STATE OF CONNECTICUT
OFFICE OF HEALTH STRATEGY AND DEPARTMENT OF PUBLIC HEALTH
STATE INNOVATION MODEL PROGRAM

REQUEST FOR PROPOSALS (RFP)

HEALTH ENHANCEMENT COMMUNITY (HEC) INITIATIVE:

HEC PRE-PLANNING

The State Innovation Model (SIM) Program is soliciting thirteen (13) to fourteen (14) Participant Communities to work with the State in planning for a new **Health Enhancement Community (HEC)** initiative as part of Connecticut's SIM strategy. Participant Communities selected through this Request for Proposals (RFP), will work closely with the State for one 90-day period to develop foundational elements of an HEC for their community. An option to extend for a second 90-day period may be offered dependent upon funding. Work to be done by Participant Communities in this RFP will inform a future procurement process to fully designate HECs. Participant Communities selected to participate in this RFP are not guaranteed future HEC designation through the HEC Implementation Procurement process, but it is anticipated that selection in this round will be a consideration in future HEC designation.

Scope of Services

The State intends to partner with communities ("Participant Communities"), to undergo collaborative planning to initiate design and development of elements of a potential HEC in their community. It also explicitly requires that applicants engage community members in the design process. Deliverables for the first 90 day-period include:

- Report on community need and drivers relative to HEC Priority Aims, drawing as appropriate from the Community Health Needs Assessment.
- Documented HEC partnership strategy, including identified partners within proposed geographic area, community partnerships outside geographic area, and planned engagement strategies.
- Documentation regarding demonstrated engagement of community residents.

This is a competitive procurement. The procurement is expected to result in a 90-day contract. The anticipated award for each Participant Community is up to $25,000, with one (1) to two (2) Participant Communities receiving up to a maximum of $35,000.

Applicable Dates:

RFP Release Date	**August 15, 2019**
Letter of Intent Due Date (OPTIONAL):	**September 12, 2019**
Application Due Date:	**October 1, 2019**
Anticipated Issuance of Notice of Award:	**October 7, 2019**
Anticipated Period of Performance:	**Nov 1, 2019 – Jan 31, 2020**

TABLE OF CONTENTS

FORWARD

The work proposed under this RFP is intended to inform ongoing planning efforts regarding the Health Enhancement Community model as part of Connecticut's State Innovation Model (SIM) test grant. This work will inform the ongoing review of this emerging model by Governor Lamont and the Center for Medicare and Medicaid Innovation (CMMI), with whom the State is working to develop a sustainable financing strategy. Neither the Governor nor CMMI has yet determined whether to proceed with the implementation phase of this initiative; however, information gathered through this opportunity will assist with the decision-making process as it evolves

1 EXECUTIVE SUMMARY

The Office of Health Strategy (OHS) and Department of Public Health (DPH), are soliciting thirteen (13) to fourteen (14) Participant Communities to work with the State in planning for a new **Health Enhancement Community (HEC)** initiative, as part of Connecticut's SIM strategy. The HEC initiative aims to foster community-wide, multi-sector collaboration, and accountability to promote community health improvement and equity. Communities selected through this Request for Proposals (RFP) will work closely with the State for one 90-day period to develop foundational elements of an HEC. Preference will be given to proposals that demonstrate a broad array of engaged partners with readiness to work with the State, and a shared commitment to examine barriers and opportunities essential to the development of an HEC strategy. Respondents to this RFP can request funding of up to $25,000 per Participant Community to support costs related to their participation in this planning process. Furthermore, Respondents can request up to an additional $10,000 if they opt-in to the rapid-cycle measures portion of the RFP. An option to extend for a second 90-day period may be offered dependent upon funding.

Questions related to this solicitation should be directed to:

Brent Miller, Office of Health Strategy, brent.miller@ct.gov

Applications must be submitted electronically on or before October 1, 2019 at 12pm to brent.miller@ct.gov

RFP Name	HEC Pre-Planning
RFP Release Date	August 15, 2019
Electronic Location of Request for Proposals	
Letter of Intent Due Date (OPTIONAL)	September 12, 2019
Request for Proposals Application Due Date	October 1, 2019
Anticipated Notice of Award	October 7, 2019
Period of Award	November 1, 2019 – January 31, 2020
Anticipated Total Available Funding	$395,000
Anticipated Number of Awards	Approximately 13 to 14 awards of up to $25,000 each; 1 to 2 awards up to $35,000

Eligible Applicants	Lead Applicants may be governmental, non-governmental for-profit, or not-for-profit organizations with strong buy-in from communities with a diverse group of stakeholders. Lead Applicants are committed to engage and rapidly contract with the state, and have insights related to the HEC planning process

2 BACKGROUND INFORMATION

2.1 STATE AGENCY PARTNERS

Connecticut Office of Health Strategy

The Office of Health Strategy (OHS) was created in 2017 by the Connecticut General Assembly, and is responsible for developing and implementing a comprehensive and cohesive health care vision for the State. This includes promoting effective health planning, and the provision of quality health care in a manner that ensures access for all state residents to cost-effective health care services, avoids the duplication of such services, and improves the availability and financial stability of such services throughout the state. OHS also directs and oversees the State Innovation Model initiative, and related successor initiatives. The mission of OHS is to implement comprehensive, data-driven strategies that promote equal access to high-quality health care, control costs, and ensure better health outcomes for all Connecticut residents.

OHS Website: http://portal.ct.gov/ohs

Connecticut Department of Public Health

Established in 1878, the Connecticut Department of Public Health (DPH) is the lead agency in protection of the public's health, and in providing health information, policy and advocacy. The agency is the center of a comprehensive network of public health services, and in partnership with local health departments, provides coordination and access to federal initiatives, training and certification, technical assistance and oversight, and specialty public health services that are not available at the local level. It is a source of up-to-date health information and analytics for the governor, the General Assembly, the federal government and local communities. This information is used to monitor the health status of Connecticut's residents, set health priorities and evaluate the effectiveness of health initiatives. Regulatory functions are focused on positive health outcomes and assuring quality and safety, while also minimizing the administrative burden on the personnel, facilities and programs regulated.

DPH Website: https://portal.ct.gov/DPH

2.2 CONNECTICUT'S STATE INNOVATION MODEL

The State Innovation Model (SIM) initiative is a Center for Medicare & Medicaid Innovation (CMMI) effort to develop and implement state-led, multi-payer healthcare payment and service delivery model

reforms that will promote healthier people, better care, and smarter spending in participating states. Connecticut received a $45 million SIM grant from CMMI to implement a multi-faceted strategy from 2015-2019 to improve the health outcomes and healthcare spending trajectory of the state, as well as to mitigate the sizeable health disparities that continue to persist. The Health Enhancement Community Initiative is the state's most recent SIM effort to drive towards these aims.

SIM Website: https://portal.ct.gov/OHS/Services/State-Innovation-Model

2.3 HEALTH ENHANCEMENT COMMUNITY INITIATIVE

The Health Enhancement Community (HEC) Initiative is aimed at improving the health and well-being of all residents in Connecticut, and reducing the rising trends of Connecticut's health care costs by improving community health, health equity, and preventing poor health. The HEC Initiative has four ambitious but achievable goals:

1. Make Connecticut the healthiest state in the country.
2. Achieve health equity for all Connecticut residents.
3. Make Connecticut the best state in which children grow up.
4. Slow the growth of Connecticut's health care spending.

These goals can be achieved through having Health Enhancement Communities (HECs) form and operate throughout the entire state. The HEC Initiative is a place-based initiative that will support long-term, collaborative, and cross-sector efforts that improve community health in defined geographies through broad, systemic change. HECs will work to improve the social, economic, and physical conditions within communities that enable individuals and families to meet their basic needs, achieve their health and well-being goals, and thrive throughout their lives. HECs will focus on two health priorities that are critical for Connecticut:

- **Improving Child Well-Being for Connecticut Children, Pre-Birth to Age 8 years:** Assuring all children are in safe, stable, and nurturing environments through preventing Adverse Childhood Experiences (ACEs), and increasing protective factors that build resilience and mitigate the negative impact of toxic stress.
- **Improving Healthy Weight and Physical Fitness for All Connecticut Residents:** Assuring that individuals and populations maintain a healthy or healthier body weight, engage in regular physical activity, and have equitable opportunities to do so.

Need for the HEC Initiative

Although Connecticut ranks fifth in overall health nationwide - behind Massachusetts, Hawaii, Vermont, and Utah[1] - between 2015 and 2017, Connecticut experienced a downward trend in rankings related to healthy weight, including physical activity and diabetes, as well as measures related to child well-being,

[1] America's Health Rankings, 2017 Annual Report. https://www.americashealthrankings.org/learn/reports/2017-annual-report/state-summaries-connecticut. Date accessed 8/14/18.

including children in poverty, low birth weight deliveries, and infant mortality.[2,3] Across these 5 measures, Connecticut currently ranks well below the top 10 states.[4] Additionally, these rankings represent the population on average, and mask the significant health disparities that persist - disparities that start early and carry throughout the lifetime. Connecticut currently ranks 40th in disparities in health status, where the higher the ranking the larger the disparities. State data finds significantly higher prevalence of having fair or poor health among (a) Non-Hispanic Black (19.6%) and Hispanic (26.5%) adults, (b) Adults from households earning less than $35,000 (29.2%) and $35,000-$74,999 (12.2%), (c) Adults without health insurance (24.6%) or with a disability (42.3%), and (d) Adults with no more than a high school education (22.8%).[5] These gaps in overall health across population groups result from many Connecticut residents and communities faring poorly across numerous measures of health.

