, primary care, practice improvement, public health, rural health).

4.2 Contractor References

Please list three references for similar projects performing similar requirements. Please include not-for-profit organizations, if any.

If possible, please share sample projects you have created for other clients that would help illustrate your qualifications for this project.

4.3 Proposal Narrative

4.3.1 **Previous Experience** – please describe contractor experience in the following areas: development of best practices or implementation handbooks/guides, colorectal cancer, cancer screening, cancer prevention and early detection, primary care, community health centers, health equity/health disparities, public health, practice improvement & systems change. A response to section 4.3.1 should not exceed two pages, single spaced, 1 inch margins, 11 point font.

4.3.2 **Proposed Project Design and Implementation** - This is the narrative of how you plan to satisfy the RFP Goals (listed in Section 3.0). A response to section 4.3.2 should not exceed four pages, single spaced, 1 inch margins, 11 point font.

Discussion about the project plan should include some, if not all, the following areas:

- Review of current iteration of the *Steps Guide* and recommendations for updates, revisions, and improvements.
- A proposed literature review of current academic and professional research to inform the toolkit.
- Interviewing a mix of subject matter experts, clinicians, quality improvement experts, office managers, nurses, and other support staff from community health centers that demonstrate exemplary models of success and proven best practice approaches.
  - Two to four refreshed case studies are desired.
  - The NCCRT and the Advisory Group will work with the selected contractor to identify the proper cross section of interviewees.
  - It will be important to draw interviewees from practices that are geographically diverse and serving a wide variety of patient populations (SES, race/ethnicity, etc).
- The project plan should include the estimated number of interviews required as well as the expected length of interviews to be conducted. In some cases, it might be beneficial to interview more than one person from a particular primary care setting or community health center. Project plans that include a robust interview process will be viewed more favorably.
- While an updated literature review and interviews should inform the content of the guide, the proposal should demonstrate a familiarity with the general topic, and the following elements could be reflected on:
  1. An understanding of the current iteration of the *Steps Guide* and its potential for implementation within community health centers and other primary care settings.
  2. A brief description of the current landscape, including unique opportunities and barriers facing community health systems and their clinicians, staff, and patient populations.
  3. Case studies/best practices highlighting successful work.
  4. Appendix Refresh: The current guide has an extensive selection of templates and tools. A review, refresh, and even a reimagining of this content is vital to make sure the new version is relevant and utilized by 80% in Every Community campaign partners.
- The project plan should include creating all relevant materials, such as literature review summary, interview guides, along with the revised and updated working draft.
- The contractor should plan on participating on an initial kick-off call with NCCRT staff and the Advisory Group, many of whom are experts in the field of public health, colorectal cancer screening, and practice improvement.
- The project plan should include allowance for NCCRT and Advisory Group review, feedback, and revision to ensure support and consensus. Several

revisions of the work can be expected, and additional conference calls are possible.
- Note: Please do address if your proposal will include graphic design updates to the document.

4.3.3 **Proposal for developing a supplemental brief that provides guidance on timely follow-up to abnormal stool-based screening test results.** A response to section 4.3.3 should not exceed 1 page, single spaced, 11 point font.

- Using information gathered from a well-researched literature review as well as interviews with 3 to 4 exemplary community health center practices (as described above), this supplement should summarize best practices and actions that lead to successful follow-up and tracking of stool-based screening programs.
- The brief should serve as a quick start recommendation guide for building successful follow-up and referral programming to abnormal stool-based testing.
- The brief will include key "how to" topics, such as:
    - Tracking and navigating patients with abnormal stool-based screening tests;
    - Establishing referral networks and processes;
    - Building a medical neighborhood; and,
    - Overcoming common pitfalls or barriers.
- Short case examples should also be included.

