



REQUEST FOR PROPOSALS

Chronic Disease Prevention and Control Program Services

RHODE ISLAND DEPARTMENT OF HEALTH
Division of Community, Family Health and Equity

Applications are due at:

*Rhode Island Department of Health
Attention: Virginia Paine, RN, MPH, CDOE
Chronic Care and Disease Management
3 Capitol Hill, Room 408
Providence, RI 02908*

by:

3:00 p.m. (EST) on Friday, May 29, 2015

Questions concerning this solicitation must be e-mailed to Virginia Paine at virginia.paine@health.ri.gov. Questions should be submitted in a *Microsoft Word* attachment and must be received no later than **May 13, 2015 at 4:00 p.m. (EST)**. Please reference RFP "Chronic Disease Prevention and Control Program Services" on all correspondence. Any questions received will be posted on the Department of Health's website at <http://www.health.ri.gov/rfp/> as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

No other contact with State parties regarding this RFP will be permitted.

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REQUEST FOR PROPOSAL

Chronic Disease Prevention and Control Program Services

SECTION 1: INTRODUCTION

The Rhode Island Department of Health (HEALTH) Division of Community, Family Health and Equity (CFHE) is requesting applications from federally-qualified health centers and other health services operating in Providence, Pawtucket or Central Falls to initiate quality improvement programs in the areas of chronic disease, obesity and tobacco use, focusing on the needs of their populations including the under-insured and uninsured. The goals of the program are to improve health outcomes and quality of care for chronic disease and related risk factor reduction through expanded initiatives including the prevention and control of disease and disability, increased patient engagement in their care, and the development of worksite wellness policies. More specifically, these funds will be applied to implement activities that address the prevention, early identification and improved management of hypertension and pre-diabetes/diabetes, staff training opportunities and worksite wellness initiatives. Programs will support the goals of the integrated Rhode Island Chronic Care Collaborative to expand access to quality clinical care for chronic disease prevention and control, and to extend care to evidence-based community resources.

Approximately \$821,564 will be distributed to fund this proposal for a three-year program cycle. The first funding period will run from approximately August 1, 2015 to June 30, 2016 and is considered Year 1 of the project. Continuation funding for Year 2 of the project will be based on the applicant's successful completion of the first funding period activities, evaluation, and available funding. The same process will be followed for Year 3 funding requests. All applicant agencies are required to include a verifiable ten percent (10%) in-kind match.

The Administrative Requirements and Scopes of Work are divided into two components as described in Section 3 of this Request for Proposals (RFP).

- **Applicants who are not currently under contract to implement the Department of HEALTH's "Chronic Disease and Risk Factor Management Program Services" must apply for both the Core and Expanded Components.**
- **Agencies currently implementing services under the "Chronic Disease and Risk Factor Management Program Services" contract are to apply for the Expanded Component only.**

Rhode Island Chronic Care Collaborative (RICCC) is supported by grants from the Centers for Disease Control and Prevention (CDC) under the "Rhode Island Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health" grant (CDC-RFA-DP13-1305 and CDC-RFA-EH09-90105CONT13), under the Heart Disease & Stroke Prevention Program and Diabetes Prevention - State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke grant (DP14-1422PPHF14) and under the Rhode Island Asthma Control Program grant (5U59EH00524-05). Under this joint funding, RICCC teams will support quality improvement for chronic disease care and clinical-community linkages to improve outcome measures for patients with prediabetes, diabetes, high blood pressure, asthma, obesity, and who use tobacco. The payment structure for participating practices is as follows:

- Funded agencies will implement one or both of the scopes of work as defined in Section 3 of this RFP. Payments will be tiered so that larger practices receive larger payments. Practice size will be based on number of patients. Funding will not exceed \$100,000 per agency.
- Specific payment amounts will be calculated based on the number of participating agencies.

SECTION 2: BACKGROUND AND PURPOSE

The Division of Community, Family Health and Equity aims to achieve improved health outcomes through quality improvement in chronic disease care and related risk factor reduction, prevention and control of disease and disability, and increased patient engagement in their care. This work focuses on quality improvement, disease management and clinical-community linkages that support both patient self-management and preventive health services. Another focus is on efforts to increase physical activity and improve nutrition to reduce obesity and prevent and control prediabetes, diabetes, heart disease and stroke, with emphasis on the prevention and control of high blood pressure by supporting clinical practices to implement evidence- and practice-based interventions. An additional focus will be on worksite wellness and the promotion of healthy eating and physical activity among employees. Health centers and other practices that have a high percentage of high-risk, under- or uninsured patients operating in Providence, Pawtucket or Central Falls are encouraged to apply.

The project seeks to promote quality improvement initiatives and clinical-community linkages to assure that patients with prediabetes, diabetes, hypertension, asthma, obesity, and who use tobacco have improved clinical outcomes. The key component of the project is to assist providers to develop the capacity to provide team-based care and to link patients to evidence-based chronic disease self-management and lifestyle change programs through the Community Health Network's centralized referral system. There is a strong need for applicants to better utilize their Electronic Health Records (EHR's) to identify their patients at risk for developing diabetes, hypertension and obesity and to implement team-based policies and procedures for patient self-monitoring of blood pressure, medication therapy management and referrals to evidence-based lifestyle change programs to prevent diabetes, hypertension and obesity. This proposal requires that the applicant identify their high-risk patients and provide support to help them become more activated and engaged in their care beyond what is provided within the practice. The applicant should have a deep appreciation of the community and history of working with diverse populations.