Safe, stable, nurturing relationships and environments in the first five years of life increase a child's opportunity for a healthy adulthood. Achieving this aim for children throughout Connecticut requires preventing Adverse Childhood Experiences (ACEs), and mitigating the impact of ACEs. ACEs are stressful or traumatic events or situations experienced by children. Ample evidence reveals the associations between ACEs, health conditions, and indicators leading to adult morbidity and mortality. The Behavioral Risk Factor Surveillance System (BRFSS), conducted by the Department of Public Health in Connecticut, reports ACEs based on several types of abuse and adverse experiences: emotional, physical, and sexual abuse; intimate partner violence; household substance abuse; household mental illness; parental separation or divorce; and incarcerated household member. Three out of five adults reported having experienced at least one ACE, and 21.2% reported three or more ACEs. One third of those who experienced at least one ACE were from separated/divorced parents, and about one fifth experienced emotional abuse and drinking problems in their households. This makes emotional abuse (27.9%) and parental divorced (26.2%), the most prevalent ACE events in the state.[6] A follow-up assessment of adults surveyed during 1995-1997 was conducted in 2009, and found that individuals with six or more ACEs compared to those who had none, died 20 years earlier on average.[7]

Excess weight leads to increased risk for heart disease, high blood pressure, stroke, type 2 diabetes, arthritis-related disability, and cancer. Maintaining a healthy weight involves choosing healthy foods, regular physical activity, and consuming about the same number of calories as your body needs.[8]

---

[2] America's Health Rankings, 2016 Annual Report. https://assets.americashealthrankings.org/app/uploads/ahr_annual-report_executive_summary_v1.pdf. Date accessed 8/14/18.

[3] America's Health Rankings, 2015 Annual Report. https://www.americashealthrankings.org/explore/annual/measure/Overall/state/CT?edition-year=2015. Date accessed 10/17/18.

[4] The 2017 Connecticut rankings for the five measures are as follows: Physical Activity – 18, Diabetes – 19, Children in Poverty – 21, Low Birthweight Births – 22, and Infant Mortality – 15.

[5] CT DPH, BRFSS Health Indicators and Risk Behaviors. 2016

[6] CT DPH, Adverse Childhood Experiences in CT. 2018

[7] Brown, DW, Anda, RF, Tiemeier, H, et al. (2009). Adverse childhood experiences and the risk of premature mortality. *Am J Prev Med, 36*(5), 389-96.

[8] CT DPH, Live Healthy Connecticut.

Based on Healthy Connecticut (HCT) 2020 Performance Dashboard, the prevalence of obesity among Connecticut adults has increased consistently from 2011 to 2017. Approximately 27% of adults are obese, and 36% are overweight. Males, non-Hispanic Black residents, residents 35 to 55 years of age, those with lower educational attainment or household income, are disproportionately affected by obesity. Approximately 16.3% of children aged 5 to 11 years old are obese, and 13.4% are overweight. Disparities among children remain as the prevalence of obesity is higher among males, younger children, and children from low-income households. Also, Hispanic/Latino children and non-Hispanic Black children have obesity prevalence rates that are over 2.5 times higher than non-Hispanic White children. The prevalence of obesity among children with a household income of <$25,000 is double the overall obesity prevalence among Connecticut children. The increased risk of obesity among children of lower socioeconomic status may result from a number of underlying causes, including lack of access to healthy foods, increased access to unhealthy foods, and fewer opportunities to engage in physical activity. Further, children living with a parent who does not participate in leisure time physical activities show a greater prevalence of obesity (23.1%) compared to children living with a parent participating in leisure time physical activities (14.3%).[9] An estimated 31.5% of Connecticut children eat fast food more than twice a week, and an estimated 29.9% drink soda or other sugar-sweetened beverages at least once per day.[10] An estimated 43.2% of children aged 2-17 exceed the threshold of excessive screen time (more than two hours) daily.[11] The prevalence of no leisure-time activity among adults in Connecticut is significantly greater among women (22.8%), non-Hispanic Black (25.3%) and Hispanic (32.1%) adults, adults from households earning less than $35,000 (34.0%), adults without insurance (32.0%), and adults with no more than a high school education (30.8%).[12]

Finally, Connecticut is a higher-cost state in overall health care spending per person relative to the national average, and health care spending has consistently outpaced growth in the state economy. While Connecticut is a comparatively high cost Medicaid state, Connecticut's Medicaid program led the nation in controlling cost trends on a per enrollee basis for the period from 2010-2014.[13] Connecticut reduced its per-person spending by a greater percentage (5.7%) than any other state in the country. Overall and in Connecticut, Medicaid tracked lower than private health insurance and Medicare.[14] This is likely due to Medicaid's innovative efforts to control costs through their managed fee-for-service model and Patient-Centered Medical Home (PCMH) initiatives, maintaining regulatory control over provider rates, and changes in case mix related to the Medicaid expansion. Medicare spending data for Connecticut, by contrast, shows a state that is both high-cost and higher-growth relative to national averages. Connecticut is also the highest cost state for Medicare in New England. Taken together, these historical trends demonstrate the need for Connecticut to control health care spending.

---

[9] CT DPH, BRFSS Children's Health in Connecticut: 2011-2015

[10] *ibid*

[11] *ibid*

[12] CT DPH, Health Indicators and Risk Behaviors, 2016.

[13] Lassman, D., Sisko, A.M., Catlin, A., Barron, M.C., Benson, J., Cuckler, G.A., Hartman, M., Martin, A.B., and Whittle, L. (2017). Health Spending By State 1991-2004: Measuring Per Capita Spending By Payers and Programs. *Health Affairs, 36*(7). doi: 10.1377/hlthaff.2017.0416.

[14] Health Affairs, June 2017

HEC Framework Development

The framework for the HEC Initiative was developed through an extensive and iterative stakeholder engagement process.

- A concise description of the initiative and its key elements can be found here: https://portal.ct.gov/-/media/OHS/SIM/Population-Health-Council/Resources/CT-SIM-HEC-Framework---final.pdf?la=en.
- A more detailed technical report is available here: https://portal.ct.gov/-/media/OHS/SIM/Population-Health-Council/Resources/CT-SIM-HEC-Framework-Technical-Report---final.pdf?la=en

The Office of Health Strategy and Department of Public Health are in the process of planning for a proposed HEC demonstration that would begin in 2021. The demonstration will include the selection of 8-12 cross-sector community collaboratives to serve as HECs. The intent is for HECs to achieve statewide geographic coverage (i.e., encompass every town in the state).

Over a 10-year period, HECs will be accountable for reducing health risk for the populations living in their defined geographies. HECs will be responsible for implementing interventions that span four key areas: systems, policies, programs, and cultural norms. They also will work across sectors to connect, improve, and/or expand existing interventions and implement new interventions to fill gaps. The State may implement or sponsor interventions that can have a statewide impact.

HEC Measurement and Performance Monitoring

The intent of the HEC measurement approach is to create multiple levels of measurement that incorporate a set of standard validated measures to provide meaningful comparisons of achievement, and improvement in health across HECs. To this end, once HECs are established, reporting will be established on two levels of measurement.

1. **Prevention Benchmarks.** To measure progress (through an attribution methodology[15]), all HECs will be held accountable for a common core set of prevention health measures, based on outcomes that relate to the two health priority aims. These prevention measures will be consistent statewide and will be assessed at both the HEC and statewide levels. For each priority aim, designated primary prevention measures will carry the most weight in evaluating the performance of each HEC. Secondary prevention measures will serve to complement the goals of the primary measures (safety, stability, and school readiness and reduced obesity).
2. **Process and Outcome Measures related to HEC-selected Interventions.** In addition to the statewide prevention measures and benchmarks, each HEC must individually choose process and outcome measures to target and track related to each of their chosen programmatic, systems, policy, and cultural norm interventions. One focus of this RFP is the development of measures that enable rapid cycle assessment of the impact of community intervention on well-being, diet and level of activity.

As baseline data is collected, sub-categories of measures will be added to address observed health disparities. Health equity/inequity measures will also be incorporated into the provisional measures list, based on the results of a concurrent project under the Health Information Technology Program

[15] Attribution determines the population for whose health the HEC is accountable. All or a sub-population within the attributed population will serve as the denominator for performance measurement.

Management Office. The purpose of that project is to identify health equity data, and to collect and incorporate those key data elements into the state's emerging health analytics architectures.

