SETTING THE STANDARD: ADVANCING BEST PRACTICES IN DIABETES MANAGEMENT

I. About the Foundation

The New York State Health Foundation (NYSHealth) is a private foundation dedicated to improving the health of all New Yorkers. NYSHealth has a three-part mission:

- **Expanding health insurance coverage** to state residents who cannot afford to purchase their own coverage or whose coverage is inadequate.
- **Increasing access to high-quality health care services** for underserved people.
- **Improving public and community health** by educating New Yorkers about health issues and empowering communities to address them.

DEADLINES:

Stage 1
Email Intent to Apply
April 17, 2007

Letter of Intent Submission
May 16, 2007

Letter of Intent Outcome Notification
July 11, 2007

Stage 2
Invited Finalists Full Proposal
August 22, 2007

II. Background

Diabetes is a growing public health problem both nationally and in New York State. Nationally, 20.8 million adults (7 percent of the population) are estimated to have diabetes. Type 2 diabetes accounts for 90 to 95 percent of cases. The number of adults with diagnosed diabetes has increased 61 percent since 1991 and is projected to more than double by 2050.

In New York State, an estimated 1.5 million people have diabetes, of which 430,000 adults with the disease remain undiagnosed. Diabetes is the fifth leading cause of death among adults 45 to 64 years of age. Diabetes rates in New York State are nearly a third higher than in the nation.

Complications related to type 2 diabetes are extensive. Heart disease and stroke are the leading cause of death among people with diabetes. The risks for heart disease and stroke are two to four times higher among adults with diabetes than adults without diabetes. In 2005, New Yorkers with diabetes accounted for nearly 400,000 hospital discharges, over 5,000 non-traumatic lower extremity amputations, 2,900 new cases of kidney failure, and 2,560 new cases of blindness annually.[1]

Nationally, an estimated one out of every ten health care dollars is spent on diabetes and its complications. Despite the resources invested in the treatment of diabetes and its complications,

Diabetes & Racial/Ethnic Disparities

Diabetes affects certain race and ethnicities differently than others. According to the results from the New York City Department of Health and Mental Hygiene's Health and Nutrition Examination Survey (HANES), Asian New Yorkers have the highest rate of diabetes of all racial and ethnic groups in New York City. Nearly one in six Asian New Yorkers (16%) has diabetes. The prevalence is 14.3% among black New Yorkers, 12.3% among Hispanics and 10.8% among whites. Significantly more blacks and Hispanic/Latinos die of diabetes complications than do non-Hispanic whites. In New York State, the rate of diabetes-related end-stage renal disease is highest among non-Hispanic blacks. Disparities in deaths associated with diabetes underscore differences in treatments, self-management, number and type of multiple medical complications, and limited access to services.

[1] New York State Department of Health. (2006) Diabetes Surveillance in New York State. http://www.health.state.ny.us/nysdoh/consumer/diabetes/surv/en/contents.htm.

55 percent of people with diabetes receive inadequate care[2] and are not receiving the support they need to make necessary healthy lifestyle changes to manage the disease.

The treatment of diabetes requires that patients maintain constant vigilance for symptoms that signal unhealthy changes in their glucose levels, follow a daily foot-care regimen, engage in regular aerobic exercise, and attend frequent medical appointments.[3]

The management of diabetes is, however, achievable. Best practices in the management of chronic conditions, like diabetes, have been well documented. Proven methods like the chronic care model[4], and adaptations of it, like the Institute for Health Improvement's[5] Breakthrough Series[6], and other innovative strategies for diabetes self management programs that fit into people lives have been shown to work. In New York State, several organizations and institutions have successfully implemented these models of care. The challenge, however, has been to institutionalize these improvements and sustain a coordinated system of care that integrates medical, psychosocial, cultural, and environmental interventions. NYSHealth seeks to advance proven methods of controlling diabetes, demonstrate their cost-effectiveness, and support systems change that will integrate, expand, and sustain comprehensive care for patients with diabetes. As part of this *Setting the Standard* initiative, the Foundation will fund efforts to spread comprehensive disease management strategies across communities in a manner that engages medical providers, community-based organizations, employers, and other groups that can collaboratively improve the management of diabetes.

III. The Program

The goal of *Setting the Standard* is to move New York State's primary care system to adopt and spread best practices in disease management and establish them as the universal standard of care for patients with diabetes. The Foundation recognizes that multiple diabetes management programs exist throughout New York and collaboratives to maximize the impact of these programs have been formed. The aim is to advance these programs and build system-wide capacity to support, sustain and institutionalize these efforts. The Foundation anticipates using the results of these initiatives to inform public and marketplace policies that will support improved diabetes management.

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[2] McGlynn, E.A. Asch, S.A. Adams, J., Keesey, J., Hicks, J , DeCristofaro, A., and Kerr, E. (2003) The Quality of Health Care Delivered to Adults in the United States. New England Journal of Medicine. 348:2635-2645

[3] Gonder-Frederick, L. A., Cox D. J., Ritterband, L. M. (2002). Diabetes and Behavioral Medicine: The second Decade. Journal of Consulting and Clinical Psychology, 70(3): 611-625.

[4] Asch S, Mangione C, Broder M, Keesey J, Rosen M, Keeler EB. (2005) Does Participation in a Collaborative Improve Quality of Care for Diabetes? RAND: Improving Chronic Illness Care Evaluation.

[5] The Institute for Health Improvement (IHI) has delineated the characteristics and practices necessary for *spread* of best practices and new ideas. To read more about the IHI Framework for Spread and about existing models for *spread*, visit http://www.ihi.org/IHI/Topics/Improvement/SpreadingChanges/

[6] The Breakthrough Series: IHI's Collaborative model for achieving breakthrough improvement. (2003) Boston, Massachusetts: Institute for Healthcare Improvement.