HEALTH will provide technical assistance to staff to develop team-based policies and procedures in health coaching, to provide in-person and on-line chronic disease and risk factor training modules with CME and CEU credits, and to assist with the utilization of the Community Health Network's centralized referral system to refer patients to evidence-based lifestyle change and disease self-management programs.

SECTION 3: SCOPES OF WORK

The overall goal of the Chronic Disease Prevention and Control Program Services is to improve the care of patients with, or at risk for, chronic disease, focusing on patients with prediabetes, diabetes, hypertension, obesity and/or who use tobacco, as well as employee wellness initiatives.

CORE COMPONENT

Administration

- Designate a Chronic Disease Coordinator at the contracted site.
- Provide the names and qualifications of Chronic Disease team members. The Team should include, at a minimum, a primary care practitioner, a registered nurse, a patient navigator and a data manager.
- Identify staff who will provide health coaching for hypertension management medication adherence
- Provide input for RICCC Chronic Disease training modules as part of new staff orientation and continuing education of all staff in the areas of quality improvement, patient activation and chronic disease care.

EHR Reporting

Use of your EHR to report on the following measures:

- Percent of patients with diabetes whose HgbA1C is $\geq 9\%$
- Percent of patients with hypertension whose blood pressure is in control (<140/90)
- Percent of patients with asthma whose asthma is in good control OR percent of patients with asthma whose baseline severity has been assessed.
- Percent of patients 5-40 years of age identified with asthma who have an asthma action plan completed
- Percent of patients with chronic disease who have self-management goals
- Percent of patients who smoke who were given tobacco cessation advice
- Percent of patients who have a BMI assessment and follow-up plan
- Percent of adults with hypertension or diabetes for which medication reconciliation was performed
- Percent of patients with, or at risk for, a chronic disease who are referred to an evidence-based chronic disease self-management education or lifestyle change program using the Community Health Network's centralized referral system
- Percent of at-risk patients who are screened for diabetes and hypertension
- Percent of at-risk patients who are diagnosed with pre-hypertension and pre-diabetes per current standards of care
- Number of patients identified with undiagnosed hypertension and/or diabetes/pre-diabetes who return for a follow-up appointment
- Number of patients at risk for or with hypertension who self-monitor their blood pressure
- Percent of patients self-monitoring their blood pressure who submit their blood pressure readings to their provider per the established plan of care
- Number of patients who have received feedback from their provider on their blood pressure readings
- Percent of Medicare and Medicaid patients with diabetes and hypertension who receive one-on-one medication management provided by a Certified Diabetes Outpatient Educator (CDOE) Pharmacist or other qualified Pharmacist
- Percent of patients with diabetes or hypertension who receive Medication Therapy Management or Medical Nutrition Therapy by a CDOE Pharmacist or Dietitian, or other qualified Pharmacist or Dietitian
- Percent of patients with hypertension who participate in health coaching and medication adherence
- Percent of women with gestational diabetes who received oral glucose tolerance testing (OGTT) post-partum
- Percent of women with gestational diabetes who are referred to a Diabetes Prevention Program (DPP) using the Community Health Network referral system
- Percent of patients diagnosed with prediabetes who are referred to a DPP using the Community Health Network referral system

Policies

- Develop and provide evidence of policies that promote a multi-disciplinary team approach to conditions/risk factors and patient self-management (e.g., NCQA Certified).
- Develop and provide evidence of policies to refer at-risk patients (e.g., prediabetes, history of gestational diabetes, high-risk for type 2 diabetes) to a CDC-recognized lifestyle change program.
- Expand opportunities for one-on-one medication management therapy for Medicare and Medicaid patients with diabetes or hypertension.
- Work with Diabetes Education Partners to coordinate the services of Registered Pharmacists and Dietitians to provide Medication Therapy Management and Medical Nutrition Therapy to patients at RICCC sites.
- Utilize HEALTH's Community Health Network's centralized referral system to refer patients with, or at risk

for, chronic disease into evidence-based disease education, self-management and lifestyle programs. (HEALTH can provide data on referrals made through the Community Health Network for all participating agencies.)

- Develop and provide evidence of protocols to provide medication adherence/reconciliation counseling for patients with hypertension and diabetes.
- Comply with the mandates of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). See Appendix A (CLAS Language).
- Develop and implement worksite wellness policies and programs including 1) nutrition guidelines for food service/vending and the Healthy Eating at Events policy, 2) posting stair prompts, 3) implementing social support programs including CDC-recognized lifestyle change programs, and 4) implementing policies and programs to increase physical activity.
- Develop policies and procedures to refer **all** patients with prediabetes and women with a history of gestational diabetes to a Diabetes Prevention Program using the Community Health Network's referral system.
- Develop policies and procedures for patients who self-monitor their blood pressure (SMBP), to include blood pressure measures reporting and provider feedback per plan of care. (For example, the Patient Portal, Open Notes, AHA 360, etc.). The policies and procedures should reflect the guidance provided in Centers for Disease Control and Prevention. *Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians*, Atlanta, GA, Centers for Disease Control and Prevention, US Dept. of Health and Human Services; 2014. This document will be provided by the Department of Health.