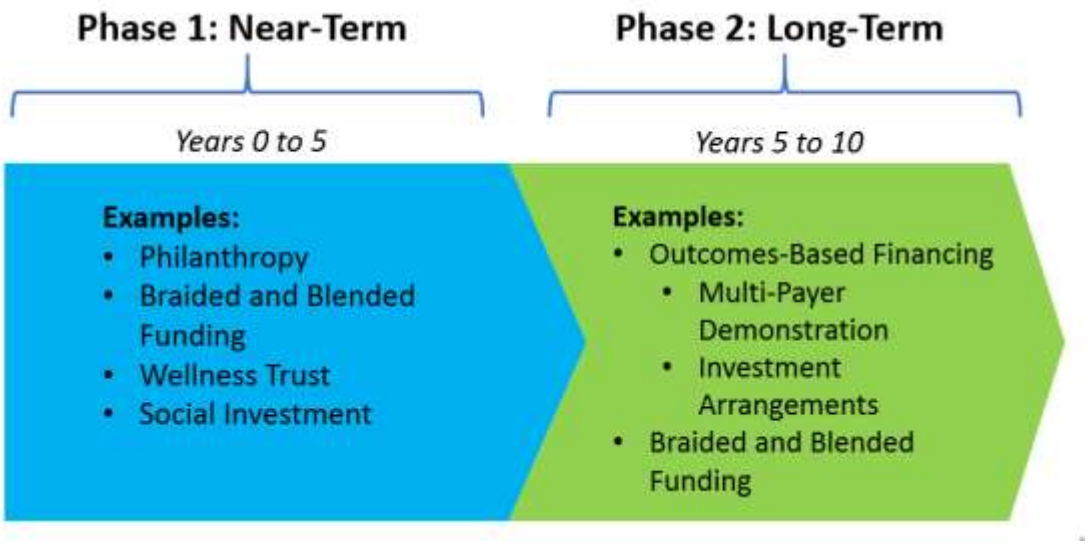
Final HEC measure selection is currently under development and will be led by a statewide consortium of key stakeholders. The final measures selected must meet the following criteria: significantly meaningful to the HEC goals, specific to the attributed population within each HEC, collected and reported on with minimal lag time, stratified to the extent possible by population characteristics, and easily accessible to each HEC.

HEC Governance

HECs will have formal governance with clearly defined decision-making roles, authorities, and processes. The HEC's governance structure must enable the HEC to perform key functions, including but not limited to providing oversight of the HEC's performance against health, health risk, and health equity benchmarks and HEC intervention metrics; fiscal planning and performance; and mitigating risks (e.g., risks related to performance under financing models). Although each HEC's governance structure should reflects the realities of its community, all HECs will need to have a defined structure that reflects the diversity within their communities, and ensures that community members are directly involved in decision-making about how their HEC is designed, formed, and operated.

HEC Financing

A central objective of the HEC Initiative is to provide a sustainable pathway to monetize prevention savings, and continuously reinvest a portion of the savings into evidence-based, or evidence-informed interventions to achieve the HEC health priority aims. To achieve these ambitious goals, HECs will require a mix of near-term, upfront financing in the first five years of implementation as well as sustainable long-term sources of financing beyond five years. It is anticipated that the near-term financing options will serve as a bridge to longer-term sustainability options, which will primarily, but not exclusively rely upon ongoing collaboration with health care purchasers such as Medicare, Medicaid, and state employee health plans administered by the Office of the State Comptroller (OSC). The following sections describe these funding sources, their likelihood of being leveraged, and how they can address near-term versus long-term needs.



Near-Term Financing. There are multiple potential vehicles to finance upfront HEC investment activities in the first five years; however, no single option offers the magnitude, breadth, or flexibility to fully

support HECs on its own. Rather, it is the interplay among these options within the context of the local HEC landscape—as examples, the specific interventions chosen or the availability of each finance option locally—that forms the basis of a working model to finance HECs across the state. A comprehensive financing approach for HECs will consider funding options for both interventions and infrastructure (at the local and state levels). The options will include leveraging existing funding by making it more aligned toward common purposes, and/or making it more flexible (e.g., pool funds through braided and blended funding options), as well as new funds through grants, debt, and tax credits. As part of the approach, mechanisms that enable funding options will also be explored (e.g., a wellness trust to house and manage pooled funding and loan funds to enable social investors to provide upfront funds).

Long-Term Financing. The HEC Initiative is unique among health care and social service reform efforts in that it aims to create a source of financing to support holistic, community-based interventions to reduce health care costs, and prevent disease and other health conditions. To do so requires the development of sustainable long-term pathways to monetize prevention savings and enable continuous reinvestment of a portion of the savings back into HECs. These long-term financing options will likely rely upon ongoing collaboration with purchasers of health care, and other services such as Medicare, Medicaid, and large self-funded employers such as OSC. The primary strategy for securing long-term funding sources will rely upon a shared-savings and reinvestment approach. Under this strategy, the state will seek to support HECs by developing ongoing shared prevention savings models with health care purchasers. Pooled funding approaches, such as braided and blended funding, will also be explored as options for long-term funds to support HECs.

Under the HEC Initiative, the state will play a critical role in identifying, negotiating, and securing long-term funding agreements with purchasers to support HECs. OHS in coordination with other state partners will explore potential payment model arrangements with HECs. These models may measure the potential health care cost savings that could accrue as a result of achievement on prevention benchmarks. If HECs are successful in decreasing the trajectory of health problems associated with child exposure to ACEs and obesity in Connecticut over a 5- and 10-year period, the associated health care savings can be calculated, and portion of the savings made available by purchasers to reinvest in HECs.

To support the outcomes-based financing strategy, it is expected that each HEC will have at least 20,000 Medicare beneficiaries, and at least 150,000 people living within their geography. To achieve statewide coverage among the 8-12 HECs, large urban areas will likely have at least 350,000 people living in their defined HEC geography.

Positioned for Success

Though the goals and structure of the HEC initiative are groundbreaking and ambitious, Connecticut is well positioned to be successful for several significant reasons. Our strategy to improve health outcomes and reduce cost by targeting Social Determinants of Health (SDoH) is well researched and proven to be extremely impactful. The interventions selected by designated HECs will be evidence-based, ensuring that the strategies implemented have demonstrated effectiveness. Finally, the HEC initiative is intended to build upon the existing work that has taken place across the state through collaboration within communities and among state partners. HECs will strengthen this foundation to elevate existing work and expand best practices to new communities and populations though its innovative structure and funding model.

3 REQUIRED SERVICE COMPONENTS AND SCOPE OF WORK

3.1 PRIMARY PARTICIPATION REQUIREMENTS

Through this RFP, the State intends to partner with up to fourteen (14) Participant Communities to undertake collaborative planning to initiate design and development of elements of a potential HEC in their community. It also explicitly requires that applicants engage community members in the design process, including involvement in planning meetings and obtaining input and feedback on elements such as needs and interventions.

Work to be done by Participant Communities will inform a future procurement process to fully designate HECs. Participant Communities selected to participate in this HEC Pre-Planning RFP are not guaranteed future HEC designation through the HEC Implementation Procurement process, but it is anticipated that selection in this round will be a consideration in future HEC designation.

Each Participant Community will be a cross-sector collaborative or coalition of partners from health, social service, and other sectors working together to improve community health and equity, and drive outcomes toward the two HEC goals. **Only one grant per geographic region will be awarded; however minor overlap of geographic areas of multiple applicants may be allowed**. A "Lead Applicant" will apply to this RFP on behalf of the Participant Community. The Lead Applicant will serve as the single point of accountability, and serve as the fiscal agent for any associated grant funds.

Awardees will be provided technical assistance (TA) to support the scope of work of this HEC Pre-Planning RFP. The State will select an HEC TA vendor to provide tools, templates, and facilitation support to awardees.

SUMMARY OF TERMS

Participant Community	A Participant Community refers to a cross-sector collaborative or coalition of partners from health, social service, and other sectors working together to improve community health and equity.
Lead Applicant/Respondent	An entity that is applying to this RFP on behalf of a Participant Community. The Lead Applicant will serve as the single point of accountability and fiscal agent for RFP funds. The Lead Applicant shall facilitate the timely execution of a contract with the state, the organization of participant organizations to meet, provide project management, and have formal representation in the HEC. The terms "Lead Applicant" and "Respondent" are interchangeable in this RFP.

Participant Organization	An entity that has indicated commitment to being a part of the Participant Community. The Participant Organization has communicated with the Lead Applicant/Respondent their intent to participate in the Health Enhancement Community (HEC), and will be active in and support the accomplishment of priority aims, goals, and requirements set forth in the HEC **Framework**.
Health Enhancement Community (HEC)	A Health Enhancement Community refers to an optimal stage of development reached by a cross-sector collaborative or coalition of partners designated as prepared to achieve health priority aims, goals, and requirements set forth in the HEC **Framework**.

