



RCHN CHF Request for Letters of Interest Population Health 2015

I. Table of Contents

a. Brief Description of the RCHN Community Health Foundation	1
b. Context for Funding Opportunity	2
c. Population Health Framework	3
d. Description of Funding Opportunity	5
e. Award Information	6
f. Eligibility Information	6
g. Submission of Letters of Interest	7
h. Timetable	7
i. Frequently Asked Questions	8
j. Evaluation of Letters of Interest	8

II. Brief Description of the RCHN Community Health Foundation

Formed in 2005, the RCHN Community Health Foundation (“RCHN CHF” or the “Foundation”) is a private, not-for-profit foundation established to support community health centers (“CHCs”) through policy research, outreach, education, and strategic investment. RCHN CHF is the only foundation in the U.S. dedicated solely to CHCs - the local, non-profit, community-governed health care providers that offer comprehensive primary and preventive care to underserved populations. RCHN CHF works to address community health centers’ primary challenges and establish opportunities to sustain health centers in the future.

This request for Letters of Interest (“LOI”) invites community health center and primary care association (“PCA”) applicants to apply for grant funds focused on population health, as further described below. The Foundation seeks proposals that capitalize on existing strengths, maximize current resources, and support innovation and collaboration to address a specified challenge in population health management. That challenge may be to improve outcomes on a clinical condition for which there are readily available, nationally recognized performance measures (e.g. UDS clinical measures, HEDIS measures, other) or to reduce overutilization of health services for a situation such as high ED utilization, high readmission rates, or other situations where there are readily available data.

III. Context for Funding Opportunity

The term “population health” has become prominent in health policy in recent years since its inclusion in The Triple Aim, first proposed by the Institute for Healthcare Improvement (IHI). The Triple Aim framework is focused on optimizing performance of the healthcare system, and has three dimensions or goals: 1) improve the health of the population; 2) enhance the patient experience of care; and, 3) reduce per capita cost of care.¹ This framework has been adapted by the Center for Medicaid and Medicare Services (CMS) in its strategy for better care and lower costs; prevention and population health; expanded health care coverage; and, enterprise excellence.² The National Strategy for Quality Improvement in Health Care (National Quality Strategy or NQS) published in 2011 has also adapted the triple aim framework to include:³

- Better care that is patient-centered, reliable, accessible, and safe.
- Affordable care for all stakeholders, including individuals, families, employers, and governments; and
- Healthy people/healthy communities - supporting proven interventions to address behavioral, social, and environmental determinants of health, in addition to delivering higher quality care.

“Population health management” is an essential element in two major closely related areas of health reform: clinical practice transformation and health system transformation, including payment reform. States and the federal government recognize that primary care is the foundation for transformation of both the care delivery system and supportive payment reforms that generate improved quality of care and control costs. As part of this strategy, almost every state Medicaid program has initiated one or more patient-centered medical home (PCMH) initiatives and close to half of these states are also working with commercial payers in multi-payer initiatives. In addition, since 2011 HRSA has embarked on its Patient-Centered Medical/Health Home Initiative and CMS initiated, in 2012, its three year Advanced Primary Care Program focused on supporting a target group of 500 Federally Qualified Health Centers (FQHCs) to achieve Level 3 NCQA recognition as PCMH. Another example of PCMH health center - focused initiatives is the Safety Net Medical Home Initiative, a five-year demonstration project to develop and demonstrate a sustainable implementation model for medical home transformation developed by the Commonwealth Fund in partnership with numerous local foundations, and supported by Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute. (www.safetynetmedicalhome.org)

¹ Berwick, DM, Nolan TW, Whittington. J. The Triple Aim: Care, Health, and Cost. Health Affairs, 27, no.3 (2008): 759-69

² CMS Strategy, 2013. (<http://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/index.html>)

³ 2014 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care (<http://www.AHRQ.gov/workingforquality>)