SMBP protocols should include:

- Adequate patient education provided by a trained health care provider
- Patients must be comfortable using the monitor (as demonstrated at clinical site) and will adhere to recommended standards for obtaining an accurate measurement
- Patients will keep a record of BP readings and regularly communicate with their provider.
- Patients and providers should agree on BP monitoring schedule.
- Patients should be willing to participate in ongoing support live, telephonically or via patient portal.
- Providers should take into consideration the patients' adherence to their currently prescribed regimen.
- SMBP should be discouraged in anxious patients and those who might become obsessed with their BP readings.

Services

- Arrange for one-on-one medication management therapy for Medicare and Medicaid patients with diabetes and hypertension that will provide reimbursement to CDOE Registered Pharmacists for this service. (HEALTH will assist sites to develop this methodology, if needed.)
- Work with the Diabetes Education Partners Coordinator to arrange for Medication Therapy Management and Medical Nutrition Therapy services for patients by CDOE registered Pharmacists and Dietitians. (The CDOEs will have individual provider numbers and will bill insurers for services that they provide to patients.)
- Implement a blood pressure self-monitoring system for patients with hypertension using a methodology for patients to regularly communicate blood pressure readings to providers. Examples of some methodologies include:
 - Blood pressure education and tracking log (Developed by HEALTH)
 - Phone applications
 - Patient Portal/ Open Notes
- Distribute materials developed by the *Million Hearts*[®] initiative, the AHA *Heart 360*[®] on-line program and the Washington State Department of Health to assist patients to self-monitor blood pressure. (Links and materials from these programs will be provided by HEALTH.)

- Provide intensive recruitment and referral of patients identified as prediabetic or at high-risk for diabetes identified through your EHR for at least two Diabetes Prevention Programs annually. (Recruitment includes mailing/e-mailing letters and program brochure, phone calls, documented face-to-face referrals by providers.)
- Provide health coaching on hypertension management and medication adherence to hypertensive patients.

Training

- Designate a minimum of two non-physician team members per site to attend a one-day training to become health coaches provided by Diabetes Education Partners for hypertension management and medication adherence.
 - The training requires a practicum of health coaching with 4 patients within a one to two month period.
- Identify Worksite Wellness lead staff to attend a one-day Work@Health training.
- Selected sites will be offered a free, 4-hour training on the Stages of Change and an on-site technical assistance training provided by ProChange representative who will demonstrate available on-line patient tools and resources.
 - Within 1 to 2 months of completing this session, sites will utilize these tools with at least four patients and provide feedback to HEALTH/ ProChange.

Patient Supplies

Each health center site will receive up to \$10,000 to purchase home blood pressure monitoring equipment and pedometers. Blood pressure monitors will be provided to patients who participate in the agency's self-monitoring blood pressure program, and who cannot afford to purchase a blood pressure monitor. Pedometers are to be given to patients as a tool to help them increase their physical activity.

Additional Payment

If funding permits, each site will receive a \$250 additional payment each quarter if five or more patients are referred each month to a Diabetes Prevention Program through the Community Health Network.

EXPANDED COMPONENT

EHR Reporting

Use of your EHR to report on the following measures:

- Percent of at-risk patients who are diagnosed with pre-hypertension and pre-diabetes per current standards of care
- Number of patients identified with undiagnosed hypertension and/or diabetes/pre-diabetes who return for a follow-up appointment
- Number of patients at risk for or with hypertension who self-monitor their blood pressure
- Percent of patients self-monitoring their blood pressure who submit their blood pressure readings to their provider per the established plan of care
- Number of patients who have received feedback from their provider on their blood pressure readings
- Percent of Medicare and Medicaid patients with diabetes and hypertension who receive one-on-one medication management provided by a Certified Diabetes Outpatient Educator (CDOE) Pharmacist or other qualified Pharmacist
- Percent of patients with diabetes or hypertension who receive Medication Therapy Management or Medical Nutrition Therapy by a CDOE Pharmacist or Dietitian, or other qualified Pharmacist or Dietitian
- Percent of patients with hypertension who participate in health coaching and medication adherence
- Percent of women with gestational diabetes who received oral glucose tolerance testing (OGTT) post-partum

- Percent of women with gestational diabetes who are referred to a Diabetes Prevention Program (DPP) using the Community Health Network referral system
- Percent of patients diagnosed with prediabetes who are referred to a DPP using the Community Health Network referral system

Policies

- Expand opportunities for one-on-one medication management therapy for Medicare and Medicaid patients with diabetes or hypertension.
- Work with Diabetes Education Partners to coordinate the services of Registered Pharmacists and Dietitians to provide Medication Therapy Management and Medical Nutrition Therapy to patients at RICCC sites.
- Utilize HEALTH's Community Health Network's centralized referral system to refer patients with, or at risk for, chronic disease into evidence-based disease education, self-management and lifestyle programs. (HEALTH can provide data on referrals made through the Community Health Network for all participating agencies.)
- Develop and implement worksite wellness policies and programs including 1) nutrition guidelines for food service/vending and the Healthy Eating at Events policy, 2) posting stair prompts, 3) implementing social support programs including CDC-recognized lifestyle change programs, and 4) implementing policies and programs to increase physical activity.
- Develop policies and procedures to refer **all** patients with prediabetes and women with a history of gestational diabetes to a Diabetes Prevention Program using the Community Health Network's referral system.
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- Patients should be willing to participate in ongoing support live, telephonically or via patient portal.
- Providers should take into consideration the patients' adherence to their currently prescribed regimen.
- SMBP should be discouraged in anxious patients and those who might become obsessed with their BP readings.