Activities of the Participant Community

The goal of the RFP is for selected communities to initiate the design of an HEC in their respective communities to accomplish the HEC health priority aims. Activities include the following:

3.1.A. In the first 90 days of the project period, the successful Participant Community shall:

1. Convene participant organization members to determine roles and responsibilities for completing the below items. The Lead Applicant shall set up the initial first meeting.
2. Identify primary and secondary drivers, impacting need related to the HEC Health Priority Aims in the Participant Community. As part of this work, communities are encouraged to use existing data sources such as available Community Health Needs Assessments (CHNAs).
3. Identify partners within the defined geographic boundary of the Participant Community that are not currently engaged that are positioned to and/or are critical for addressing community needs and drivers identified in 3.1.A.1. Participant Communities shall develop a strategy to engage those partners.
4. Identify potential cities or towns outside the Participant Community's initial geographic boundary with which it would be beneficial to align due to like factors such as similar community needs and drivers, ability to collaborate/partner with to create economies of scale, and would increase the population size served by the Participant Community to intended HEC levels (e.g., approximately 150,000 individuals in predominantly rural communities and approximately 350,000 in communities that encompass a major population center). Participant Communities shall develop a strategy to engage those cities or towns.
5. Ensure community resident engagement in Activities 3.1.A.1-3. This includes inclusion of community residents in identifying needs, drivers, and potential partners and representation of community residents in decision-making. The Participant Community shall identify and implement strategies to ensure community resident engagement, including items such as flexibility regarding meeting scheduling and location, childcare arrangements, transportation, and utilizing alternative technologies for engagement (e.g., WebEx, social media, etc.)

3.1.B. In the second 90 days of the project period (contingent upon availability of funds), the successful Participant Community shall:

1) Implement partnership strategy developed as part of 3.1.A.2-3. The Participant Community shall initiate discussion with potential partners and partner communities, identifying areas of alignment and creating value proposition regarding why partnership would be advantageous. Participant Communities shall update geography and target population accordingly, seeking to achieve the HEC population goal of no less than 150,000/350,000 residents per HEC. Applicants shall work with partners to identify a preliminary or core set of interventions they may wish to pursue as part of an HEC.
2) Develop a preliminary HEC structure and corresponding Memorandum of Agreement. Participant Communities shall develop a framework regarding how partners would work together under an HEC model. Attributes include proposed geographic area and target population, partners, governance structure, accountability mechanisms, and community/resident engagement strategy.
3) Ensure community resident engagement in Activities 3.1.B.1–2. This includes inclusion of community residents in partnership development and HEC structure development. The Participant Community shall identify and implement strategies to ensure community resident engagement, including items such as flexibility regarding meeting scheduling and location, childcare arrangements, transportation, and utilizing alternative technologies for engagement (e.g., WebEx, social media, etc.)

3.1.C. In order to complete the activities in 3.1.A and 3.1.B, the successful Participant Community shall remain actively engaged for the duration of the grant period. This includes:

1) Commit dedicated personnel to work on this effort, interact with the State on an agreed-upon schedule, and participate in workshops, meetings, webinars, and information requests.

2) Maintain active community resident participation and engagement in the planning process and representation in the decision-making process.

3) Maintain active multisector engagement in the planning process. This may include hospitals, social service organizations, municipal governments, local public health departments, non-profit organizations, businesses, and more.

4) Collect relevant data that can shed light on community characteristics, strategies, and opportunities/barriers aligned with HEC goals.

5) Collect relevant information related to past experiences and future plans.

6) Produce a Final Report, capturing the outputs described in 3.1.A and 3.1.B. The report will illustrate what the collaborative/community would do if they were to enter into an HEC demonstration as described in Section 2.1.3. The State will provide a report template for awardees aligned with the anticipated HEC Implementation Procurement application.

3.2 Optional Participation Opportunity: Development of HEC Rapid-Cycle Community Measures

As part of the RFP, the State is soliciting up to one (1), but no more than two (2) communities, to work with the State and Yale New Haven Health Services Corporation - Center for Outcomes Research and Evaluation (CORE), to expand and improve the measurement tools available to communities that are seeking to improve health in the HEC priority areas. **This sub-initiative is OPTIONAL for applicants and will not impact RFP scoring as it pertains to the selection of Participant Communities for the scope of work described in Section 3.1.** Being a part of this optional sub-initiative will enable the Participant Community to participate in the development of an approach to collect measurement information intended to provide rapid-cycle feedback on the effectiveness of HEC interventions. An additional award of up to $10,000 will be considered for Lead Applicants that are selected to participate in the rapid-cycle community measure development option.

This project aims to achieve two objectives:

1. Foster community-wide, multi-sector collaboration to support the collection of information regarding key outcomes and drivers of health, well-being, and equity in the community.
2. Support communities to identify feasible and scalable solutions for measuring discrete aspects of health/well-being, drivers of health, and well-being at geographic levels that are small enough to inform community-based, rapid-cycle improvement initiatives fueled by real-time, accurate measurement and data visualization.

The Participant Community shall engage key stakeholders across multiple sectors, including healthcare, schools, and state resources to define a set of feasible measures, including those based on information generated directly by community members, such as self-reported activity levels or well-being, and a plan for implementing data collection to measure population outcomes at the local community level. These measures may include overall well-being among children and selected individual behaviors associated with well-being and healthy weight (such sleep, physical activity, nutrition, or screen time). The aim is to help communities find feasible means to assess their interventions to improve well-being in real-time as part of future HEC activities.

The successful Participant Community will work closely with the above partners to confirm a set of novel measures to be collected throughout the community, and to determine an implementation plan for both data collection and sharing of results. Preference will be given to proposals that demonstrate a broad array of engaged partners, with readiness to work with the partners, and a commitment to examine barriers and opportunities essential to the development of novel measurement strategies. Participant Communities must have an identified individual with demonstrated skills to lead this project, and dedicated time to this specific aspect of the work. In the second 90-days, the aim is for the community to work on a pilot project to implement data collection (contingent on further funding), and with ongoing technical support from Yale-CORE.

Yale-CORE will partner with communities that are selected for this optional initiative to provide technical assistance, such as assistance in identifying validated measures focused on the area of interest

for the community (such as assessments of well-being, or means of reporting activity levels), support to investigate technology options for data collection, and help in determining the number of people to include and how often to administer measures to gain meaningful information.

Activities of the Participant Community

The Participant Community is expected to lead the convening of community stakeholder meetings to achieve the following activities during the first 90 days, with technical assistance from Yale CORE:

1) Identify a multi-sector stakeholder group to focus on novel measurement tools and implementation that align with community health aims.
2) Conduct a limited, focused process to prioritize community member reported or generated outcomes (such as activity level), and select one or more focus measure(s) with consideration to both its significance and practicality of measurement.
3) Define the appropriate sampling and data collection strategy necessary to speak to the defined measures within small geographic area units relevant to local communities (with support from Yale-CORE).
4) Define the basic principles of a dashboard, through which data collected on these outcomes could be presented back to communities in a way that supports accountability and fuels rapid-cycle innovation and improvement
5) Produce a roadmap/timeline of specific steps to launch data collection within the community, including risks and mitigation plans
6) Produce a final report that provides a roadmap/timeline of specific steps to launch a pilot data collection project within the community, including risks and mitigation plans. The project should illustrate what the Participating Community might undertake if they were to enter into a demonstration as described in the RFP.

The above activities aim to prepare a community to embark on a pilot of data collection launched in the second 90-days, pending funding.

3.3 OTHER REQUIREMENTS

3.3.1 Qualifications

The Participant Community must possess the following attributes:

1) Must have formally accepted representation by the Lead Applicant, for the purpose of this RFP, with requisite experience in cross-sector coordination, project management, and financial management;

2) Must include a variety of sectors as participant organizations. This may include hospitals, social service organizations, municipal government, local public health departments, non-profit organizations, businesses, and more;

3) Must have an established regional geographic service area with:

i) The intent of supporting all residents within the geographic area; and that

ii) Represents a significant population (e.g., at least 60,000 residents); rural Participant Communities that cannot meet this threshold may still apply.

4) Must demonstrate a shared commitment to achieve the goals of this specific RFP among participant organizations and leadership to work closely with the State as active participants and co-creators of the HEC strategy;

5) Must have access to community-specific information and data relevant to the population served, including the use of completed community health needs assessment(s)/community health improvement plan(s);

6) Must demonstrate collective readiness to examine opportunities to collaborate on shared infrastructure elements which may include governance, management, infrastructure, data, measurement, and financing with respect to cross-sector health and prevention activities.

7) Lead Applicant is able to rapidly execute a contract with the state of CT within 14 days and secure identified personnel and other resources should the Participant Community be awarded.

3.4 KEY OUTPUTS AND TIMELINE

The following table lists high-level outputs associated with the required scope of work as established in Section 3.1. The applicant will also be responsible for the milestones and timelines it submits as part of their proposal. The applicant may assess the timeline below and propose modifications based on its own subject-matter expertise.

