



CALIFORNIA
HEALTHCARE
FOUNDATION

Request for Proposals

Team Up for Health: Supporting Patients for Better Chronic Care

Intent to Apply Due: Tuesday, September 9, 2008
Full Applications Due: Tuesday, September 30, 2008

I. About the California HealthCare Foundation

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

II. The Issue

More than 45 percent of Americans have at least one chronic condition and 44 percent of these have two or more. Their direct health care costs account for over 75 percent of total health care expenditures. The need for improved chronic disease care is clear, yet clinicians alone cannot improve the health status of their patients. People with chronic diseases must make and sustain the life changes (at-home testing and monitoring, appropriate medication use, diet, exercise, etc.) required to manage their conditions. To do so effectively, they need to be educated, motivated, and supported in making and maintaining these behavior changes.

“Chronic disease self-management support” can be broadly defined as the *process* of providing patients (and their families) with the education and support they need to increase their knowledge, skills, and confidence to manage their chronic conditions. This includes regular assessments of progress, goal setting, problem-solving support, and follow-up to enable patients to manage medical regimens as well as the functional and emotional changes brought about by chronic illness. “Self-management” refers to the tasks that an *individual* with one or more chronic conditions must undertake to live well.

Evidence is growing that self-management for a variety of chronic diseases leads to improvements in health status and outcomes, increased patient satisfaction and, in some cases, to reductions in service utilization and costs.

Patient- and family-centered care is defined as a philosophy and an approach to care that is grounded in mutually beneficial partnerships among patients, families, and health care professionals at all levels of care. The core concepts include:

- Dignity and respect: health care practitioners listen to and honor patient and family perspectives and choices;
- Information sharing: health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful;
- Participation: patients and families are encouraged and supported in participating in care and decision making at the level they choose; and
- Collaboration: patients, families, and health care practitioners collaborate in policy and program development, implementation and evaluation, health care facility design, professional education, and in the delivery of care.

The health care system can play a critical role in partnering with patients to enable effective self-management activities. At the individual patient encounter level, this requires patients, clinicians, and staff to work together to develop, implement, and sustain a plan for managing the patient's condition(s). While the health care system is essential for supporting patients in self-management, patients still spend most of their lives outside of the health system. It is therefore critical to actively involve family, friends, peers, and the general community in supporting patients to be healthy. At the practice level, patient and family advisors, who live with a chronic condition, need to be involved in efforts to redesign and improve office-based systems, develop peer support and educational programs, provide orientation and continuing education to clinicians and staff, and participate in evaluation and research.

III. Prior CHCF Work in Self-Management

In 2004, CHCF launched the *Promoting Consumer Partnerships in Chronic Disease Care: Strategies for the Safety Net* initiative. The purpose of the initiative was to identify and to implement innovative strategies to help people with diabetes or asthma become more active partners in their own care. The Foundation targeted projects that were ready for implementation and did not require extensive planning. A summary of the lessons learned is available at www.chcf.org/topics/chronicdisease/index.cfm?itemID=133518.

In 2006, CHCF launched two complementary self-management efforts:

1. Grants to ten clinics and medical groups to strengthen organizational structures, improve staff training, and provide tools to enable provider organizations to support their patients' growth in self-management. A summary of the lessons learned is available at www.chcf.org/topics/chronicdisease/index.cfm?itemID=133622
2. A partnership with the Robert Wood Johnson Foundation for the Quality Allies initiative focused on fostering innovations within clinics and medical groups with a specific emphasis on patient/family involvement to strengthen self-management support.

The previous initiatives helped clarify the importance of self-management and identify key components required for integrating these concepts into clinical practice. The most successful approaches involve a combination of the following:

- Teams effectively communicating with patients and supported by intensive communication training and team redesign;
- Involvement of patient and family advisors to ensure approaches meet the needs of patients and their families;
- Information systems to support outreach and follow-up; and
- An array of options for peers, family, friends, and providers to support patients.

This new initiative aims to institutionalize these lessons learned and other supportive self-management techniques in health care organizations while also building mechanisms outside the traditional health care system to support patients in their daily lives.

IV. Project Overview and Grants

The California HealthCare Foundation is pleased to announce a new \$2.37-million, three-year initiative, called *Team Up for Health: Supporting Patients for Better Chronic Care*. The primary goal for this initiative is to improve patients' confidence, behaviors, and clinical outcomes by helping health care delivery systems to (1) strengthen their capability to support patients and families in self-care by implementing and spreading proven approaches, and (2) reinforce linkages among people with chronic conditions through community organizations and virtual networks.

This RFP targets provider organizations (such as multi-site clinics – community or hospital-based, IPAs, and large medical groups) with experience supporting patient self-management, a strong interest in increasing the breadth and depth of their organizational approaches across clinical sites, and leadership commitment to support patients with chronic conditions in self-care.

