

Request for Proposals: Improving Care Transitions

Proposals Due Friday, February 23, 2007



I. Introduction

The California HealthCare Foundation is pleased to announce the introduction of the Improving Care Transitions project. The purpose of this project is to stimulate change in practice and care delivery systems to improve patient transitions from one care setting to another. Current evidence-based research indicates that better management of patient transitions improves continuity of care; reduces error and delay; and increases patient control of health decisions. The specific approach selected for this project is the Coleman Care Transitions Intervention.

This project will implement the Coleman Care Transitions Intervention in up to ten locations in California; provide education and expert coaching to develop provider skills in the model; provide up to \$50,000 per site team to support implementation during the grant period from May 2007 through April 2008; serve a total of 1,000 patients or more during the grant period; and develop plans to sustain the model in each location.

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. Formed in 1996, CHCF's goal is to ensure that all Californians have access to affordable, quality health care. CHCF commissions research and analysis, publishes and disseminates information, convenes stakeholders, and funds development of programs and models aimed at improving the health care delivery and financing systems. A key priority for CHCF is promoting better chronic disease care for Californians. For more information, visit www.chcf.org.

II. Problem Statement

If patients are asked about their experiences during care transitions, they describe frustrations around information not making it from one care setting to the next: 'Why do I have to tell you my allergies again? I just told that other person two doors down.' What comes across even more strongly is that patients feel unprepared. It's partially a fear of the unknown, but they also don't feel prepared about their role—the self-care aspect. When they're in a hospital or nursing home, they're largely in a dependent role. Then, literally moments before discharge or transfer, suddenly the tables are turned and they're asked to assume a major role in their care. That, understandably, creates a lot of anxiety.

Even when patients try to do what's asked of them, if they run into problems or have questions, they can't reach the individuals who gave them the initial instructions. In

addition, older adults—who may be overly respectful of their health care team—find their preferences are not taken into account. They don't feel like they have permission to speak up, to provide realistic insight when a care plan is not reasonable.

—Eric Coleman, M.D., M.P.H., 2006

Our health care system is complex and poorly connected, and patients are not well prepared to navigate it, especially during transitions. Care transitions refer to the movement of patients from one health care practitioner or setting to another as their condition and care needs change. This may include transitions from hospitals to nursing homes to home care or home without care. The locations and care practitioners involved in care transitions are many. As a result, information shared with patients and their caregivers is often confusing, contradictory, or missing critical elements. Appropriate transitions of care include understanding the needs of patients, understanding their health goals and wishes, making appropriate logistical arrangements, educating patients and families about expectations and next steps, and coordinating between health care providers at both settings. Elders and others with chronic diseases are at highest risk.

Most of the focus on medical error is on patients in institutional settings; however the seriousness of the problems that exist as a result of movement *between* settings is significant and often overlooked. Most health care providers practice in only one setting and are not familiar with the specific requirements of other settings. In addition, health care practitioners usually do not follow the patient to the next level of care, thereby increasing the risk for error and problems with continuity of care.

III. Proposed Intervention Model: Coleman Care Transitions Intervention

The basic structure of the Coleman Care Transitions Intervention (CTI) involves project teams working together to implement the model. For this project, teams generally consist of one or more community-based organizations that manage or coordinate services for the elderly or disabled (Linkages, Multi-purpose Senior Services Programs, home health agencies) and one or more local hospitals and/or a managed care plan contracting with local hospitals.

The CTI is a four-week intervention that supports patients to assert a more active role in their health care. Patients receive specific tools and skills that are reinforced by a “transition coach” who follows patients across settings for the first four weeks after leaving the hospital and focuses on the following four components:

1. A patient-centered record of the essential care elements for facilitating communication during the care transition
2. A structured checklist of critical activities to help patients and their families enlist assistance throughout the transition
3. Transition coach-facilitated patient activation and self-management sessions to help patients and their caregivers understand and apply the first two components, and assert their role in managing transitions

4. Transition coach follow-up visit(s) in the transitioned site (often skilled nursing facility and/or in the home) and phone calls designed to sustain all the above and provide continuity across the transition.

For more information about the CTI model, visit www.caretransitions.org.

Benefits of the CTI

In a randomized controlled trial, use of the CTI resulted in lower hospital re-admission rates; on average, for every 17 patients that works with a transition coach, one re-hospitalization will be prevented. Researchers estimate that for every 350 patients who receive the intervention, hospital costs will be reduced by approximately \$300,000. In addition, people who have experienced the care transitions model rate their hospital discharge experience as very good or excellent (*Archives of Internal Medicine*, September 2006).

Not only did older participants stay out of the hospital while a transition coach was working with them (the first four weeks after discharge from the index hospitalization), they were significantly more likely to remain out of the hospital for up to six months following the initial hospitalization. Despite facing the challenges of a change in health status, anxiety, and sleep deprivation, these older adults were able to learn and apply new skills and tools that led to a sustained benefit long after the coach was gone. This approach represents an investment in self-care.

