*Brief Proposal Deadline: April 18, 2014*

Robert Wood Johnson Foundation

# REDUCING HEALTH CARE DISPARITIES THROUGH PAYMENT AND DELIVERY SYSTEM REFORM

## BACKGROUND

### *Disparities in health care*

The National Health Care Disparities Report from the Agency for Healthcare Research and Quality (AHRQ) identifies persistent, serious disparities in care that negatively affect minority populations.[i] Many groups of people suffer from disparities including patients of lower socioeconomic status, racial and ethnic minorities, women, older patients, and the uninsured. For example, between 2000 and 2007, mortality rates from breast cancer declined overall from 27 to 23 per 100,000 women, but African American women persistently had higher death rates than non-Hispanic white women.[ii] Between 2001 and 2009, residents from low-income areas had higher rates of hospitalization for heart failure than residents from high-income areas.[iii]

The field has learned much over the past decade about what interventions can reduce disparities in care.[iv,v] Examples of successful interventions demonstrated to reduce racial and ethnic disparities include programs that address the different barriers to high quality care, culturally tailored care, team-based care, interventions that involve families and the community, patient navigators and community health workers, and interactive skills-based patient education. In addition, more is known about the types of processes and supports health care organizations and plans must undertake to lead to sustainable reductions in disparities: In particular, interventions to improve the quality of care and reduce disparities must take place in reformed systems that allow these efforts to be financially sustainable.

### *Value-based payments, system redesign, and disparities*

We need more information about how it might be possible to design and implement policies that could support the reduction of health care disparities in the context of broader payment and delivery system reform. Health care purchasers and policy-makers have started experimenting with delivery system redesign tied directly to payment reform as they attempt to lower costs and improve quality. Examples of these efforts include the implementation of accountable care organizations (ACOs) supported by shared savings arrangements, patient-centered medical homes (PCMHs), bundled payment models, value-based purchasing efforts such as pay-for-performance, and penalties for hospital readmissions and avoidable hospital-acquired infections. However, little research has been done to identify how these innovations might impact health and health care disparities. Even less is known about how to design such programs explicitly to reduce disparities in care and outcomes. For example, the Massachusetts Medicaid program launched a limited experiment in 2007, but it was unsuccessful.[vi]

To reduce disparities in health care, it is likely important to reinforce the intrinsic motivation of administrators and providers to reduce disparities ("it's the right thing to do") with increasing self-efficacy ("I am confident I have the knowledge and skills to reduce disparities") and extrinsic motivators (financial/ organizational/ reimbursement models that allocate sufficient resources to encourage and allow providers the flexibility to develop effective approaches to reduce disparities). As yet, it is unclear how best to integrate these elements. For example, one study of race-stratified clinical performance data and cultural competency training increased intrinsic motivation (provider awareness of disparities) but was insufficient to improve HgbA1c, cholesterol, or blood pressure control in patients with diabetes.[vii]

Combinations of incentives with removals of disincentives may be useful. For example, one might combine the principles of an ACO with accountability performance standards that include specific equity measures. Financial reforms combined with specific delivery system reforms or quality improvement interventions that are targeted to reducing disparities are likely to be more effective than either payment reforms or delivery system reforms alone.

Reducing disparities is not easy, and does not only entail making changes to the health care system. Social determinants, such as education, support systems, income, and the physical environment play a significant role in influencing a person's health and accordingly, their health care outcomes. However, delivering equitable health care is important to achieving a high-quality health care system, which we believe contributes substantially to an overall culture of health. Given the relatively rapid proliferation of new care delivery and payment reform models, it is imperative to attempt to advance our understanding of how these models might be implemented with an integrated focus on equity.

## PURPOSE

The goal of this call for proposals is to develop evidence that payment and delivery system reform designs that attempt to manage extrinsic and intrinsic incentives for overall quality and efficiency, while also explicitly attempting to reduce health care disparities, can produce positive results for each goal.