The ACA set the stage for transforming what is now a *medical* care marketplace to a *health* care marketplace. Still, in the current health care environment, with policies embracing greater access to care and payment and other incentives designed to control costs and improve quality, the notion of population health is tightly aligned with payment. Along with the Patient-Centered Medical Home (PCMH), Accountable Care Organizations (ACOs) are part of a major strategy to create this new health marketplace. The concept of the ACO where providers take responsibility for patient care over time and across all care settings has three principle characteristics: 1) the capacity to provide and manage the continuum of care as an integrated delivery system; 2) the capacity for performance measurement and improvement; and 3) the capability of prospectively planning budgets, human resource and infrastructure needs as a collaborative effort with all ACO participant providers.⁴ Successful implementation of these characteristics will lead to health system transformation.

The success of the ACO and similar models rests upon a firm foundation of comprehensive primary care as reflected by health centers that are able to function as true medical homes. In fact, given the extent to which population health management is embedded in the PCMH model, transformation of the overall health system in a region or state depends on the strength of its primary care system and a payment model that sustains the model and ensures continuing improvement of both quality and cost outcomes. Population health management within a PCMH is also necessary to succeed in payment reform,⁵ including the expansion of both Medicaid and private or commercial insurance.

IV. Population Health Framework

Organizations seeking to enhance their patient-centered focus, prepare for shared savings contemplated in an ACO model and improve population health for a defined geographic service area must excel in two key population health management domains: clinical practice transformation and health systems transformation. For CHCs, this translates as having all of the features of a patient-centered medical home: integrating clinical services - including mental/behavioral health and dental health - at the site of care; providing proactive case management; and participating in clinically integrated regional networks that include hospitals, specialists, and other care settings necessary to manage the health of patients. In addition, CHCs must actively engage in identifying needs in the broader community to provide access and appropriate services. Finally, electronic health record connectivity and interoperability and health informatics expertise that includes analytics for individual and population health management and financial management are critical.

Many health center organizations are on a pathway toward attaining PCMH recognition, revamping systems and operations to support new models of care. In order to effectively

⁴ Fisher, E. "Growing Demand for Accountability." National Quality Forum Webinar October 1, 2009.

⁵ Ibid.

achieve *practice transformation* in the safety-net context, a number of issues need to be targeted:

- Empanelment that includes increasing capacity of registries and associated analytic reports which support timely patient health assessment to identify behavioral, socio-economic, preventive, and chronic disease issues that inform risk stratification and assure patient specific care planning, support, and timely follow up.
- Patient-centered interactions to support patient engagement and self-management by a pro-active and well prepared and trained practice team.
- Workforce development that focuses on hiring, training, job descriptions, and human resource policies to support effective teams for population health management systems.
- Quality Improvement systems that are based at the practice level, involve patients/families feedback, and provide on-going feedback to the practice team on performance and identify areas for improving patient health management systems, not just categorical diseases or prevention issues.

Further, to effectively influence *health system transformation* in the safety-net context, several additional issues need to be targeted:

- Care Coordination that assures patient access to appropriate care, timely and seamless transitions across difference settings of care, and metrics such as inappropriate ED utilization and patient evaluation of hospital transitions to home that support continuous improvement of coordination processes.
- Access to off-site specialty care.
- Seamless referral arrangements among various levels of care such as acute care hospitals, home care programs, long term care facilities and hospice programs, among others.
- Ongoing assessment of community need.
- Adoption and implementation of interoperable HIT systems to support seamless, point of service, real-time access to all relevant health care information, across levels of care, for a specific patient as well as patient portals to support greater patient engagement.

Several programs have emerged to support health center practice transformation including the use of peer-to-peer support, practice coaches, and on-line learning communities. In addition, a number of health center controlled networks and Primary Care Associations have established or are creating improved systems for population health management. These include supporting re-designed work processes to reinforce evidence-based care, sophisticated patient registries for patient identification and risk stratification and outreach.⁶ These and many other innovations at the local, state and national levels need to be shared rapidly through locally based systems of learning, both for potential adaptation

⁶ Meaningful Use Data and Case Studies <http://www.healthit.gov/providers-professionals/meaningful-use-case-studies>

and to provide on-going feedback to the developers of these innovations at the practice, system and policy levels.