EXHIBIT 1: PRIMARY SCOPE (3.1) - KEY OUTPUTS AND TIMELINE GRID

Phase	Key Deliverables	Timeline
Phase 1	Report on community need and drivers relative to HEC Priority Aims, including recommendations regarding alignment of future CHNAs with HEC Priority Aims	0 - 60 days
	Documented partnership strategy, including: • Inclusion of partners within the current Participant Community geographic area not currently engaged • Partnership with other communities outside current Participant Community geographic area to achieve HEC population coverage goals • Planned engagement strategies	60-90 days
	Documentation regarding demonstrated engagement of community residents in Phase 1 activities and a strategy for ongoing community resident consultation and participation in this RFP HEC Pre-Planning process.	0-90 days

Phase 2	Documentation (e.g., MOU or other agreement) regarding proposed preliminary HEC model, including partners, geographic area, target population, core interventions, governance framework, accountability, and community resident engagement strategy	90-120 days
	Documentation regarding demonstrated engagement of community residents in Phase 2 activities	

EXHIBIT 2: OPTIONAL SCOPE (3.2) - KEY OUTPUTS AND TIMELINE GRID

Phase	**Key Deliverables**	**Timeline**
Phase 1	Documentation of efforts to engage multi-sector stakeholders and evidence of engagement through Phase 1.	0-90 days
	Documentation of approach used to achieve consensus among stakeholders on key products.	
	Documentation of the following key products: • a prioritized set of measures to be collected in the community, including measures that are directly reported by existing community-level measures • a feasible implementation plan for sampling and data collection • principles of an optimal visualization platform	
	Produce a final report including a detailed roadmap/timeline of specific steps to launch data collection within the community, including risks and mitigation plans, which will illustrate what the collaborative/community would undertake if they were to enter into a demonstration as described in the RFP.	
Phase 2	Begin pilot of measures as formulated in the plan, contingent on available funding.	90-180 days

4 AWARD INFORMATION

4.1 AWARD AMOUNT

The Connecticut State Innovation Model Program Management Office (PMO) is making available **total awards of up to $25,000 per Participant Community. Up to $10,000 in additional award funds is available to up to two Participant Communities selected to participate in the rapid-cycle measure development project.**

Both awards apply to the first of two anticipated 90-day performance periods. The amount awarded may vary depending on the strength of the application and the proposed scope of work. Awardees may not receive the award amount requested and may be asked to revise the work plan and budget to reflect the final award amount.

Participant Communities may use awarded funds for the following:

- Appoint or hire a part-time project coordinator/facilitator to:
    - Serve as a liaison between the collaborative, lead organizing entity and the State;
    - Coordinate the activities of the community partners (e.g., scheduling, email, etc.)
    - Facilitate and/or document meeting discussions and decisions
    - Provide regular status updates and attend project meetings;
    - Perform networking and communication activities;
    - Conduct research and local strategy analysis as needed
- Provide compensation for community member consultants that are substantively engaged in the conduct of grant-related work. For the purpose of this RFP, this includes activities related to section 3.1.A in this proposal. This may include:
    - Materially contributing to the development of the Phase 1 deliverable identifying community needs and drivers for conditions related to HEC Health Priority Aims
    - Materially contributing to the development of the Phase 1 deliverables related to identifying additional partners/partner communities

  Note: Stipends solely to offset the cost of attending meetings, focus groups or other forums are not allowable costs under federal rules.
- Supplies, equipment, travel, and meals are not allowable costs under this award.

4.2 ELIGIBILITY INFORMATION

To be eligible, the applicant must be recognized as a single legal entity by the state where it is incorporated and must have a unique Taxpayer Identification Number (TIN) designated to receive payment. Applications will be screened to determine eligibility for further review using criteria detailed in this RFP and in applicable law.

4.3 Period of Performance

The anticipated Period of Performance is listed in the **Executive Summary** and in **Section 3.5. Key Outputs and Timeline.**

4.4 Termination of Award

Funding is dependent on satisfactory performance against the scope of work and outputs and a decision that continued funding is in the best interest of the State. Proposals will be funded subject to meeting terms and conditions specified in the resulting Contract and available funds. Awards may be terminated if these terms and conditions are not met. The State reserves the right to terminate in any case.

4.5 Issuing Office and Contract Administration

The Office of Health Strategy ("OHS") is issuing this Request for Proposal (RFP) and is the only contact in the State of Connecticut (State) for this competitive bidding process. The address of the issuing office is as follows:

Name: Office of Health Strategy
Address: P.O. Box 340308
410 Capitol Avenue MS#OHS
Hartford, CT 06134-0308

OHS has designated the individual below as the Official Contact for purposes of this RFP. All communications with the Official Contact must be in writing.

The Official Contact is the only authorized contact for this procurement and, as such, handles all related communications on behalf of the State. Respondents, Prospective Respondents, and other interested parties are advised that any communication with any other employee(s) of OHS (including appointed officials) or personnel under contract to OHS about this RFP is strictly prohibited. Respondents or Prospective Respondents who violate this instruction risk disqualification from further consideration.

Name: Brent Miller
Address: P.O. Box 340308
410 Capitol Avenue MS#OHS
Hartford, CT 06134-0308
E-Mail: brent.miller@ct.gov

5 APPLICATION DETAILS

5.1 SUBMISSION INSTRUCTIONS

This Request for Proposals serves as the application package and contains all the instructions to enable a potential applicant to apply.

5.1.1 Respondents' Questions

Respondents are encouraged to submit questions seeking clarification of the RFP requirements by email to Brent Miller, Office of Health Strategy (brent.miller@ct.gov). Questions will be reviewed on an ongoing basis and responses will be posted within 5 business days of receipt. The State will respond to all questions in one or more official addenda that will be posted to the Department of Administrative Services (DAS) website (http://das.ct.gov/cr1.aspx?page=12).

5.1.2 Submission Requirements

The proposal must be submitted to Brent Miller, Office of Health Strategy (brent.miller@ct.gov), no later than the established deadline listed in the Executive Summary. All documents should be submitted as PDFs, with the exception of the budget (Attachment D), which should be submitted as an Excel spreadsheet.

5.1.3 Format Requirements

In order to ensure readability by reviewers, fairness in the review process, and consistency among applications, each application must follow the following specifications to be reviewed:

- Use 8.5" x 11" letter-size pages with 1" margins (top, bottom, and sides).
- All pages of the Response must be paginated in a single sequence.
- Font size must be no smaller than 12-point
- Follow the page limits as detailed in the next section.

5.2 APPLICATION CONTENT

The application should be written primarily as a narrative with detailed specific actions highlighted to emphasize the proposed activities of the Participant Community. The Lead Applicant should organize its response based on the sections detailed below.

I. **PROPOSAL FACE SHEET**
See **Attachment A**

II. **TRANSMITTAL LETTER** *(No more than 2 pages, single spaced)*
Written statement that addresses:
- That the Respondent accepts without qualification:
  - Assurances and Acceptance (RFP Section 6.2.9);
  - all Mandatory Terms and Conditions;

- Brief statement outlining experience and qualifications to undertake this project;
- A statement that any submitted response and cost shall remain valid for one hundred twenty (120) days after the proposed due date or until the contract is approved, whichever comes first;
- Evidence of Qualified Entity: The Respondent shall provide written assurance to OHS from its legal counsel that it is qualified to conduct business in Connecticut and is not prohibited by its articles of incorporation, bylaws, or the law under which it is incorporated from performing the services required under any resultant contract.
- Sanction – Disclosure: The Respondent shall provide a statement that attests that no sanction, penalty or compliance action has been imposed on the Respondent within three years immediately preceding the date of this RFP. If the Respondent proposes the use of a subcontractor, each proposed subcontractor must provide the same statement.

III. PROJECT ABSTRACT *(1 page, single-spaced)*

A succinct description of the proposal, how the funds will be used, and the projected impact.

IV. PROJECT NARRATIVE *(5 pages, single-spaced if applying for HEC Pre-Planning project only; 7 pages, single spaced if applying for the HEC Pre-Planning and Rapid Cycle Measures Development projects)*

The Project Narrative should address how the Respondent will carry out the required service components. The Respondent should organize the narrative in the following bolded sections:

1. **Participant Community Attributes**

The Application Narrative should address the nature of the Participant Community collaboration, including resources, past and current activities, level of commitment and the overall state of readiness to participate in the HEC Pre-Planning process.

a. Provide Participant Community name and service area geography (boundaries, urban or rural, etc.)

b. Describe Participant Community demographics for the area served. Include overall health status information, including known indicators related to HEC Priority Areas[16]. Include information regarding needs and barriers to care/services for individuals and families to access services related to the HEC Priority Areas.

c. Describe size of Participant Community collaboration, including number and type of participating organizations and clients served. Provide attachment with list all

[16] HEC Priority Areas Include: (1) **Improving Child Well-Being in Connecticut Pre-Birth to Age 8 Years:** Assuring all children are in safe, stable, and nurturing environments; (2) **Improving Healthy Weight and Physical Fitness for All Connecticut Residents:** Assuring that individuals and populations maintain a healthy or healthier body weight, engage in regular physical activity, and have equitable opportunities to do so

collaborative partners by sector, organization name, and representative's role/title *(does not count toward page count)*.

d. Describe the nature of the structure of the Participant Community partnership, including (if applicable) governance structure, lead organizing entity or backbone organization, decision making structure, and/or any other formal or informal roles or working processes.

e. Describe current level of engagement of community residents in the Participant Community partnership. Include any organizations included in the partnership that represent community interests as well as the current and/or planned engagement of community residents in the partnership planning and decision-making structure.

f. Describe the current state of the data infrastructure of the Participant Community, including the ability to track and report on measures within and across partners and use of data to meet accountability and performance targets.

g. Describe why the Participant Community seeks to participate in this initiative.

h. Describe the institutional commitment to advance the HEC strategy (including leadership support) for Participant Community partner organizations

i. Describe the top three overall strengths and the top three areas of need for the Participant Community relative to the goals and objectives of the project.