Services

- Arrange for one-on-one medication management therapy for Medicare and Medicaid patients with diabetes and hypertension.
- Work with the Diabetes Education Partners Coordinator to arrange for Medication Therapy Management and Medical Nutrition Therapy services for patients by CDOE registered Pharmacists and Dietitians. (The CDOEs will have individual provider numbers and will bill insurers for services that they provide to patients.)
- Implement a blood pressure self-monitoring system for patients with hypertension using a methodology for patients to regularly communicate blood pressure readings to providers. Examples of some

methodologies include:

- Blood pressure education and tracking log (Developed by HEALTH)
- Phone applications
- Patient Portal/ Open Notes
- Distribute materials developed by the *Million Hearts*® initiative, the AHA *Heart 360*® on-line program and the Washington State Department of Health to assist patients to self-monitor blood pressure. (Links and materials from these programs will be provided by HEALTH.)
- Provide intensive recruitment and referral of patients identified as prediabetic or at high-risk for diabetes identified through your EHR for at least two Diabetes Prevention Programs annually. (Recruitment includes mailing/e-mailing letters and program brochure, phone calls, documented face-to-face referrals by providers.)
- Provide health coaching on hypertension management and medication adherence to hypertensive patients.

Training

- Designate a minimum of two non-physician team members per site to attend a one-day training to become health coaches provided by Diabetes Education Partners for hypertension management and medication adherence.
 - The training requires a practicum of health coaching with 4 patients within a one to two month period.
- Identify Worksite Wellness lead staff to attend a one-day Work@Health training.
- Selected sites will be offered a free, 4-hour training on the Stages of Change and an on-site technical assistance training provided by ProChange representative who will demonstrate available on-line patient tools and resources.
 - Within 1 to 2 months of completing this session, sites will utilize these tools with at least four patients and provide feedback to HEALTH/ ProChange.

Patient Supplies

Each health center site will receive up to \$10,000 to purchase home blood pressure monitoring equipment and pedometers. Blood pressure monitors will be provided to patients who participate in the agency's self-monitoring blood pressure program, and who cannot afford to purchase a blood pressure monitor. Pedometers are to be given to patients as a tool to help them increase their physical activity.

Additional Payment

If funding permits, each site will receive a \$250 additional payment each quarter if five or more patients are referred each month to a Diabetes Prevention Program through the Community Health Network.

SECTION 4: DELIVERABLES

Data Collection Methodology and Reporting

- Submit quarterly process and outcome measure reports as outlined in the Scope of Work. Monthly reports must be submitted quarterly on *Basecamp*. (HEALTH will provide sample data and narrative report templates and instructions on how to post on Basecamp.)
- Submit a quarterly narrative report on steps taken and progress made on improving the measures. Any changes to personnel assigned to the project team must also be noted in the narrative report.

Required Meetings

- Meet with HEALTH's Quality Improvement (QI) Coordinator at least quarterly, and as needed.

- Attend quarterly RICCC Planning Meetings in person or by phone to provide input regarding training needs, conference planning, measure reporting, administrative issues, and other topics as needed to improve team performance and patient outcome measures.

SECTION 5: ELIGIBILITY REQUIREMENTS

Priority will be given to former Rhode Island Chronic Care Collaborative (RICCC) sites and practices operating in Providence, Pawtucket or Central Falls, and who have a high percentage of high-risk, under-served, and/or uninsured patients, and/or practices that are addressing quality improvement initiatives in the areas noted in the scope of work.

SECTION 6: ADMINISTRATIVE INFORMATION

Questions concerning this solicitation must be e-mailed to Virginia Paine at virginia.paine@health.ri.gov. Questions should be submitted in a *Microsoft Word* attachment and must be received no later than **May 13, 2015 at 4:00 p.m. (EST)**. Please reference RFP “Chronic Disease Prevention and Control Program Services” on all correspondence. Answers to any questions received will be posted on the Department of Health’s website at <http://www.health.ri.gov/rfp/> as an addendum to this solicitation. It is the responsibility of all interested parties to download this information. No other communication with State parties regarding this RFP will be permitted.

SECTION 7: PROPOSAL SUBMISSION

All applicants must submit their proposals on or before the date and time listed on the cover page of this solicitation. Proposals (**an original plus three [3] copies**) should be mailed or hand-delivered in a sealed envelope marked “**RFP –Chronic Disease Prevention and Control Program Services**” to:

*Rhode Island Department of Health
Attention: Virginia Paine, Chronic Care and Disease Management Team
Division of Community, Family Health and Equity
3 Capitol Hill, Room 408
Providence RI 02908*

NOTE: Proposals received after the above-referenced due date and time will not be considered. Proposals misdirected to other State locations or those not presented to the Rhode Island Department of Health by the scheduled due date and time will be determined to be late and will not be considered. Proposals faxed or emailed to HEALTH will not be considered.