4.3.4 **Project Deliverables** - At the conclusion of the project, the contractor will deliver:
- By September 29, 2020:
    - Review and provide recommendations for changes/updates to the *Steps Guide*
    - Literature review
    - An interview guide, survey, or questionnaire
    - Records of interview (requested) or detailed notes of any completed interviews
    - A robust outline of toolkit, including a started appendix of templates and tools.
- By December 30 2020:
    - Complete transcripts (or detailed notes) of completed interviews.
    - Final manuscript draft, with appendix of templates and tools.
    - A "how to brief" informing community health centers about best practices, potential opportunities, and lessons learned on timely follow up to abnormal stool testing.

4.4 Project Timeline and Budget

The target start date for the project is August 10, 2020. Two sets of deliverables should be completed by previously agreed dates, which include September 29, 2020 and December 30, 2020.

The proposal should include a timeline that clearly indicates when major tasks and activities will be accomplished. The proposal should provide a summary of the costs and fees to complete each section referenced in 4.3. Project Deliverables and Expectations as presented in the project plan. The timeline should allow for feedback from relevant NCCRT staff and the associated Advisory Group.

The estimated budget should range from $30,000 to $35,000, which includes personnel and administrative costs. The contractor should provide a detailed proposed budget, including estimated hourly labor costs, estimated hours, and a brief description of what will be accomplished monthly.

Please note that all anticipated fees and expenses for delivery of the project should be included; materials, shipping costs, etc. The project plan will be viewed more favorably if it includes submission of high and low estimates for deliverables around each section of the plan. This project is being funded by Cooperative Agreement Grant No. No. NU58DP006460the Centers for Disease Control and Prevention. Under this terms of this funding, this project may NOT include the following activities:

- Lobbying
- Clinical Care
- Research

5.0 Minimal Contract Requirements, if selected

5.0.1 **Tobacco-related affiliation:** ACS defines a "Tobacco Company" as any company that manufactures tobacco products and is commonly considered to be part of the tobacco industry, including subsidiaries and parent companies, as well as philanthropic foundations and other organizations closely linked with the tobacco industry

Contractor must answer the following questions:

5.0.1.1 Do you own 5% or more of a Tobacco Company?
5.0.1.2 Are you 5% or more owned by a Tobacco Company?
5.0.1.3 Are any of your clients Tobacco Companies?
5.0.1.4 If so, how many and what percentage of your revenues are derived from those clients?
5.5.1.5 Will you and your employees adhere to ACS's no smoking policy when on ACS premises?

5.0.2 **Conflict of Interest**:

Contractor must answer the following:

5.0.2.1 Are any of your employees, officers or majority owners employed by, or national volunteers of, the American Cancer Society, Inc. (a national volunteer is defined as being a member of the ACS national Board)?
5.0.2.2 Are you able to state that your company will not enter into a contract or agreement, or execute a document, which will create a conflict of interest or which will prevent you from freely performing for ACS?

5.0.2 Intellectual Property/Data: The Contractor must include in its proposal a statement acknowledging its understanding that the proposed scope of work will be deemed “work for hire” and the American Cancer Society and the NCCRT will retain ownership of all deliverables and intellectual property, and further that the American Cancer Society and NCCRT is entitled to utilize and publicly disseminate aggregate outcome data collected and/or reported by Contractor in connection with this project.

5.0.3 Indemnification. Contractor must indemnify, defend, and hold ACS and its representatives and employees harmless from any claims arising out of or resulting in any manner from (i) Vendor's breach of the contract, (ii) Vendor's negligence or intentional misconduct, and (iii) materials developed for ACS by Contractor or materials utilized by Contractor in programs or materials created or used for ACS under the engagement (including, but not limited to, claims relating to patent, trade secrets, copyright or other proprietary rights infringement).