Our hope is that the knowledge gained through these grants will inform the development of new care delivery and payment models, by demonstrating potential ways to build-in a financially-supported focus on equity. The grants will also inform health care organizations and providers with new practices for developing and implementing disparities interventions within the context of new and emerging payment models.

## TOTAL AWARDS

- The program will award up to three grants.
- Each grant will be up to $500,000.
- Each grant will last up to 3 years.

- The grants will fund implementation of paired payment and delivery system changes that incorporate a focus on reducing disparities in care and/or outcomes, and the collection of evaluation data. Technical assistance will be provided.

## PROGRAM COMPONENTS

Grantees will be expected to develop and implement a combined payment and delivery change model that includes incentives for meeting disparities reduction benchmarks/targets while also meeting general quality improvement expectations. As part of their work, grantees will be expected to have undergone a root-cause analysis of their disparity of interest, identify and select performance targets, work with RWJF-supported technical assistance providers to refine their approach, make payments in some way contingent on disparities reduction, and monitor progress.

Grantees will also be expected to participate in an evaluation of the initiative to be conducted by an external evaluator.

The program will provide grantees with access to technical assistance experts to help with the design and implementation of the payment and delivery system interventions to reduce disparities.

## ELIGIBILITY CRITERIA

Preference will be given to applicants that are either public entities or nonprofit organizations that are tax-exempt under Section 501(c)(3) of the Internal Revenue Code and are not private foundations or Type III supporting organizations. The Foundation may require additional documentation. Applicant organizations must be based in the United States or its territories.

Applicant organizations should have an active collaboration that includes at least one payer (e.g., health plan, insurance company, employer, government payer) and one or more provider / health care organizations (e.g. health centers/clinics, provider organizations, hospitals, network of physician offices, regional coalition of providers and health care organizations). Applicants may also be a single integrated delivery system and health plan. Multi-payer partnerships are encouraged. Any partner can be the lead applicant. The remaining partner(s) must play active roles throughout the project.

### *Programmatic requirements*

- Applicants must document at least one disparity in health care processes (e.g., screening for colorectal cancer, appropriate prescription of inhalers in patients with asthma, appropriate screening for depression), and/or outcomes (e.g., adequate control of blood pressure in patients with hypertension, readmissions for heart failure, patient experience scores) among the patients that they will address. Preference will be given to applicants documenting and addressing multiple health care processes or outcomes (e.g., multiple measures related to diabetes such as HbA1c, blood pressure, low-density lipoprotein and smoking cessation).

- Applicants must demonstrate a large and diverse patient population to ensure that progress can be measured and monitored. For the purposes of this CFP, an ideal grantee setting would either be one organization with a large and sufficiently diverse patient mix to measure change over a relatively short period of time, or an integrated or accountable care-like network of hospitals and other providers that could provide the opportunity to look across sites and measure relative reductions in disparities between organizations. Preference will be given to applicants who can demonstrate the potential for significant intervention uptake across organizations, providers and/or patients.

- Applicants must propose to adapt at least one existing or nearly fully-developed payment reform initiative to incorporate a focus on the reduction of associated disparities in health care, health outcomes, and /or patient experience, and propose at least one component of the payment reform model that will directly support its specific disparity reduction goals.

    - The payment reform model should be a value-based alternative to traditional fee-for-service. Example payment models include, but are not limited to, shared savings arrangements, population-based payments, and bundled/episode-of-care payments; or value-based purchasing, pay-for-performance, or patient centered medical homes that include reimbursement reform linked to outcomes-based performance measurements. Applicants should provide an overview of the payment reform model including a description of how the model moves away from fee-for-service approaches.

    - The payment reform model should already be operational by the participating payer to avoid significant delays.

- Applicants must describe the health condition that is the target of their disparities-reduction efforts, including the procedures and outcomes that will be measured. Outcomes must be ones for which metrics can reasonably be expected to move within 18−24 months.