2. Proposed Approach – HEC Pre-Planning

a. Describe the Participant Community's strategy for delivering on each of the objectives outlined in **Section 3. Required Service Components and Scope of Work**. *Note: If applying for the optional Rapid-Cycle Community Measures project, provide separate narrative under IV.3 below.*

b. Engagement of community residents in all aspects of the HEC (design, implementation, ongoing operation) is a critical component of the HEC model. Describe how the Participant Community has engaged in similar past arrangements and provide examples. Describe plans to engage community residents in this effort (e.g., identification of residents, number of residents, engagement process(es), accommodations to ensure involvement, etc.)

c. Describe the activities the Respondent will undertake to complete the scope of work.

(a) How frequently will the work group meet? How much time will be spent using other modes of engagement, e.g., video-conference, webinar, etc.

d. Describe how the work will be organized and managed.

e. Describe the tools, methods, and subject matter expertise that will be leveraged.

f. Provide a project plan and timeline for completing proposed deliverables. Provide key activities and outputs, beginning and end dates for each, and the accountable person.

3. OPTIONAL - Proposed Approach – Rapid Cycle Measures Development

If the Participant Community seeks to participate in the optional Rapid Cycle Measures Development sub-project, please answer the following questions.

a. Describe the Participant Community's strategy for delivering on each of the objectives outlined in **Section 3.2 Optional Participation: Development of HEC Rapid-Cycle Community Measures.**
b. Describe how the Participant Community plans to engage community residents in this effort
c. Describe the activities the Participant Community will undertake to complete the scope of work.
    (a) How frequently will the work group meet? How much time will be spent using other modes of engagement, e.g., video-conference, webinar, etc.
d. Describe how the work will be organized and managed.
e. Describe the tools, methods, and subject matter expertise that will be leveraged.
f. Provide a project plan and timeline for completing proposed deliverables. Provide key activities and outputs, beginning and end dates for each, and the accountable person.
g. Describe potential opportunities and barriers to collecting information directly from community members either through surveys or through collection of person-generated data (e.g., data from wearable devices), barriers.
h. Describe any relevant prior experience around community wide data collection (preferred but not required)?
i. What experience do you have/what strategies would you use to report results back to the community?

V. QUALIFICATIONS AND PROJECT MANAGEMENT *(2 pages, single-spaced. Resumes do not count towards the page limit)*

This section should describe the background and experience of the Lead Applicant necessary to carry out this project. The Lead Applicant should organize the narrative in the following bolded sections:

1. Qualifications and Experience

a. Describe the Lead Applicant's overall qualifications and background to carry out a project of this nature and scope. Should include its experience with managing a diverse group of stakeholders, project management, and group facilitation.
b. Describe the Lead Applicant's content level knowledge relevant to the scope of work, including related to community need with the proposed services outlined in Section 3.2.
c. Describe contracts held within the past five years with a scope similar to this one. Indicate what lessons learned (success, challenges) will be applied toward this project.

2. References

a. Provide information for at least three references. Must include brief description of work done, the organization's name, specific contact person name, address, phone number, and e-mail.

b. Provide a letter of support from each participant organization indicating their willingness and commitment to participating in the activities of the RFP (*will not count towards page limit*).

3. Organizational and Project Structure

a. Provide an organizational structure of the Lead Applicant indicating lines of authority and detail how this proposed project fits within the larger structure of the organization.
b. Describe how the project structure will enable effective implementation.

4. Project Management

a. Explain the staffing and management model of the Lead Applicant organization as well as for the specific individual/team who would be working with the State.
b. Detail the names of proposed personnel, their proposed role, expertise, functions and time commitments.
c. Include the name of a Project Manager who will serve as a single point of contact for the implementation of the project and who will be available to provide status updates and attend all project meetings.
d. Provide assurance of the capacity to deploy the required staff and resources to complete the scope of work, including identifying any other current or planned contractual obligations that might have an influence on the Respondent's capacity.
e. Identify and describe the role of any and all subcontractors and subject matter experts. Provide the following for each proposed subcontractor:
    - Legal Name of Agency, Address, FEIN
    - Contact Person, Title, Phone, Fax, E-mail
    - Services To Be Provided Under Subcontract

    Note: The resultant contractor must receive written approval from the State for staff changes. These changes must not adversely affect the ability of the Contractor to meet any requirement or deliverable set forth in this RFP and/or the resultant contract.

5. Speed to Contracting and Establish Identified Resources

a. Describe the Lead Applicant's ability to rapidly execute a contract with the state of CT within 14 days and secure identified personnel and other resources should the Participant Community be awarded

6. Resumes (limit 2 pages per resume)

Provide resumes for each proposed personnel and subcontractor. The resume shall include contract-related experience, credentials, education, training, and work experience.

VI. COST PROPOSAL *(2 page, single-spaced)*

Complete the cost proposal using the template provided in **Attachment C**. The budget table must include % FTE and fringe (<u>with breakdown</u>) for employed staff and/or an all-inclusive hourly rate of compensation and an estimate of hours to be expended by subcontracted staff. Community member consultants, if any, should be listed as subcontracted staff.

Provide a written narrative in support of the cost proposal including the role and qualifications of staff and subcontractors using the guidance provided in **Attachment C.**

Respondents that are applying for the "Rapid Cycle Community Measures" component of this RFP should provide two separate cost proposals (including budget template and narrative), one for the HEC Pre-Planning project and one for the add-on Rapid Cycle Community Measures project. Please clearly mark each proposal as "HEC Pre-Planning" and "Rapid Cycle Community Measures."

VII. STANDARD FORMS

The Respondent shall submit the following standard forms:

- **Procurement Agreement Signatory Acceptance:** Proposal must include a Statement of Acceptance, without qualification of all terms and conditions within this RFP and the **Mandatory Terms and Conditions** for a PSA contract (with proposal, see Attachment B)
- **Consulting Agreement Affidavit** (with proposal, OPM Ethics Form 5, see section 6.2.11)
- **Affirmation of Receipt of State Ethics Laws Summary** (with proposal, OPM Ethics Form 6)
- **Iran Certification** (with proposal, OPM Ethics Form 7)
- **Gift and Campaign Contributions** (prior to contract, OPM Ethics Form 1, see section 6.2.11)
- **Nondiscrimination Certification Form** (prior to contract, see section 6.2.11)

6 EVALUATION AND SELECTION

6.1 REVIEW AND SELECTION PROCESS

It is the intent of the State to conduct a comprehensive, fair and impartial evaluation of the responses received to this competitive procurement. Only those submissions found to be responsive to the RFP requirements will be evaluated and scored.

A team consisting of qualified experts will review the applications to assess the degree of responsiveness, and clarity in their plan to meet the project goals and milestones. The review process will include the following:

- To be considered for review, applications will first be screened for completeness and adherence to eligibility.
- The review panel will assess each application to determine the merits of the proposal. SIM reserves the right to request that Respondents revise or otherwise modify their proposals and budget based on the State's recommendations.
- The State may elect to conduct interviews with the finalists prior to awarding the right to negotiate a contract. Any expenses incurred by the Respondent to participate in such interview shall be the responsibility of the Respondent.
- The results of the review of the applications will be used to advise OHS approving official. Final award decisions will be made by the designated approving official. In making these decisions, the approving official will take into consideration: recommendations of the review panel; the readiness of the applicant to complete the scope of work and objectives; and the reasonableness of the estimated cost to the government and anticipated results.

- The State reserves the right to conduct negotiations with applicants upon receipt of their proposals.

6.2 PROCUREMENT PROCESS

6.2.1 Contract Execution

The contract developed as a result of this RFP is subject to State contracting procedures for executing a contract, which includes approval by the Connecticut Office of the Attorney General. Contracts become executed upon the signature of the Office of the Attorney General. No financial commitments can be made until and unless the contracts have been approved by the Office of the Attorney General. No payment for work performed prior to execution of the contract issued pursuant to this RFP can be approved. The Office of the Attorney General reviews the contract only after the Program Director and the Contractor have agreed to the provisions.

6.2.2 Acceptance of Content

If acquisition action ensues, the contents of this RFP and the Response of the successful Respondent will form the basis of contractual obligations in the final contract. The resulting contract will be a Personal Service Agreement (PSA) contract between the successful Respondent and the State. The State is solely responsible for rendering decisions in matters of interpretation on all terms and conditions.