This RFP contains the administrative procedures and instructions for preparation and submission of both the Core and Expanded proposals. Both proposals must be typed in 12-point font, double-spaced, and paginated on paper with 1-inch margins.

The Core Application Proposal is not to exceed 27 pages, excluding the Proposal Checklist, Title Page, Cover Letter, Table of Contents, Project Abstract, Budget, Budget Narrative, and Appendices. Core applications must follow the sequence of sections as per below.

CORE PROPOSAL SUBMISSION

PROPOSAL CHECKLIST (1 page)

Include the Proposal Checklist (Appendix B) to ensure your agency submits all the required documents.

TITLE PAGE (1 page)

Include the Title Page (Appendix C) to provide information about your agency and contact person.

COVER LETTER (1 page)

The applicant must include a signed cover letter on official organization letterhead from an agent who is authorized to sign contracts on behalf of the applicant.

TABLE OF CONTENTS (1 page)**PROJECT ABSTRACT (1 page)**

Submit a project abstract as a one-page, single-spaced general summary of the project.

APPLICANT DESCRIPTION (up to 2 pages)

In this section, the applicant should explain why their organization/practice is an appropriate choice to implement the project services. Also, provide a detailed description of the organization/practice as follows:

- Type (e.g. public/private, for profit/not-for-profit);
- Governing or management structure (e.g. Boards, Advisory Committees, etc.);
- History (date established, major accomplishments etc.);
- Mission and vision;
- Staffing; type of track record in serving racial and ethnic minority populations;
- Any prior experience with the HEALTH's Division of Community, Family Health and Equity.

PROJECT NARRATIVE (up to 25 pages)

The information contained in this section should constitute the bulk of the project proposal. Requested information should address the contract period of August 1, 2015 – June 30, 2016 and cover the elements of Parts A through C as outlined below.

Part A: Background

This section must describe the organization/practice's policies that promote a multi-disciplinary team approach to providing care to patients with diabetes, asthma, hypertension, obesity or who smoke in one or more of the target areas. Describe current efforts to achieve improved health outcomes through quality improvement in chronic disease care and related risk factor reduction, prevention and control of disease and disability, and increased patient engagement for patients with diabetes, asthma, hypertension, obesity or who smoke. Include organizational efforts to target at-risk populations and quality improvement activities related to measures' tracking and reporting. Describe your organization's efforts and strategies to increase your patients' self-management efforts to control their prediabetes, diabetes, asthma, hypertension, obesity and to stop smoking. Describe policies and procedures to promote clinical-community linkages to facilitate patient referrals to evidence-based chronic disease self-management education or lifestyle modification programs using the Department of Health Community Health Network's centralized referral system. Describe your policies and procedures for screening and referring patients with prediabetes or at high risk for type 2 diabetes to CDC-recognized lifestyle change programs.

Part B: Objectives and Narrative

In this section, applicants are required to outline the project objectives and associated activities. The objectives and activities are best presented in a timeline listing Year 1 objectives, and activities. All objectives and activities must be specific, measurable, attainable, realistic, and time specific (SMART).

Process Objectives:

Focus on activities/events that the Applicant will undertake to improve processes to identify patients with or at risk for hypertension and diabetes, improved management of patients already diagnosed with hypertension and diabetes and elevated BMI, increase the proportion of patients with asthma who have undergone a baseline severity assessment and have an asthma action plan in place, increase the proportion of smokers who are advised to quit, and the increase the number of patients with chronic disease or at risk for chronic disease who are

referred to self-management education or lifestyle modification programs. Provide an overview of your proposed process for the development of a patient blood pressure self-monitoring and medication management therapy policies and procedures.

Outcome Objectives:

Provide your organization's baseline and target population outcome measures for the control of hypertension, diabetes, asthma, BMI, patients whose use tobacco, number of at-risk patients screened for prediabetes and hypertension and the number of patients referred to evidence-based lifestyle change and chronic disease self-management programs.

Part C: Project Administration and Staffing Plan

This section should describe the supervision and management of the proposed project. Specifically, it should address the following:

- Indicate all staff that will be funded through this proposal and the percentage of time that each staff member will allocate to the project activities. The specific work responsibilities of each staff member should be fully described with emphasis on the duties each staff member will assume to support the work funded through this grant; and
- Designate one staff person from the applicant's organization to be the Chronic Disease Coordinator. Provide the names and qualifications of all Chronic Disease team members. Team members should include at a minimum, a primary care practitioner, a registered nurse, a patient navigator and a data manager.

BUDGET AND BUDGET NARRATIVE

Submit a Financial Budget and Budget Narrative for an **11-month Budget Period** (August 1, 2015 – June 30, 2016).

Project Budget

The project budget describes in detail the expenses of the program and consists of a financial budget and a budget narrative. The budget should not exceed \$100,000 per agency. **All applicant agencies are required to include a verifiable ten percent (10%) in-kind match.**

Applicants are also required to discuss future sources of program funding within their budget narratives and attach to the narrative, a matrix of other Department of Health funding sources. Applicants are advised that HEALTH is not responsible for any expenses incurred by the Applicant prior to the contract award. The components of both the financial budget and the budget narrative are described below.