- Applicants must propose at least one delivery system change or quality improvement initiative designed to facilitate reduction of the documented disparities in health care, health outcomes, and/or patient experience, and describe how those activities will be supported through the proposed payment reform. The strategy and pathway for change should be clear.

- Applicants should describe how their projects will document the impact of their interventions on cost, or how they might plan to position their interventions as financially viable.

- Strong preference will be given to intervention designs that are tied to community-based resources, or to care delivery changes, that leverage the community outside of the health care setting in ways that address more upstream social determinants of health. Examples include community health workers visiting the homes of patients with asthma to identify and remediate asthma triggers (e.g., mold, inadequately vented gas appliances) or partnering with local grocers and a culinary institute to increase the availability of low-cost fresh produce, nutrition education, and healthy cooking classes for patients with diabetes living in food deserts.

- Applicants must describe the generalizable or translatable elements of their intervention designs. Applicants must also be willing to work with RWJF, the University of Chicago, and appropriate technical assistance providers to adapt intervention designs and negotiate targets.
- Applicants must demonstrate willingness to participate in data collection and an external evaluation, supported by RWJF. Applicants must also be willing to share interim and final findings with RWJF, the University of Chicago program office, and evaluation staff.

Consistent with RWJF values, this program embraces diversity and inclusion across multiple dimensions, such as race, ethnicity, gender, age and disadvantaged socioeconomic status. We strongly encourage applications that will help us expand the perspectives and experiences we bring to our work. We believe that the more we include diverse perspectives and experiences in our work, the better we are able to help all Americans live healthier lives and get the care they need.

## SELECTION CRITERIA

*Evidence of readiness*

The successful applicant will:

- Provide evidence that the project will be capable of beginning to operate effectively under the payment reform model on or soon after when grants begin October 15, 2014 (i.e., have the processes and systems in place to run the model and take meaningful action to reduce disparities). This includes evidence that applicant organization(s) are already implementing relevant adaptable payment changes to minimize start-up time for this project.
- Document at least one disparity in health care, health outcomes, and/or patient experience that it will address among its patients. Preference will be given to applicants documenting and addressing multiple health care processes or outcomes.
- Provide evidence that the proposed financial payment reform model will adequately draw enough providers, provider groups, health centers/clinics, and/or hospital(s) to participate so that evaluation of the program will have the potential to inform best practices for developing and implementing disparities interventions within the context of new payment and delivery system models.
- Include a brief literature review that demonstrates the conceptual logic behind the disparities intervention, and describe the process through which the intervention was designed.
- Describe any prior work and/or pilot studies that illustrate success at similar endeavors and provide evidence that the proposed intervention merits further evaluation.

*Organization description and relationships*

Applicants should:

- Describe the processes utilized to obtain senior leadership and front-line staff buy-in. Applicants who do not provide evidence of collaboration and an agreement regarding the mutual objectives, goals and activities will not be considered for funding.
- Describe the relationships between organizations for the proposed project.
- Describe the organizational structure of the team and the process through which the partners interact.
- Describe the extent to which funded grant activities might connect to other quality improvement and disparities reduction efforts in their community.
- Describe how the intervention will leverage or otherwise connect to external, community-based organizations or supports.

*Conditions and patients*

Applicants should describe the:

- Health condition(s) addressed through their proposed intervention.
- Targeted health care process, outcome, and/or patient experience measures, along with sufficient evidence of the disparities that will be addressed.
- Population to be targeted through the intervention, including approximations of the following:
    - Percentage of patients ages: 0 to 17 years, 18 to 64 years, and 65+ years.
    - Percentage of female patients.
    - Percentage of patients in the following health insurance categories: Privately Insured, Medicaid, Medicare, Uninsured.
    - Volume of racial/ethnic populations currently utilizing services for your target condition(s) at your organization/partner organization(s).
    - Volume of the population of interest currently utilizing services for the target condition(s) at applicant organization/partner organization(s).