5.0.4 Federal Funding Compliance Language: Contractor must acknowledge that it understands that this project will be funded by the CDC and that any resulting contract between ACS and Contractor must contain the following compliance provisions:

(a) Compliance with Requirements of Primary Funding. Contractor acknowledges that this Agreement will be funded in whole or in part by Cooperative Agreement Grant No. CDC Grant NU58DP006460, CFDA #93.283 (the "Cooperative Agreement") from the Centers for Disease Control and Prevention ("CDC") and agrees to comply with all requirements and regulations applicable to Contractors/subcontractors contained therein. This Section incorporates the procurement provisions required to be included in federally funded contracts, including small purchases, awarded by ACS pursuant to the Office of Management and Budget Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, as adopted by HHS in 2 CFR Part 300 and implemented in 45 CFR Part 75 ("OMB Uniform Guidance").

(b) Compliance with Laws and Regulations. Contractor agrees to comply with all laws and regulations applicable to the performance of Services under the Agreement, including the applicable provisions of Appendix II to Part 200 of the Uniform Guidance. Contractor further agrees during the course of performing the Agreement to comply with the applicable Federal cost principles as set forth in the Uniform Guidance all of which are hereby incorporated by reference.

(c) Debarment and Suspension. Contractor hereby certifies that it has not been debarred, suspended or otherwise excluded from conducting business with the United States Federal Government or participating in Federal assistance programs or activities. Contractor will require a similar certification from each subcontractor performing federally funded Services under this Agreement.

(d) Conferences; Publications. Contractor shall follow all instructions from ACS regarding acknowledgements of funding and/or disclaimers required by the CDC to be included in conference materials, promotional materials, publications, journal articles, etc. produced under the Cooperative Agreement. Contractor will also comply with the applicable requirements of the CDC Public Access Policy.

(e) Controlled Substances. Contractor hereby certifies that it will not engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance in conducting any activity pursuant to this Agreement; and if convicted of a criminal drug offense resulting from a violation occurring during the conduct of any grant activity, Contractor will report the conviction, in writing, within 10 calendar days of the conviction, to ACS.

(f) Records and Audit Rights. Pursuant to 2 C.F.R. §200.318 of the Uniform Guidance, ACS is required to maintain oversight of contractors under a grant from the Federal Government. Contractor agrees to maintain and make available to ACS or government officials all records

pertaining to the goods or services provided under the Agreement for at least three (3) years from the date that ACS makes final payment to Contractor; provided that, if litigation or a government audit relating to the records commences during the three year period, Contractor shall retain the records until the litigation or audit has ended. Contractor agrees to provide such information as is reasonably requested by ACS to monitor the activity supported by a grant from the Federal Government.

(g) Reporting. Contractor will submit interim performance reports from time to time as requested by ACS, and a final performance report by February 28, 2018. ACS will provide timely notice of when any such performance reports are due. Performance reports shall reference CFDA #93.283 and shall contain a summary of the Services provided by Contractor at such date, and if any Services have not been completed in a timely manner, an explanation of why such Services have not been provided.

(h) Timely Invoicing. Contractor understands that ACS must follow the grant closeout procedures set forth in 2 C.F.R. §200.343 of the Uniform Guidance. Contractor will timely submit all invoices required under the Agreement and agrees that ACS has no obligation to pay invoices submitted more than 30 days after services are rendered or goods are provided by Contractor.

(i) Refund of Unallowable Funds. Contractor agrees to refund any sum of money which a Federal Government auditor or grant official determines to be an unallowable, unallocable, or unreasonable cost under the applicable cost principles, or ineligible due to Contractor's noncompliance with applicable laws, regulations or requirements. Notwithstanding any other provision of the Agreement, payment to Contractor does not affect ACS's right to recover funds on the basis of a later audit or other review, nor does it affect Contractor's obligation to return any funds due as a result of later disallowances.

(j) Employee Whistleblower Rights and Requirement To Inform Employees of Whistleblower Rights. This Agreement and employees working on this Agreement 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. 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. Contractor shall insert the substance of this clause, including this paragraph, in all subcontracts over the simplified acquisition threshold.