Financial Budget

The financial budget is a listing of all project expenses. Please refer to the Sample Budget Worksheet (Appendix D) to prepare the financial budget. Please include your agency's required verifiable ten-percent in-kind match in your financial budget. The following is a description of allowable expenses:

Allowable Expenses

- Personnel - Indicate each staff position for this project, including name and title. Show percent of time allocated to this project, the total hourly rate, and the number of hours per week. Also indicate the percent of time that will be in-kind, if any.
- Fringe Benefits - Include those benefits normally provided by your organization, such as state/federal taxes, health coverage, FICA, pension plans. Also indicate the fringe benefit rate for the organization.
- Office Supplies - List cost and quantity of office supplies needed to implement the scope of work
- Patient Supplies – Each agency site will receive \$10,000 to purchase home blood pressure monitors and pedometers for patients. List cost and quantity of blood pressure monitors and pedometers to be purchased.
- Diabetes Prevention Program Referrals - A bonus payment of \$250/quarter will be paid if the grantee refers at least 5 patient each month to the Diabetes Prevention Program through the Community Health

- Network referral system.
- Indirect Cost Rate – Your agency’s federally-approved indirect cost rate

Duplication of Services/Cost Avoidance

Applicants must be certain to assure HEALTH that the funds to be utilized associated with this scope of work are not duplicated in other areas of the agency. These funds are specific to the agreed-upon scope of work via this contract and therefore should be utilized to service populations in need as specified in the RFP.

Budget Narrative: The budget narrative must clearly explain the purpose of each item listed in the financial budget and include a description of matching funds that represent no less than 10% of the total proposed budget. Please refer to the Sample Budget Narrative (Appendix E) for further guidance.

a. Justification of Project Expenses

The budget narrative must clearly explain the purpose of each line item listed in the financial budget.

b. Matching Funds

The budget narrative must include a description of matching funds that represent no less than 10% of the total proposed budget. These funds may be in-kind.

EXPANDED PROPOSAL SUBMISSION

COVER LETTER (1 page)

The applicant must include a signed cover letter on official organization letterhead from an agent who is authorized to sign contracts on behalf of the applicant.

BUDGET AND BUDGET NARRATIVE

Submit a Financial Budget and Budget Narrative for an **11-month Budget Period** (August 1, 2015 – June 30, 2016)

Project Budget

The project budget describes in detail the expenses of the program and consists of a financial budget and a budget narrative. The budget should not exceed \$100,000 per agency. **All applicant agencies are required to include a verifiable ten percent (10%) in-kind match.**

Financial Budget

The financial budget is a listing of all project expenses. Please refer to the Sample Budget Worksheet (Appendix D) to prepare the financial budget. Please include your agency’s required verifiable ten-percent in-kind match in your financial budget. The following is a description of allowable expenses.

Allowable Expenses

- Personnel - Indicate each staff position for this project, including name and title. Show the total hourly rate and number of hours that will be worked on this project. Also show the amount that will be in-kind, if any.
- Fringe Benefits - Include those benefits normally provided by your organization, such as state/federal taxes, health coverage, FICA, pension plans. Also indicate the fringe benefit rate for the organization.
- Patient Supplies – Each agency site will receive a maximum of \$10,000 to purchase home blood pressure monitors and pedometers for patients. Unit cost and quantity of blood pressure monitors and pedometers to be purchased must be indicated.
- Diabetes Prevention Program Referrals - A bonus payment of \$250/quarter will be paid if the grantee refers at least 5 patient each month to the Diabetes Prevention Program through the Community Health Network referral system.
- Indirect Costs – Include your agency’s allowable federally-approved indirect cost rate.

Duplication of Services/Cost Avoidance

Applicants must be certain to assure HEALTH that the funds to be utilized associated with this scope of work are

not duplicated in other areas of the agency. These funds are specific to the agreed-upon scope of work via this contract and therefore should be utilized to service populations in need as specified in the RFP.

Budget Narrative: The budget narrative must clearly explain the purpose of each item listed in the financial budget and include a description of matching funds that represent no less than 10% of the total proposed budget. Please refer to the Sample Budget Narrative (Appendix E) for further guidance.

- a. Justification of Project Expenses - The budget narrative must clearly explain the purpose of each line item listed in the financial budget.
- b. Matching Funds - The budget narrative must include a description of matching funds that represent no less than 10% of the total proposed budget. These funds may be in-kind.

SECTION 8: EVALUATION AND SELECTION OF NEW APPLICANTS

Proposals will be reviewed by a Technical Review Committee comprised of staff from the Department of Health's Division of CFHE. To be eligible for funding under this RFP, the Technical/Cost Proposal must receive a minimum of 70 out of a maximum of 100 points (70%). Proposals scoring less than 70 points will not qualify for further consideration. Points will be assigned based on the applicant's clear demonstration of abilities to apply appropriate strategies to complete the work, create innovative solutions and quality of past performance in similar projects. Applicants may be required to submit additional written information or be asked to make an oral presentation before the technical review committee to clarify statements made in their proposal.