Guided by the expertise of an advisory committee including patients and families, the project will provide planning and implementation grants, provider communication training, coaching for team redesign, support to involve patient and family advisors, consultation around patient and organization tracking measures, and consultation with self-management experts. The two-phase grant process will be utilized to ensure provider organization readiness and success.

Planning Phase

Provider organizations would receive \$25,000 per site for up to six months to participate in a structured assessment, education, and planning phase. Grantees would participate in multi-day training sessions in provider communication and involving patient and family advisors in care. In addition, organizations would have access to technical assistance to support care redesign, communication, and other successful self-management strategies. The planning phase would clarify the components and requirements of the initiative (including development of a core set of tracking measures) and verify commitment from staff and leadership necessary for success.

Implementation Phase

Outcomes of the planning phase will inform the grant making for the implementation phase. Grantees assessed as being ready and willing to commit to the implementation phase would be awarded grants of \$150,000 over two years. Phase two grantees would also have access to additional resources, training, and technical assistance to further institutionalize patient and family centered self-management strategies. The areas of focus for technical assistance would include redesign and team changes, communication skills, and strategies for sustaining involvement of patient and family advisors in improvement activities.

Beyond these health system-based approaches, organizations must be willing to experiment with ways to leverage virtual networks and community resources that support patient self-care. Grantees would work with experts in the area of social networking, online support, and community partnerships to link patients to resources outside the health system.

Technical Assistance

CHCF will engage a team of consultants with knowledge of and expertise in quality improvement and care team redesign, provider communication, patient-family centered care, community linkages, and social media. These consultants will work with grantees to assess organizational knowledge and experience with self-management, provide in-person training and information on available resources and tools, and help support successful implementation.

The following table outlines the types of technical assistance available during implementation to strengthen internal expertise and capacity to effectively support patients and families in self-care. The organizational assessments completed in the planning phase will guide the specific technical assistance resources for each grantee and the format and length of the educational sessions.

Technical Assistance	Format / Length	Content	Target Audience
<i>Provider Communication</i>	Train-the-trainer model requiring participation in 3-5 day workshop and phone coaching. More training tools provided.	Build collaborative relationships with patients including goal setting, action plans and problem solving.	Key individuals (1-2 people) at each organization with interest and time to train other clinicians and staff.
<i>Care Team Redesign</i>	Coaching model requiring participation in 2-3 day coaching workshop and ongoing phone coaching.	Coaches work with teams to use Quality Improvement approaches to redesign team roles and workflow.	Key individuals (1-2 people) at each organization to coach teams. May be same staff as trainers above.
<i>Patient and Family Centered Care</i>	Educational seminar (1-2 days), on-site consultation, and phone coaching for patients and teams.	Train teams in selecting and utilizing patients and families as advisors on care teams.	Key team members to participate in educational seminar and on-site consultation.
<i>Community Partnerships and Social Networking</i>	TBD	Develop approaches to link community partners with online resources.	Key team members including clinicians and patients.

CHCF is offering potential grantees an opportunity to benefit from experts in the area of self-management support and community partnerships and to receive the training necessary to implement self-management support. At the end of the grant period, grantees will have developed organizational capacity and further expertise in self-management support, have healthier and more satisfied patients, and increased job satisfaction among clinicians and staff.

Evaluation

All teams are expected to participate in a formal evaluation of the program. CHCF will engage an outside evaluator to assess the impact of the overall initiative, including the impact of the training, support, and follow-up systems on clinical and process outcomes, and success in engaging patients in their care. Grantees will be responsible for tracking and reporting on a uniform measure set in addition to working with the evaluation team to develop any site-specific measures they wish to track.

V. Eligibility

To be eligible, applicant organizations must either provide clinical care to persons with chronic conditions or act to organize clinical providers, such as community clinic consortia, independent practice associations (IPAs), medical groups, or integrated health systems. Health care organizations with the capacity and internal staff or partners to develop trainers and coaches are strongly encouraged to apply. The lead applicant organizations must be based in California.

This initiative will focus on patients with chronic conditions with preference for populations with multiple chronic conditions. The chronic condition(s) selected must involve large enough target populations to warrant organizational changes that will need to be made. In addition, there must be a clear case for how the communication skills training, redesign work, and patient/family involvement could benefit the target population.

Applicants must show how they will include patients with chronic conditions and their families in the planning, implementation, and review efforts to ensure that interventions are patient- and family-centered and responsive to individual strengths, needs, goals, priorities, and values.

Selection Criteria

CHCF is interested in supporting provider organizations that have experience in and understanding of how to implement self-management support in clinical practice and that also have a strong commitment to strengthening the support they provide. Specifically, organizations will be expected to have the following in place:

- Strong buy-in from senior leadership, including one or more physician champion(s);
- Strong support and interest from providers and teams to move beyond existing self-management practices;
- Organizational interest and commitment to involve patients and families in care, partner with community organizations and link patients to online communities;

- Staff that is willing and interested in receiving additional training and coaching;
- A population-based strategy to capture and track clinical data for patients with multiple chronic diseases (such as a registry system) and a commitment to provide summary information periodically as requested by program and evaluation staff; and
- Multi-disciplinary team(s) in place to manage patients with chronic conditions (could include registered nurse, health educator, dietician, medical assistant, and/or others).