The objectives of this initiative are to:

- Expand existing diabetes management initiatives, including, but not limited to,
    - Spreading the implementation of the chronic care model or other diabetes management initiatives in the delivery of primary care.
    - Further developing community health worker programs to strengthen partnerships between health care facilities and community based organizations.
    - Integrating the use of disease registries among providers of care for people with diabetes.
- Demonstrate cost effectiveness of diabetes management programs, for example,
    - Examining the potential savings to payers associated with effective diabetes clinical care models.
    - Examining the cost-effectiveness of community health worker programs as part of a diabetes management initiative.
- Develop viable approaches to sustain best practices in diabetes management**,** such as,
    - Integrating organizational and/or financial strategies that will sustain the use of disease management in primary care settings.
    - Integrate the use of registries across practices.

The Foundation expects to make up to 20 awards totaling $4 million. Grant awards will range between $50,000 and $1 million and projects are expected to last 24 months or less. We anticipate the average grant awards will be $200,000.

Assessing Progress and Evaluation

Grantees will be required to submit periodic information and annual reports needed for overall program management and progress assessment. Grantees will also be expected to document and conduct an evaluation of their local work. Additionally, grantees will participate in an evaluation to be conducted by an independent group selected by the Foundation.

III. Type of Activities that May be Funded

The following is a description of eligible types of interventions that might be considered for *Setting the Standard*. These examples are not intended to exhaustive or prescriptive.

a. **Provider Interventions**. These interventions include programs that seek to improve the capacity of health and social service providers to deliver coordinated and efficient care to patients with diabetes. These types of interventions can also include programs targeted to increasing patients' self-management skills.

b. **Organizational Interventions**. These interventions include, but are not limited to, programs seeking to integrate health information technology (e.g. disease registry, telehealth, electronic medical records), and/or the redesign of clinical practice operations.

c. **Policy Interventions**. These interventions include activities that will inform public and marketplace policies to sustain disease management and the advancement of best practices for diabetes care (e.g., demonstration projects to restructure insurance reimbursement systems to support services that improve the coordination of services across care settings.)

d. **Community Interventions**. These interventions include community-based partnerships with service providers that address the social and environmental barriers to coordinated and efficient care for patients with diabetes (e.g. community health worker programs integrated into patient clinic visits, peer-support groups established in the community in partnership with primary care practice.)

IV. Who May Apply

The following are examples of lead organizations and organization partnerships eligible to apply:

a. Primary care providers (e.g., community health centers, migrant health clinics, rural health clinics, outpatient departments, and private practices)

b. Primary care networks and/or associations

c. County health departments

d. Community-based organizations in partnership with primary care provider(s)

e. Community-academic partnerships

f. Health Plans and Insurers

g. Other non-health organization (e.g., employers, schools, unions)

Initiatives involving multi-site practices and/or consortiums of providers who can learn from one another as they implement the projects are encouraged to apply. Proposals requiring support for the spread of diabetes management programs in multiple sites and spearheaded by county or city health departments, provider associations, primary care collaboratives, community-academic partnerships, or other appropriate agencies are also encouraged. Applicants that can demonstrate organizational and/or financial support for existing programs and the ability to expand these programs will be highly considered.

V. Selection Criteria

Proposals will be evaluated on the following selection criteria:

- Extent to which the project will complement or leverage established or existing programs
- Feasibility of the proposed strategies and interventions
- Capability of applicant to achieve stated goals
- Ability to build upon existing community resources and to capitalize on cultural assets
- Sensitivity of the initiative to the needs of low income and medically underserved populations

VI. Application Timeline and Process

The Foundation is inviting letters of intent at this time. Guidelines for submission are below. Finalists will be asked to submit full proposals later in this process.

Timeline

1. To help us assess the volume of potential submissions, we ask that you email us your intent to apply to this letter of intent by **April 17, 2007** to DiabetesRFP@NYSHealth.org. Please include your name, organization and website.
2. Letters of intent must be received no later than **5:00 PM** on **May 16, 2007.**
3. All applicants will be notified on **July 11, 2007** about the outcome of their letter of intent. Finalists will be furnished with application guidelines for full proposals at this time.
4. Finalists' full proposals will be due **August 22, 2007.**

Letter of Intent Guidelines and Submission Process

Letters of intent are to be submitted using NYSHealth's online application system located on our Web site (www.NYSHealth.org), on the Request for Proposals page; applicants will be requested to supply the following information:

1. **Organizational information** including a description of the organization's purpose and activities. If the applicant is working in a unit or department of a much larger organization, please describe your unit or department only (including information about the larger organization only if it is relevant to the project).

2. **Letter of Intent** which provides a brief description of the target community and/or geographical region. Please identify existing challenges and opportunities as related to your target community or region. Clearly state the goals and objectives of your project, the expected outcomes, the number of patients expected to be affected by the project, and key strategies and activities to achieve these targets. If appropriate, describe the organization's readiness for policy and systems change and/or the approach to achieving policy and systems changes. (750 word maximum)

3. **Summary Budget Information:** All proposals must include a budget summary. Applicants may use their own style for developing this attachment but the file format should be Microsoft Word or Excel. The Word or Excel document must be uploaded into the Foundation's online application system.

Inquiries

Inquiries about this letter of intent can be addressed to DiabetesRFP@NYSHealth.org.

Project Management

Jacqueline Martinez, senior program director, provides oversight, direction and assistance for this project. Mark Barreiro, grants and operations manager and George Suttles, National Urban Fellow/Grants Coordinator, also contribute to the direction of this project.