The Department of Health reserves the exclusive right to select the organizations it deems to be in its best interest to accomplish the project as specified herein; and conversely, reserves the right not to fund any proposal(s). Proposals will be reviewed and scored based upon the following criteria:

<hr/> 0-5 points	Applicant Description The applicant provided a detailed description of the type of organization; governing or management structure, type of track record in serving racial and ethnic minority populations; and prior experience with the RI Department of Health's Division of CFHE. The applicant explained why their organization/practice is an appropriate choice to implement the project services.
<hr/> 0-20 points	Applicant Background The applicant provided evidence of policies and procedures that promote a multi-disciplinary team approach to providing care and efforts to achieve improved health outcomes through quality improvement in chronic disease care and related risk factor reduction, prevention and control of disease and disability, and increased patient engagement for patients with diabetes, asthma, hypertension, obesity or who smoke. The applicant has policies and procedures in place to promote clinical-community linkages to facilitate patient referrals to evidence-based chronic disease self-management education or lifestyle modification programs using the Department of Health Centralized Referral System. The Applicant has an existing or past partnership with the Department of Health, the RI Chronic Care Collaborative and other community organizations.
<hr/> 0-35 points	Goals and Objectives The applicant has demonstrated experience working with the targeted population to provide the requirements and services in the Scope of Work. The applicant has clearly outlined the objectives and activities that will be implemented to improve the quality of care and patient health outcomes. Activities included quality improvement initiatives and the establishment of clinical-community linkages to assure that patients with diabetes, hypertension, asthma, obesity, and who use tobacco have improved clinical outcomes.

_____ **Project Administration and Staffing Plan**
0-10 points The applicant has demonstrated that the staff proposed for the project is qualified and capable of implementing the program’s responsibilities and activities.

_____ **Budget**
0-30 points The applicant has submitted a budget and budget narrative that reflects appropriate expenses and is cost effective.

SECTION 9: EVALUATION AND SELECTION OF EXPANDED COMPONENT APPLICANTS

_____ **Project Administration and Staffing Plan**
0-70 points The applicant has demonstrated the successful implementation of the “Enhanced Chronic Disease and Risk Factor Management Program Services”.

_____ **Budget**
0-30 points The applicant has submitted a budget and budget narrative that reflects appropriate expenses and is cost effective.

SECTION 10: REPORTING REQUIREMENTS

- Submit quarterly data reports by month and by site on all measures outlined in the scope of work.
- Provide quarterly progress narrative reports by site describing multidisciplinary team participation in planning and quality improvement activities associated with the chronic disease model. Sites are encouraged to use the Plan Do Study Act (PDSA) Model to affect outcomes improvements.
- Data and narrative reports are to be posted on Basecamp by the 15th of the month following the close of the quarter.
- Project invoices may be submitted subsequent to submission of the required quarterly data and narrative reports. Receipts for blood pressure monitor and pedometer purchases must be submitted with the quarterly invoices.

SECTION 11: REQUIRED ATTACHMENTS

For Core Proposal Applicants only

- Attachment 1: Copy of 501(c)(3) Non-Profit Status
- Attachment 2: A completed and signed W-9 downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.
- Attachment 3: Copy of your agency’s federally-approved indirect cost rate
- Attachment 4: List of designated staff with title, name, qualification, and job description
- Attachment 5: In addition to the multiple hard copies of proposals required, applicants are requested to provide their proposal in **electronic format (disc, or flash drive)** in Microsoft Word and/or Excel

For Expanded Component Applicants only

- Attachment 1: Copy of your agency’s federally-approved indirect cost rate
- Attachment 2: In addition to the multiple hard copies of proposals required, applicants are requested to provide their proposal in **electronic format (disc, or flash drive)** in Microsoft Word and/or Excel

SECTION 12: CONCLUDING STATEMENTS

Notwithstanding the above, the State reserves the right not to award this contract, or to award on the basis of cost alone, to accept or reject any or all proposals, and to award in its best interest.

Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further. The State may, at its sole option, elect to require presentation(s) by offerors clearly in consideration for award.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded to the RFP. The State's General Conditions of Purchases/General Terms and Conditions can be found at the following URL: <https://www.purchasing.ri.gov/RVIP/publicdocuments/ATTA.pdf>

SECTION 13: APPENDICES

Appendix A - CLAS LANGUAGE

Cultural Competence

Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes. Competence in cross-cultural functioning means learning new patterns of behavior and effectively applying them in appropriate settings.

Limited English Proficiency

Under the authority of Title VI of the Civil Rights Act of 1964, Presidential Executive Order No. 13166 requires that recipients of federal financial assistance ensure meaningful access by persons with limited English proficiency (LEP) to their programs and activities. A 2002 report from the U.S. Department of Justice, *Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, provides guidance on uniform policies for all federal agencies to implement Executive Order No. 13166. Further, the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) issued by the Federal Office of Minority Health in 2004 outline mandates, guidelines, and a recommendation for the provision of language access services, culturally competent care, and organizational supports for cultural competence in health care settings. CLAS Standards 4-7 (see below) are mandates and address language access services that should be provided by every organization that receives federal funding, whether directly or indirectly.

Effective immediately, all vendors who contract with HEALTH must perform the following tasks and provide documentation of such tasks upon request of a HEALTH employee:

1. The supports and services provided by vendor shall demonstrate a commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area or target population. Such commitment includes acceptance and respect for cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services. Vendor shall have an education, training and staff development plan for assuring culturally and linguistically appropriate service delivery.
2. Vendor shall have a comprehensive cultural competency plan that addresses the following: 1) the identification and assessment of the cultural needs of potential and active clients served, 2) sufficient policies and procedures to reflect the agency's value and practice expectations, 3) a method of service assessment and monitoring, and 4) ongoing training to assure that staff are aware of and able to effectively implement policies.