6.2.3 Appeal Process

The Respondent may appeal any aspect of the competitive procurement; however, such appeal must be in writing and must set forth facts or evidence in sufficient and convincing detail for OHS to determine whether – during any aspect of the competitive procurement – there was a failure to comply with the State's statutes, regulations, or standards concerning competitive procurement or the provisions of the Procurement Document. Appeals must be submitted by the Respondent to Victoria Veltri (Victoria.Veltri@ct.gov), with a copy to the Official Contact for this procurement.

Respondents may submit an Appeal to OHS any time after the submission due date, but not later than thirty (30) days after the State notifies Respondents about the outcome of a competitive procurement. The e-mail sent date or the postmark date on the notification envelope will be considered "day one" of the thirty (30) days.

Following the review process of the documentation submitted, but not later than thirty (30) days after receipt of any such Appeal, a written decision will be issued and delivered to the Respondent who filed the Appeal and any other interested party. The decision will summarize the State's process for the procurement in question; and indicate the Agency Head's finding(s) as to the merits of the Respondent's Appeal.

Any additional information regarding the Debriefing and/or the Appeal processes may be requested from the Official Contact for this RFP.

6.2.4 Contest of Solicitation of Award

Pursuant to Section 4e-36 of the Connecticut General Statutes, "Any Respondent or RESPONDENT on a state contract may contest the solicitation or award of a contract to a subcommittee of the State Contracting Standards Board…" Refer to the State Contracting Standards Board website at www.ct.gov/scsb.

6.2.5 Disposition of Responses - Rights Reserved

Upon determination that its best interests would be served, the State shall have the right to the following:

1. **Cancellation:** Cancel this procurement at any time prior to contract award.
2. **Amend procurement:** Amend this procurement at any time prior to contract award.
3. **Refuse to accept:** Refuse to accept, or return accepted Responses that do not comply with procurement requirements.
4. **Incomplete Business Section**: Reject any Response in which the Business Section is incomplete or in which there are significant inconsistencies or inaccuracies. The State reserves the right to reject all Responses.
5. **Prior contract default:** Reject the submission of any Respondent in default of any prior contract or for misrepresentation of material presented.
6. **Received after due date:** Reject any Response that is received after the deadline.
7. **Written clarification:** Require Respondents, at their own expense, to submit written clarification of their Response in a manner or format that the State may require.
8. **Oral clarification:** Require Respondents, at their own expense, to make oral presentations at a time selected and in a place provided by OHS. Invite Respondents, but not necessarily all, to make an oral presentation to assist OHS in their determination of award. The SIM further reserves the right to limit the number of Respondents invited to make such a presentation. The oral presentation shall only be permitted for clarification purposes and not to allow changes to be made to the submission.
9. **No changes:** Allow no additions or changes to the original Response after the due date specified herein, except as may be authorized by the State.
10. **Property of the State:** Own all Responses submitted in response to this procurement upon receipt by the State.
11. **Separate service negotiation:** Negotiate separately any service in any manner necessary to serve the best interest of the State.
12. **All or any portion:** Contract for all or any portion of the scope of work or tasks contained within this RFP, with one or more Respondents.
13. **Most advantageous Response:** Consider cost and all factors in determining the most advantageous Response for the State when awarding the right to negotiate a contract.
14. **Technical defects:** Waive technical defects, irregularities and omissions, if in its judgment the best interests of the State will be served.
15. **Privileged and confidential communication:** Share the contents of any Response with any of its designees for purposes of evaluating the Response to make an award. The contents of all

meetings, including the first, second and any subsequent meetings and all communications in the course of negotiating and arriving at the terms of the Contract shall be privileged and confidential.

16. **Best and Final Offers:** Seek Best and Final Offers (BFO) on price from Respondents upon review of the scored criteria. In addition, the State reserves the right to set parameters on any BFOs it receives.
17. **Unacceptable Responses:** Reopen the bidding process if the SIM determines that all Responses are unacceptable.

6.2.6 Qualification Preparation Expenses

OHS assume no liability for payment of expenses incurred by Respondents in preparing and submitting Responses to this procurement.

6.2.7 Response Date and Time

To be considered for selection, a Response must be received by OHS by the date and time stated in the Executive Summary of this RFP. Respondents should not interpret or otherwise construe receipt of a Response after the closing date and time as acceptance of the Response, since the actual receipt of the document is a clerical function. OHS suggests the Respondent e-mail the proposal with receipt confirmation. Respondents must address all RFP communications to OHS.

6.2.8 Assurances and Acceptances

1. **Independent Price Determination**: By submission of a Response and through assurances given in its Transmittal Letter, the Respondent certifies that in connection with this procurement the following requirements have been met.
    a. Costs: The costs proposed have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such process with any other organization or with any competitor;
    b. Disclosure: Unless otherwise required by law, the costs quoted have not been knowingly disclosed by the Respondent on a prior basis directly or indirectly to any other organization or to any competitor;
    c. Competition: No attempt has been made or will be made by the Respondent to induce any other person or firm to submit or not to submit a Response for the purpose of restricting competition;
    d. Prior Knowledge: The Respondent had no prior knowledge of the RFP contents prior to actual receipt of the RFP and had no part in the RFP development; and
    e. Offer of Gratuities: The Respondent certifies that no elected or appointed official or employee of the State of Connecticut has or will benefit financially or materially from this procurement. Any contract arising from this procurement may be terminated by the State if it is determined that gratuities of any kind were either offered to or received by any of the aforementioned officials or employees from the contractor, the contractor's agent or the contractor's employee(s).
2. **Valid and Binding Offer:** Each Response represents a valid and binding offer to OHS to provide services in accordance with the terms and provisions described in this RFP and any amendments or attachments hereto.

3. **Press Releases**: The Respondent agrees to obtain prior written consent and approval from the SIM for press releases that relate in any manner to this RFP or any resulting contract.

4. **Restrictions on Communications with SIM Staff:** The Respondent agrees that from the date of release of this RFP until OHS makes an award that it shall not communicate with OHS staff on matters relating to this RFP except as provided herein through the SIM. Any other communication concerning this RFP with any OHS staff may, at the discretion of OHS, result in the disqualification of that Respondent's Submission.

5. **Acceptance of the OHS's Rights Reserved:** The Respondent accepts the rights reserved by OHS.

6. **Experience**: The Respondent has sufficient project design and management experience to perform the tasks identified in this RFP. The Respondent also acknowledges and allows OHS to examine the Respondent's claim with regard to experience by allowing OHS to review the related contracts or to interview contracting entities for the related contracts.

6.2.9 Incurring Costs

OHS is not liable for any cost incurred by the Respondent prior to the effective date of a contract.

6.2.10 Statutory and Regulatory Compliance

By submitting a proposal in response to this RFP, the proposer implicitly agrees to comply with all applicable State and federal laws and regulations, including, but not limited to, the following:

1. Freedom of Information, C.G.S. § 1-210(b). This Contract is subject to C.G.S. § 1-1210(b). The Freedom of Information Act (FOIA) requires the disclosure of documents in the possession of the State upon request of any citizen, unless the content of the document falls within certain categories of exemption, as defined by C.G.S. § 1-1210(b). The proposer shall indicate if it believes that certain documents or a portion(s) of documents, as required by this RFP is confidential, proprietary or trade secret by clearly marking such in its response to this RFP. The State will make an independent determination as to the validity under FOIA of the proposer's marking of documents or portions of documents it believes should be exempt from disclosure. While a proposer may claim an exemption to the State's FOIA, the final administrative authority to release or exempt any or all material so identified rests with the State. The State has no obligation to initiate, prosecute, or defend any legal proceeding or to seek a protective order or other similar relief to prevent disclosure of any information pursuant to a FOIA request. The proposer has the burden of establishing the availability of any FOIA exemption in any proceeding where it is an issue. In no event shall the State or any of its employees have any liability for disclosure of documents or information in the possession of the State and which the State or its employees believe(s) to be required pursuant to the FOIA or other requirements of law.

2. Contract Compliance, C.G.S. § 4a-60 and Regulations of CT State Agencies § 46a-68j-21 thru 43, inclusive. CT statute and regulations impose certain obligations on State agencies (as well as contractors and subcontractors doing business with the State) to insure that State agencies do not enter into contracts with organizations or businesses that discriminate against protected class persons.