V. Description of Funding Opportunity

Given the current healthcare landscape and the rapid evolution of health reform at the state and national levels, successful health centers will require capacity for strong population health management that is sustainable and improves over time to keep pace with health reforms and pressures from the marketplace. This new RCHN CHF initiative will support community health center and PCA proposals to develop and implement programs focused on population health management. The Foundation seeks to identify and support a representative and committed group of health center grantees and partners that are planning or are engaged in local or state initiatives to engage in “health neighborhoods” that support systems for population health management. We aim to identify and disseminate a spectrum of best practices that may be adapted by most health center organizations to help accelerate health center progress, while building upon past and current initiatives and addressing remaining gaps for health centers at the local and national levels. Fundable proposals must include the following four elements:

- A. **Target Condition or Health Services Situation** – Identify and describe a target clinical condition or the health services utilization situation as the target for this proposal. Discuss why this is important to your community, and the major social determinants that may be associated with this condition or health services utilization pattern in your community. If the target is a clinical condition, describe the nationally - recognized performance measures (e.g. UDS clinical measures, HEDIS measures. other) that are associated with this condition. If the target is a utilization situation such as high ED utilization or high readmission rates, describe the source of the readily available data related to this situation.
- B. **Population of Focus** – (1) Describe the population of focus for the selected condition or situation (i.e. registered patients only, patients in designated health plan, residents of a designated geographic area, etc.). Describe what is currently known about target condition or situation in your population of focus. (2) Describe which social determinants of health are important factors influencing the selected condition or utilization pattern in the target population.
- C. **Intervention** – Propose an evidence-informed intervention addressing the role of multiple partners in a coordinated approach to the selected condition or situation. Include at least one approach to address one or more social determinants related to the clinical condition or the utilization situation. If the target is a clinical condition, discuss the management of at least one related prevention strategy as applicable as well as the coordinated approach for ongoing care management. If the target is a services utilization situation (i.e. ED over-utilization, high readmission rate, etc.) describe the proposed intervention

among the key stakeholder partners, i.e. health center, health department, hospital, health plan, payor partners, etc.

- D. **Partnerships** – Briefly describe the designated partnerships. This can either be taking one or more existing partnerships to the next level, or providing evidence of one or more viable new partnerships with documented agreements to collaborate, including data collection and timely sharing of patient population information for care coordination, etc. Partners may include Health Center Controlled Networks (HCCNs), Regional Extension Centers (RECs) or other organizations engaged in supporting CHC adoption and implementation of HIT to support quality improvement.

Grantees will be asked to demonstrate the impact of their work through:

- Measurement and evaluation. Metrics may include UDS or HEDIS measures or locally-aligned measures with Medicaid or other local health initiatives and programs.
- Participating in a learning community of other grantees.
- Communication and dissemination of results including best practices.

Proposals should capitalize on existing strengths and community relationships. Creative proposals that are informed by community needs, show current or evolving partnerships with public health and other health system components and leverage available resources are encouraged. We are especially interested in local models that may be applicable to or replicated across broader geographies.

While we recognize that some organizations projects may require facility development in support of population health management initiatives, this LOI is not geared toward capital, facilities, or significant infrastructure needs.

VI. Award Information

The Foundation expects to fund up to 6 awards under this program, with grant awards of approximately \$150,000 per award, including up to 10% for indirect costs. Requests should not exceed \$150,000. The Foundation anticipates making these awards for single-year funding, beginning on or about July 1, 2015. Grantees that fulfill year one requirements may be funded for a second year to bring ideas to scale or replicate interventions at additional sites.

VII. Eligibility Information

Entities that are currently designated by the HHS' Health Resources and Services Administration's ("HRSA's") Bureau of Primary Health Care as federally-qualified health centers ("FQHCs") or FQHC Look-Alikes, as well as state PCAs (if the PCAs are specifically

proposing in the application to sub-grant to FQHCs or FQHC-Look-Alikes for a portion of the project) are solely eligible to receive these awards.