In addition, older patients were asked to identify a personal goal that they wished to achieve during the four-week period following their hospital discharge. Patients who received the CTI were significantly more likely to achieve their personal goals that addressed symptom control or functional improvement than those who did not receive the CTI.

IV. Project Description

This Request for Proposals seeks to fund up to ten communities to implement the Coleman Care Transition Intervention to improve care and health outcomes for patients who are moving between care settings. Each community team will provide at least 100 patients with transition support during the 12-month grant period.

Teams formed for this work should include key stakeholders from hospitals, nursing homes, community case management programs, or home health agencies. A team must include at least one hospital and one community case management provider.

Participation in the CTI training workshops is required of all potential grantees, and allows them to fully understand the model and determine if they have the capacity to successfully implement CTI. Specifically, the implementations will include leadership engagement and community partners, identification of patient populations for intervention, selection of team members, staff training, development of transition coaches, and data collection.

The California HealthCare Foundation will fund expert consultation from Dr. Coleman and his colleagues, coaching and education, and site visits during the grant period.

Each team (consisting of two or more care settings) is eligible to receive up to \$50,000 to support the coordination of the team's work and the measurement of the project's progress. This will be paid to the lead organization thusly: \$25,000 upon approval and completion of a grant agreement; \$20,000 after six months for teams who have demonstrated full and successful participation in the project; and \$5,000 following submission of the grantee final report.

Teams are expected to fully participate in monthly conference calls, meeting work plan goals, training on the transition coach skills, and completing all required reports on a timely basis. Successful participation means the team has demonstrated progress based on their work plans.

Participating organizations are expected to contribute some of their own staff and other resources to ensure the success of this intervention. The funds being provided to grantees are not meant to fully fund the implementation, but rather to support the start up of a new way of providing transitional care that will eventually be financially self-sustaining.

The project will receive overall management by Kate O'Malley, senior program officer with CHCF. Monique Parrish, Dr.Ph., M.P.H., L.C.S.W., will provide operational project management. Eric Coleman, M.D., M.P.H., will serve as an expert advisor along with members of his staff.

V. Eligibility and Selection Criteria

Eligibility

Eligible grantees will apply as a local community collaboration team that includes at least one or more organization from each group:

1. Community-based organization that manages or coordinates services for the elderly or disabled (such as Linkages, Multi-purpose Senior Services Programs, home health agencies); and
2. Local hospital and/or a local managed care plan contracting with local hospital(s).

The applicant will serve as the lead organization and must name the other participating organization on the team. The two health care organizations must agree to work together to improve care transitions. Applications will be evaluated based on focus, commitment and the inclusion of a good mix of providers, regions, experience, and expectations.

Selection Criteria

CHCF is interested in supporting organizations that have the interest, leadership support, and commitment to implement the Coleman CTI in California communities. Organizations will be

expected to have the following components in place to support successful implementation of the program:

- Strong support from senior management of the respective participating organizations;
- The commitment of discharge planners and case managers to improve the process of care transitions with this model;
- Ability to commit key staff to attend required meetings and participate in training (total of 12 conferences calls, and three to four days of training off site over 12 months);
- Demonstrated working relationships between team collaborators, especially across several disciplines (e.g., physician, nursing, social work, etc.);
- Commitment to continue the program should it prove its success in the local setting.

VI. Grantee Activities

Work Plan Development

Once grantees have been selected, collaborating teams will detail their plans to implement the Care Transitions model, including leadership engagement, staff training, development of transition coaches, prepare for data collection, identify patient populations for study, and select members of the team. Draft work plans should be completed by May 2007.

Team Organization & Site Visits

The CHCF staff and/or consultants will visit each site in May or June 2007 to meet with the collaborative team and review work plans. Because each team is made up of at least two organizations and will include multi-disciplinary members from each organization, a solid team process must be established at the onset of the initiative. The lead organization will designate a team leader to coordinate the work and name enough team members to provide depth and stability to the intervention. The commitment of senior management is critical to the success of this effort, and the project manager will also meet with senior management during site visits.

Transition Coach Skill Development

Individuals working as transition coaches will participate in a CTI training program in June 2007 to develop a set of skills apart from those commonly used in discharge planning and case management. One of the corner stones of this model is patient and family empowerment, and transition coaches are the key to encouraging older adults and their families to take a more active role in their care. Coaches will work with patients/families using techniques such as scripting requests for follow-up appointments, or role-playing conversations with a home care agency nurse. Transition coaches also help patients and families develop and use a personal health record to manage their own information and overcome the cross-provider communication gap.

Monthly Conference Calls

Project teams will participate in conference calls or WebEx presentations each month. These sessions will be structured with opportunities for the teams to learn from experts working on improving transitions, receive specific feedback on the team's specific challenges, brainstorm on effective strategies to overcome the challenges, and learn from other grantees' experiences.

Grantee Meeting

Grantees will be expected to build into their budget funds to attend an in-person meeting in Oakland in October 2007. The purpose of the meeting will be to collaborate with other teams through shared learning, mutual support, coaching, information sharing, and problem solving.