3. Consulting Agreements, C.G.S. § 4a-81. Proposals for State contracts with a value of $50,000 or more in a calendar or fiscal year, excluding leases and licensing agreements of any value, shall include a consulting agreement affidavit attesting to whether any consulting agreement has been entered into in connection with the proposal. As used herein "consulting agreement" means any

written or oral agreement to retain the services, for a fee, of a consultant for the purposes of (a) Providing counsel to a contractor, vendor, consultant or other entity seeking to conduct, or conducting, business with the State, (b) Contacting, whether in writing or orally, any executive, judicial, or administrative office of the State, including any department, institution, bureau, board, commission, authority, official or employee for the purpose of solicitation, dispute resolution, introduction, requests for information or (c) Any other similar activity related to such contract. Consulting agreement does not include any agreements entered into with a consultant who is registered under the provisions of C.G.S. Chapter 10 as of the date such affidavit is submitted in accordance with the provisions of C.G.S. § 4a-81. The Consulting Agreement Affidavit (OPM Ethics Form 5) is available on OPM's website at http://www.ct.gov/opm/fin/ethics_forms

4. Gift and Campaign Contributions, C.G.S. §§ 4-250 and 4-252(c); Governor M. Jodi Rell's Executive Orders No. 1, Para. 8 and No. 7C, Para. 10; C.G.S. § 9-612(g)(2). If a proposer is awarded an opportunity to negotiate a contract with an anticipated value of $50,000 or more in a calendar or fiscal year, the proposer must fully disclose any gifts or lawful contributions made to campaigns of candidates for statewide public office or the General Assembly. Municipalities and CT State agencies are exempt from this requirement. The gift and campaign contributions certification (OPM Ethics Form 1) is available on OPM's website at http://www.ct.gov/opm/fin/ethics_forms

5. Nondiscrimination Certification, C.G.S. §§ 4a-60(a)(1) and 4a-60a(a)(1). If a proposer is awarded an opportunity to negotiate a contract, the proposer must provide the Department with written representation or documentation that certifies the proposer complies with the State's nondiscrimination agreements and warranties. A nondiscrimination certification is required for all State contracts–regardless of type, term, cost, or value. Municipalities and CT State agencies are exempt from this requirement. The nondiscrimination certification forms are available on OPM's website at http://www.ct.gov/opm/fin/nondiscrim_forms.

6.2.11 Key Personnel

OHS reserves the right to approve any additions, deletions, or changes in key personnel, with the exception of key personnel who have terminated employment. The department also reserves the right to approve replacements for key personnel who have terminated employment. OHS further reserves the right to require the removal and replacement of any of the proposer's key personnel who do not perform adequately, regardless of whether they were previously approved by OHS.

6.2.12 Other

Bidding on and/or being awarded this contract shall not automatically preclude the Respondent from bidding on any future contracts related to OHS. Continued funding is contingent upon the ongoing availability of funds, satisfactory program performance, and demonstrated need for these services.

7 DEFINITIONS AND ACRONYMS

DEFINITIONS

Contract: The contract awarded to the successful Respondents pursuant to this RFP.

Health Enhancement Community (HEC) A Health Enhancement Community refers to an optimal stage of development reached by a cross-sector collaborative or coalition of partners designated as prepared to achieve health priority aims, goals, and requirements set forth in the HEC Framework.

HEC Health Priority Aims: The HEC initiative has two health priority aims:

- **Improving Child Well-Being in Connecticut Pre-Birth to Age 8 Years:** Assuring all children are in safe, stable, and nurturing environments
- **Improving Healthy Weight and Physical Fitness for All Connecticut Residents:** Assuring that individuals and populations maintain a healthy or healthier body weight, engage in regular physical activity, and have equitable opportunities to do so

HEC Planning Consultant: The organization that provides, among other services, subject matter expertise, facilitation, and other services to the State as part of the Health Enhancement Community Initiative.

Lead Applicant/Respondent: An entity that is applying to this RFP on behalf of a Participant Community. The Lead Applicant will serve as the single point of accountability and fiscal agent for RFP funds. The Lead Applicant shall facilitate the timely execution of a contract with the state, the organization of participant organizations to meet, provide project management, and have formal representation in the HEC. The terms “Lead Applicant” and “Respondent” are interchangeable in this RFP.

Participant Community: A Participant Community refers to a cross-sector collaborative or coalition of partners from health, social service, and other sectors working together to improve community health and equity.

Participant Organization: An entity that has indicated commitment to being a part of the Participant Community. The Participant Organization has communicated with the Lead Applicant/Respondent their intent to participate in the Health Enhancement Community (HEC), and will be active in and support the accomplishment of priority aims, goals, and requirements set forth in the HEC Framework.

Respondent: An organization that has submitted a proposal on behalf of the Participant Community to the SIM PMO in response to this RFP. Also referred to as “Lead Applicant.”

Subcontractor: An individual (other than an employee of the Respondent) or business entity hired by the Respondent to provide a specific service as part of a Contract with the SIM PMO as a result of this RFP.

ACRONYMS

CMMI Center for Medicare & Medicaid Innovations
DPH Department of Public Health
OHS Office of Health Strategy
OSC Office of the State Comptroller
RFP Request for Proposals
SIM State Innovation Model
TA Technical Assistance

ATTACHMENT A: PROPOSAL FACE SHEET

OFFICE OF HEALTH STRATEGY
REQUEST FOR PROPOSALS (RFP)
HEC PRE-PLANNING
PROPOSAL FACE SHEET

1	**LEAD APPLICANT** (Legal name and address of organization as filed with the Secretary of State): Legal Name: _____ Street Address: _____ Town/City/State/Zip: _____ FEIN: _____
2	**DIRECTOR/CEO** Name: _____ Title: _____ Telephone: _____ FAX: _____ Email: _____
3	**CONTACT PERSON** Name: _____ Title: _____ Telephone: _____ FAX: _____ Email: _____

ATTACHMENT B: PROCUREMENT AND CONTRACTUAL AGREEMENTS SIGNATORY ACCEPTANCE

Statement of Acceptance

The terms and conditions contained in this Request for Proposals constitute a basis for this procurement. These terms and conditions, as well as others so labeled elsewhere in this document are mandatory for the resultant contract. The Office of Health Strategy is solely responsible for rendering decisions in matters of interpretation on all terms and conditions.

On behalf of_____

I, _____agree to accept the Mandatory Terms and Conditions and all other terms and conditions as set forth in the HEC Pre-Planning Request for Proposals.

_____

Signature

_____ _____

Title Date

ATTACHMENT C: BUDGET NARRATIVE GUIDANCE

BUDGET NARRATIVE

The Respondent must provide a budget narrative according to the instructions provided here. Costs must be reasonable and consistent with the proposed scope.

The resultant Contract shall include a maximum cost for the contract period for the proposed services. Payment shall be based on actual costs incurred not to exceed the Contract maximum for each budget category, and for the Contract overall.

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by ensuring that the required or needed information is provided.

Please note that the Respondent may wish to request funding for personnel from their organization for the activities under this RFP. The Respondent may, alternatively, decide to request the funding for consulting services. Supplies, travel, and other costs are not permitted under this opportunity.

Please provide the following related to the budget:

1. **Budget.** Please provide a completed budget utilizing the excel budget template (the "Budget Template" tab) provided with this RFP. A "Budget Example" tab is provided in the spreadsheet for guidance.

2. **Budget Justification Narrative.** Please provide a written budget narrative justifying each of the budget template categories for Tables 1-4, following the guidance below

Please include narrative justification as follows:

Table 1: Indirect Costs

Table 1 will auto populate. Currently the indirect cost rate is set at 10% in the excel budget template. Should your indirect costs rate be different, please adjust accordingly in the excel template and provide the indirect cost rate used here in the budget narrative. Please note that to claim indirect costs the applicant organization must have a current approved indirect cost rate agreement established with the Cognizant Federal agency. A copy of the most recent indirect cost rate agreement must be provided with the application. **SIM-funded contracts and activities cannot exceed 10% in indirect costs.**

Table 2: Salaries and Wages

For each requested position, provide the following information: name of staff member occupying the position, if available; percentage of time budgeted for this program; and provide a justification

and describe the scope of responsibility for the position, relating it to the accomplishment of program objectives.

Sample Justification

The format may vary, but the description of responsibilities should be directly related to specific program objectives.

Job Description: Project Coordinator - (Name)

This position directs the overall operation of the project; responsible for overseeing the implementation of project activities; coordination with other agencies; development of materials, provisions of in service and training; conducting meetings; designs and directs the gathering, tabulating and interpreting of required data; responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to HHS. This position relates to all program objectives.

Table 3: Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed.

Sample Justification: Fringe rate = 31% of salary, broken down as follows:

Healthcare and Dental Insurance 15.25%

Life Insurance 0.10%

Unemployment 6.8%

Medicare 1.45%

Social Security 6.2%

Worker's Compensation 1.2%

Table 4: Consultant Costs

This category is appropriate when hiring an individual to give professional advice or services for a fee but not as an employee of the awardee organization. Hiring a consultant requires submission of the following information:

1. Name of Consultant;
2. Organizational Affiliation (if applicable);
3. Nature of Services to be Rendered;
4. Relevance of Service to the Project;
5. The Number of Days of Consultation (basis for fee); and

6. The Expected Rate of Compensation (travel, per diem, other related expenses)—list a subtotal for each consultant in this category.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget.

Supplies - Supplies are not an eligible cost under this opportunity.

Travel - Travel is not an eligible cost under this opportunity.

Other - Other costs are not eligible costs under this opportunity.