3. Vendor shall have a plan to recruit, retain and promote a diverse staff and leadership team, including Board members, representative of the demographic characteristics of the populations served.
4. Vendor shall assure equal access for people with diverse cultural backgrounds and/or limited English proficiency, as outlined by the Department of Justice, *Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*. Vendor shall provide language assistance services (i.e. interpretation and translation) and interpreters for the deaf and hard of hearing at no cost to the client.

National Standards for Culturally and Linguistically Appropriate Services in Health Care

Culturally Competent Care (Standards 1-3)

Standard 1

Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language Access Services (Standards 4-7)

Standard 4*

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5*

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6*

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7*

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports for Cultural Competence (Standards 8-14)

Standard 8

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear

goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

*** Mandates 11/28/11**

Appendix B - PROPOSAL CHECKLIST

Name of Applicant Organization: _____

- The proposal is written according to the RFP specifications.
- The proposal is typed, 12 CPI or an equivalent font, English, single-spaced, paginated, 1-inch margins, one-sided, and submitted in the proper sequence, adhering to the following outline:
 - Proposal Checklist (1 page)
 - Title Page (1 page)
 - Cover Letter (1 page)
 - Table of Contents (1 page)
 - Project Abstract (1 page)
 - Applicant Description (no more than 2 pages)
 - Project narrative (no more than 25 pages)
 - Budget and Budget Narrative (2 pages)
 - Appendices as needed

REQUIRED ATTACHMENTS

- Attachment 1: Evidence of Non-Profit Status (copy of 501c3)
- Attachment 2: Completed and signed W-9
- Attachment 3: Copy of your agency's federally- approved indirect cost rate agreement
- Attachment 4: List of designated staff with title, name, qualification, and job description

Appendix C - TITLE PAGE

AGENCY INFORMATION:

NAME OF APPLICANT AGENCY _____

ADDRESS OF APPLICANT AGENCY _____

TELEPHONE # _____

FAX # _____

E-MAIL ADDRESS _____

F.E.I.N. # _____

PROJECT TITLE _____

CONTACT INFORMATION:

CONTACT PERSON NAME / TITLE

(Must be able to answer questions regarding the RFP)

TELEPHONE # _____

E-MAIL ADDRESS _____

PERSON COMPLETING THIS APPLICATION:

NAME

TITLE

SIGNATURE

AMOUNT of AWARD REQUEST: \$ _____

Appendix D - SAMPLE BUDGET WORKSHEET

*Use this format to submit your **11-month** budget. All items included in this Budget Form must be fully explained in the Budget Narrative. The Organization In-Kind Contribution may not be less than 10% of the requested funding.*

<i>Expense Category</i>	<i>Grant Request</i>	<i>Organization In-Kind Contribution</i>
Personnel (Salary)	\$ 0	\$ 0
Fringe Benefits @ _____%	\$ 0	\$ 0
Patient Supplies	\$ 0	\$ 0
Office Supplies	\$ 0	\$ 0
DPP Referral Bonus (\$250/quarter for 11 months pro-rated)	\$ 917	\$ 0
Indirect Cost Rate @ _____%	\$ 0	\$ 0
TOTAL BUDGET REQUEST	\$ 0	\$ 0

Appendix E - SAMPLE BUDGET NARRATIVE

Please use the following sample as a guide:

A. Justification of Budget Expenses

- Personnel: Indicate personnel names, position titles, number of hours per week to be worked on this project, and hourly wage.

Example:

- Joe Smith, Project Director (PD) - This position is needed to provide overall administrative oversight for the project. 35 hours per week @ \$30/hour.
- Mary Jones, Program Coordinator - This position is needed to provide coordination for the daily activities of the project. 20 hours per week @ \$25/hour.
- Fringe Benefits – Indicate percent of fringe benefits and include percent allocated to each category normally provided by your organization.

Example:

Full-time and part-time (50%) employees are eligible for health insurance. Taxes and fringe @ 30% are calculated as follows: Health Insurance 13.67%, Social Security 6.20%, Medicare 1.45%, Workmen's Comp 2.54%, Unemployment Insurance 2.46%, Dental Insurance 1.00%, Life Insurance .68%, and Pension 2.00%

- Patient Supplies - Blood pressure monitors and pedometers for the patient self-management activities. Indicate number and cost of each, not to exceed \$10,000.

Example:

- *Blood Pressure Cuffs: 250 @ \$25.00 each = \$6,250*
- *Pedometers: 750 @ \$5.00 each = \$3,750*
- Office Supplies - Office supplies as needed for training and administrative needs. Does not include equipment.
- Community Health Network (CHN) Referrals: A bonus payment of \$250 will be paid each quarter if grantee refers at least 5 patients/month to the CHN using the CHN referral system.
- Indirect Cost – Indicate the percent of your federally-approved indirect cost rate.

B. Possible Future Sources of Funding

During the program year, we will apply for funding from the following foundations. Please list any other funding sources.