*Intervention design*

Applicants should describe the:

- Payment reform model designed to reduce targeted disparities in health care, health outcomes, and or patient experience. Applicants must indicate how the payment reform model will help to incentivize disparities reduction and/or negate the current incentives to overlook disparities. How will the model ensure that financial incentives do not reduce health care providers' intrinsic motivation to provide high quality of care to all (i.e., avoid providers doing just what is financially rewarded)?

- Role that key stakeholders, such as community representatives, consumers, and staff members played in designing the intervention.
- Associated delivery system intervention designed to reduce disparities.

*Data collection and management*

Proposals should describe:

- Relevant data to be collected, the method and process by which it will be collected, willingness of partners to share data, timeframe and frequency of data collection and sharing, and how it will be transferred into an electronic database and data storage/security procedures.
- Processes to ensure valid, reliable and accurate data collection.
- Proof of feasibility of data collection for all key process, outcome and utilization measures.
- The ability of the applicant to characterize subgroups for patient populations, for instance, ability, to break out Hispanic patient populations having Mexican and Puerto Rican heritage or to state whether an Asian-American population is Chinese or Korean in origin.
- Ability to determine and track direct program implementation and maintenance costs

*Anticipated challenges*

Applicants should describe significant anticipated challenges, along with plans to address them. Applicants should also indicate expertise or technical assistance they might wish to leverage with support from RWJF, and how that assistance might advance the intervention.

## EVALUATION AND MONITORING

The purpose of evaluation at RWJF is learning rather than accountability. RWJF will support an independent research team to evaluate the projects funded through this solicitation. As a condition of accepting RWJF funds, grantees must participate in the evaluation. Grantee participation includes assisting with necessary data collection to accomplish the evaluation objectives. These data collection efforts may include interviews with key stakeholders, phone or mail surveys, cost and quality data, document collection and analysis and participation in key meetings.

Applicants will not be prohibited from conducting and/or publishing their own, private evaluations of their work. Applicants performing their own evaluations must describe when and how institutional review board approval will be obtained.

Grantees are expected to meet RWJF requirements for the submission of narrative and financial reports, as well as periodic information needed for overall project performance monitoring and management. We will ask project directors to participate in periodic meetings and give progress reports on their grants. At

the close of each grant, the lead agency is expected to provide a written report on the project and its findings suitable for wide dissemination.

*Applicant survey process*

To help us measure the effectiveness of RWJF grantmaking and improve the grant application experience, we will survey the project director (PD) listed in proposals submitted under this CFP. Shortly after the proposal deadline, the PD will be contacted by Princeton Survey Research Associates International (PSRAI), an independent research firm, and asked to complete a brief, online survey about the application process and applicant characteristics. This voluntary questionnaire will take no more than 15 minutes to complete. Responses provided to PSRAI will not impact the funding decision for the proposal in any way.

PSRAI will protect the confidentiality of the responses. RWJF will not receive any data that links a name with the survey responses. If you have any questions about the survey or the use of the data, feel free to email *applicantfeedback@rwjf.org*.

## USE OF GRANT FUNDS

Grant funds may be used for project staff salaries, consultant fees, contracts, data collection and analysis, meetings, supplies, project-related travel, and other direct project expenses, including a limited amount of equipment essential to the project. In keeping with RWJF policy, grant funds may not be used to subsidize individuals for the costs of their health care, to support clinical trials of unapproved drugs or devices, to construct or renovate facilities, for lobbying, for political activities, or as a substitute for funds currently being used to support similar activities.

Grantees should include in their budgets travel for two people to participate in a grantee kickoff meeting, using the RWJF travel cost estimate of $1,300 per person for a two-day, two-night trip with air travel.

## HOW TO APPLY

Proposals for this solicitation must be submitted via the RWJF online system. Visit *www.rwjf.org/cfp/req* and use the Apply Online link. If you have not already done so, you will be required to register at *http://my.rwjf.org* before you begin the application process.