FQHC applicants must document that the entity is currently 'in good standing' as a FQHC with the Bureau of Primary Health Care by attaching a copy of the most recent Notice of Grant Award from HRSA or as a Look-Alike by attaching a copy of the current Designation Letter from HRSA. Proposals received from health centers that are not currently in good standing with the Bureau of Primary Health Care as FQHCs or FQHC Look-Alikes will not be reviewed. Those PCA applicants that receive federal funding from HRSA should also include a copy of their most recent Notice of Award. To meet the Foundation's funding requirements, all applicants must also submit proof of their federal tax exemption as 501(c)(3) tax exempt not-for-profit organizations. This may either be in the form of an IRS tax exemption letter or the most recently filed Form 990.

Please note that while the applicant must be a designated FQHC, Look-Alike, or state PCA working with FQHCs or Look-Alikes, the Foundation is seeking collaborative proposals. Applicants should include other entities in the proposed project, such as other health centers, or public health agencies, hospitals or managed care organizations. Such additional entities would be listed in the application as Identified Partners, not as the applicant

VIII. Submission of Letters of Interest

All applications for funding through this program are initiated with the submission of a Letter of Interest (LOI). [Selected applicants will be invited to complete a full proposal – see below]

STEP 1 – Letters of interest must be submitted through the Foundation's online grant portal, via this [link](#). (A PDF with detailed instructions for the online application is available [here](#))

STEP 2 – REGISTRATION/LOGIN - Prior to accessing the Letter of Interest form, the system will prompt you to create a new account. This registration process has several steps, and requires submission of basic information about the organization, and contact information for the designated grant contact, and the organization's Executive Officer. Once registered, you may create a password that you must use each time you access our secure online system.

TECHNICAL SUPPORT – If you have any questions or difficulties using our online system, please email grants@rchnfoundation.org with the subject line TECH SUPPORT and the name of your organization.

IX. Timetable for Submission of LOIs and Notification

The deadline for submission of all Letters of Interest (LOIs) is **5:00 pm eastern time on WEDNESDAY MARCH 18, 2015** and no exceptions will be made. To be considered timely received the application must be logged in the online system by the date and time above.

Incomplete proposals will be deemed unresponsive and will not be reviewed. You will receive an electronic confirmation of your completed submission.

Anticipated Notification Date:

The Foundation anticipate completing review of LOIs and notifying applicants by mid-April. Organizations whose LOI generates interest from the Foundation will be invited to submit a full, more detailed proposal. Invited organizations will have four weeks following notification to prepare and submit the full proposal.

Any changes to this timetable will be announced on the Foundation’s website. Notification will also be sent via email to the Primary Contact identified by your organization in the LOI submission.

X. Frequently Asked Questions/Submitting Questions about the LOI

Additional information and FAQs are found at our website www.rchnfoundation.org. Other questions regarding this funding opportunity may be posed to the Foundation via email to grants@rchnfoundation.org. Please include in the subject line: “POP HEALTH LOI QUESTION” and the NAME of your organization. The deadline for submission of all questions about the program is: 12:00 pm (noon) eastern time on WEDNESDAY February 25. Note that no individual responses will be provided. Rather, responses will be posted in the form of additional FAQs. The Foundation expects to post all responses on or before 6:00 pm eastern time by COB TUESDAY MARCH 3.

XI. Evaluation of Letters of Interest

The Foundation will consider the following criteria in reviewing the submitted LOIs and proposals:

- a. Fit with overall objectives of the initiative;
- b. Clear identification of community need, target condition(s), population focus, proposed intervention, and partnerships;
- c. Articulation of innovation and best practices;
- d. Opportunity for quantifiable impact on designated issue and population served;
- e. Project feasibility and organization’s capacity to rapidly implement and sustain the project over time in terms of staff and collaborator qualifications, organizational infrastructure and/or technology, experience and knowledge, and community support;
- f. Willingness and capacity to collect and report on impact criteria and progress in meeting goals.