Commitment to Participation

In addition to the criteria above, organizations must be willing to commit to the following activities in the Planning Phase:

- Participate in an organizational assessment;
- Participate in educational training sessions;
- Participate in site visits by CHCF staff and advisors; and
- Provide feedback to evaluation framework and metrics required for external evaluation.

In addition to the items required in the planning phase, organizations selected to participate in the Implementation Phase must be willing to commit to these additional activities:

- Participate in an independent evaluation including measurement tracking, periodic surveys of staff and interviews;
- Participate in periodic phone support and Web-Ex training (2-3 hours per month);
- Participate in educational seminars and work with technical assistance providers;
- Participate in three in-person meetings with all grantees, CHCF staff, and advisors;
- Provide the staff and resources to conduct self-management support and follow-up; and
- Share lessons learned (for example, give presentations or host site visits) with other organizations in the state.

VI. Project Timeline

<u>Activity</u>	<u>Timing</u>
RFP Released	August 20, 2008
Informational Q&A Call	September 3, 2008 (12:00 p.m.)
Alternate Q&A Call	September 5, 2008 (12:00 p.m.)
Email Intent to Apply	September 9, 2008 (5:00 p.m.)
Full Proposals Due	September 30, 2008 (5:00 p.m.)
Grant Recipients Announced	November 21, 2008
Projects Begin	January 2009

Q&A Calls number: 1-866-270-7427

Pass-code: *5873107* (enter * before and after the number)

VII. Application Process

Intent to Apply

Organizations intending to apply should email Nandi Brown, program assistant, at nbrown@chcf.org before 5:00 p.m. on Tuesday, September 9, 2008. The email should include the applicant name, organization, address, and phone number.

Full Proposals

Applicants should email an electronic proposal of no more than 11 pages, double-spaced, in a 12-point font. The proposal should include the following:

1. Project Cover Sheet: Available at www.chcf.org/grantinfo/solicited/. This does not count in the 11-page limit.
2. A brief description of the patient population currently served, number of patients served, the practice size (number of providers and number of clinics), and a description of the practice setting, that is, community health center, commercial medical group, etc.
3. A brief description of the patient population to be addressed, specific chronic conditions or multiple conditions, and the approximate number of patients with the targeted condition(s) who will be impacted in the initiative.
4. Description of the health care organization(s) in which the training, patient/family involvement, and redesign will occur, including size and composition of clinical staff. Also include the names and titles of the leadership and staff who will manage the project.
5. Description of how patients with chronic conditions are currently managed (such as the types of information technology systems used, teams of providers, evidence-based guidelines, or other methods).
6. Description of any prior or existing organizational self-management supports, such as communication training, disease-specific class offerings, group visits, phone or Web-based support, or other resources.
7. Description of any prior or current participation in quality improvement initiatives (for example, California Quality Collaborative, Bureau of Primary Health Care, etc.) and overall experience in tracking measures for quality improvement. Also describe the types of measures that would be useful to track for this initiative.
8. Description of any prior organizational experience with the following: (a) using internal staff to train other team members; (b) conducting quality improvement for care process/team redesign; or (c) involving patients and families in improving care delivery.
9. Brief description of organization's experiences with enhancing the practice of patient- and family-centered care. If this area is new to the organization, describe the specific area(s) of focus for improving patient- and family-centered care.
10. A statement of how the project's objectives are relevant to the organization and target population. Describe how the specific technical assistance could be utilized,

implemented, and integrated into the care processes and be used to meet organizational goals for supporting patients and families.

11. Description of organizational commitment to full participation in project including evaluation, organizational assessment, phone and online support, key in-person meetings and educational trainings, and identifying staff as designated trainers and coaches to provide self-management support to patients with chronic conditions.
12. Plan for sustaining the intervention after the funding ends and disseminating self-management supports to other parts of the organization.
13. Discussion of anticipated barriers and challenges to implementing and sustaining efforts.
14. Applicants should include **two** separate budgets (using the form available at www.chcf.org/grantinfo/solicited/) that reflect actual project costs. The planning phase budget should include travel-related expenses for one in-person meeting. The implementation phase budget should include travel expenses for three in-person meetings. The budgets should reflect both grant funding and the additional funds provided as in-kind resources by the organization (if any). (The budgets do not count in the 11-page limit.)

The following hardcopy documents should be mailed to Nandi Brown at the address below.

- Documentation of tax status (W-9 form or IRS determination letter).
- Signed letter from the chief executive of the applicant organization confirming a commitment to support the lead team and indicating the level of staff engagement.

Full proposals must be emailed to nbrown@chcf.org by **5:00 p.m. on Tuesday, September 30, 2008**.

Hardcopy documents with relevant signatures should be mailed to:

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