There are two phases in the competitive proposal process:

*Phase 1: Brief Proposals*:

Applicants must submit a brief proposal of no more than five pages that describes the project and include a preliminary budget estimate.

*Phase 2: Full Proposals*:

Selected Phase 1 applicants will be invited to submit a full proposal of no more than 15 pages accompanied by a detailed budget, budget narrative, and additional supporting information.

Please direct inquiries to:

Scott Cook
Phone: (866) 344-9800
Email: *payment@solvingdisparities.org*

All applicants should log in to the system and familiarize themselves with online submission requirements well before the submission deadline. Staff may not be able to assist all applicants in the final 24 hours before the submission deadline. In fairness to all applicants, the program will not accept late submissions.

RWJF does not provide individual critiques of proposals submitted.

This program has a technical advisory committee that makes recommendations about grants to Foundation staff. RWJF will make all final grant decisions.

## PROGRAM DIRECTION

Direction and technical assistance for this program are provided by the University of Chicago.

The University of Chicago
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Responsible staff members at the University of Chicago are:

- Marshall Chin, MD, MPH *director*
- Scott Cook, PhD *deputy director*
- Robert Nocon, MHS *senior health services researcher*
- Rachel Voss-DeMeester, MPH *program manager*
- Morgan Ealey, BA *program administrator*

Responsible staff members at the Robert Wood Johnson Foundation are:

- Andrea M. Ducas, MPH *program officer*

- Anne F. Weiss, MPP, *team director and senior program officer*
- Stephen Theisen, *program financial analyst*

## KEY DATES AND DEADLINES

*March 17, 2014 (2–3 p.m. ET)* https://cc.readytalk.com/r/aurds8gvmxve&eom*; and March 21, 2014 (11:30 a.m.–12:30 p.m. ET)* https://cc.readytalk.com/r/lrmaqbml98np&eom

Brief proposal applicant webinars.

*April 18, 2014 (3 p.m. ET)*

Deadline for receipt of brief proposals.

*May 15, 2014*

Applicants notified if they have been invited to submit a full proposal.

*May 21, 2014 (11 a.m.–12 p.m. ET)* https://cc.readytalk.com/r/rdt6sxj6icfc&eom*; and May 23, 2014 (10–11a.m. ET)* https://cc.readytalk.com/r/47hw0fvhn616&eom

Full proposal applicant webinars.

*June 12, 2014 (3 p.m. ET)*

Deadline for receipt of full proposals.

*August 4–August 8, 2014*

Virtual visits with select applicants.

*August 26, 2014*

Notification of awards.

*October 15, 2014*

Grants begin.

## ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national culture of health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information, visit *www.rwjf.org*. Follow the Foundation on Twitter at *www.rwjf.org/twitter* or on Facebook at *www.rwjf.org/facebook*.

Sign up to receive email alerts on upcoming calls for proposals at www.rwjf.org/funding.

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[i] Agency for Healthcare Research and Quality. National Healthcare Disparities Report 2012.
[ii] Agency for Healthcare Research and Quality. National Healthcare Disparities Report 2011.
[iii] Agency for Healthcare Research and Quality. National Healthcare Disparities Report 2012.
[iv] Chin MH, et al. A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. Journal of General Internal Medicine. 2012; 27(8):992-1000.
[v] Cook SC, et al. Lessons for reducing disparities in regional quality improvement efforts. American Journal of Managed Care. 2012; 18(6 Suppl):s102-105.
[vi] Blustein J, et al. Analysis raises questions on whether pay-for-performance in Medicaid can efficiently reduce racial and ethnic disparities. Health Affairs (Millwood). 2011;30(6):1165-75.
[vii] Sequist TD, et al. Cultural competency training and performance reports to improve diabetes care for black patients: a cluster randomized, controlled trial. Annals of Internal Medicine. 2010;152(1):40-6.