Data and Measurement

At the onset of the project, each team will be given a measurement template to support tracking and reporting of data. Using Eric Coleman's Care Transitions Measure© (available at www.caretransitions.org) the teams will assess patient satisfaction with care practice and fidelity to the care transitions model with each patient transfer using the four key components of the model. The data will be reported to the project manager on a routine basis and the schedule will be developed as part of the site work plan.

VII. Application Process

Timeline

January 4, 2007	Q & A teleconference 12:00 – 1:00 p.m.
January 9, 2007	Q & A teleconference 3:00 – 4:00 p.m.
January 12, 2007	Registration deadline for required workshops
January 25, 2007	Required workshop in Pasadena, 10:00 a.m. to 3:00 p.m. for organizations in Southern California
January 26, 2007	Required workshop in Oakland, 10:00 a.m. to 3:00 p.m. for organizations in Northern California
February 23, 2007	Proposal submission by 5:00 p.m.
March 22, 2007	Grantee notification of selected projects
May 1, 2007 – April 30, 2008	Care Transition Interventions implemented

Step 1: Q&A Conference Calls. Prior to developing a proposal, potential grantees are *encouraged* to participate in a question and answer session in one of the two teleconference calls. The calls provide an opportunity to find out more about the care transitions program, this request for proposals, and determine if you want to attend the workshop.

Thursday, January 4, 2007

12:00 – 1:00 p.m.

Call toll-free 800.510.9723

Participant passcode 44304881

Tuesday, January 9, 2007

3:00 – to 4:00 p.m.

Call toll-free 800.510.9723

Participant passcode 37692676

Step 2: Care Transitions Workshop (*mandatory*). Also before developing a proposal, teams that plan to apply must attend one of two workshops provided by Eric Coleman, the developer of Care Transitions Intervention. The workshop will present an overview of the CTI, descriptions of successful implementations in a variety of sites, and a tool to assess implementation readiness. Workshop participants will complete this tool at the session and use the results as part of the proposal submission process. The workshops will take place:

Thursday, January 25, 2007

Sheraton Hotel

Pasadena, CA

Friday, January 26, 2007

Washington Inn

Oakland, CA

Please contact Maisha Nkhume at 510.587.3148 or caretransitions@chcf.org to register for one of the workshops by Friday, January 12.

Step 3: Application Submission. The paper application package must be received in the Foundation office at 476 Ninth Street, Oakland, CA 94607 no later than 5:00 p.m. Pacific time **Friday, February 23**. In addition to a hard copy, please email items 1, 2, and 3 to caretransitions@chcf.org at the same time. Preferred electronic format for documents is Adobe PDF or Microsoft Word. Proposals will be acknowledged by a return email within 24 hours.

VIII. Application Packet

Please include the following materials in the application packet submitted to the Foundation.

1. Project Cover Sheet form: The signed original form providing senior executive commitment to participation in the collaborative. (Form at www.chcf.org/grantinfo.)
2. Application Narrative (see below for details): The application must address the parameters described and should be no more than eight pages of text in a 12-point font. Applicants are expected to honor the space limitation. CHCF may contact applicants for additional information if required.
3. Proposal Budget: One form for each organization in the team that will be drawing on grant funds. (Form at www.chcf.org/grantinfo.)
4. One copy of the current IRS determination letter indicating Section 501(c)(3) tax-exempt status or a W-9.

Application Narrative

Interested organizations must complete an application narrative, *not to exceed eight pages*, including verification of organizational commitment to the project.

Organizational Information

For each organization on the project team, provide a brief description of the type and size of organization, structure, and services provided. For the hospital or health plan setting, describe the number and type of discharges on an annual basis. Describe how the two or more organizations have worked together in the past. If this is a new opportunity to work together, describe the incentives to work on this project.

Project Description

Describe the current process for patient transition to other care settings and a description of how the four elements of the Care Transitions Intervention would be implemented in your setting, including a description of how the two agencies would work together. How would the project meet the goal of supporting 100 patients through the transition process using the CTI? Define the proposed population group for the intervention, such as a specific chronic illness or a group identified by frequency of transitions. Describe the selection of staff to work as transition coaches, and how this role would be integrated into staff responsibilities. Address any issues that were identified by the readiness assessment completed during the workshop. Discuss strategies for sustainability of the CTI in your settings after the grant period is completed.

Anticipated Use of Foundation Resources

Based on your understanding of care transitions and your plans for participation in this collaborative, explain how you expect to use the CHCF funds. Explain how the funds will be distributed among the team organizations, if this applies. Refer to the budget sheets that are submitted for each organization.

Leadership

Identify the lead organization and provide the name of the medical and/or administrative leader who will be responsible. This person will provide counsel to the team as needed, obtain essential resources, and remove obstacles as necessary. The application cover page must be completed and signed to show organizational commitment.

Team Members

Please provide the name and title for the team leader and the names, titles, and organizations for two other people who will commit to participate in the project. How are staff organized into a team and who is ultimately responsible for implementation?

Questions? All questions should be submitted to caretransitions@chcf.org before Thursday, February 22. Questions and responses will be posted at www.chcf.org/grantinfo.