



CALIFORNIA
HEALTHCARE
FOUNDATION

Request for Proposals:

Evaluation of Small Practice eDesign

Bidders conference	Tuesday, May 26, 2009, 12:00 PM Pacific Time 866-270-7427 (access code *5873134*) Submit questions in advance to fwu@chcf.org
Intent to apply due	Friday, May 29, 2009, 5:00 PM Pacific Time
Proposals due	Wednesday, June 17, 2009, 5:00 PM Pacific Time
Grant recipient announced	June 30, 2009
Evaluation begins	Mid-July 2009
Evaluation ends	April 2011
Award	Up to \$150,000

I. About the California HealthCare Foundation

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

The goal of CHCF's Better Chronic Disease Care program is to improve the quality of care for Californians with chronic disease. Nearly half of all Americans live with a chronic medical condition and this number is expected to rise by 25% during the next two decades. In California, individuals with multiple chronic conditions -- 20% of the population -- account for 60% of the state's health care expenditures.

The objectives of the Better Chronic Disease Care program area are:

- Expand the number of providers who can effectively care for patients with chronic disease.
- Increase the participation of patients and families in all aspects of care.
- Promote appropriate care towards the end of life.

For details about this and other program areas, visit www.chcf.org/aboutchcf/.

II. Background

The recently approved Health Information Technology for Economic and Clinical Health (HITECH) Act will provide at least \$34 billion in electronic health record (EHR) adoption incentive payments to providers who demonstrate “meaningful use” of EHRs, with the first set of payments starting in 2011. “Meaningful use” has yet to be defined, but will likely include demonstrating that providers prescribe medication electronically, have a disease registry, use decision support (prompts and reminders), meet clinical guidelines; and report quality measures. While as much as 57% of large practices (under ten providers) have adopted EHRs in California, fewer than one-fourth of providers in small practices have done so. The most commonly cited barriers include cost to purchase; complexity to implement; difficulty in selecting vendors; and lack of capacity to retrain and redesign workflow.

Two successful organizations supporting hundreds of small practices and clinics have emerged in Massachusetts and New York.¹ These organizations incorporate a centralized support model to negotiate vendor contracts (group purchase), manage the development of complex interfaces with labs and pharmacies, and provide technical and practice reengineering.

The Better Chronic Disease Care program area has viewed the properly designed implementation of health information technology as a key enabler for health care providers to learn the concepts of and to practice data driven improvement, and particularly, to expand the number of providers who can effectively care for patients with chronic disease.

III. Project Description

In April, CHCF committed \$1.5 million to the Small Practices eDesign project, which will support the development of: (1) a community model that supports adoption, integration, and meaningful use of EHR systems for small primary care practices, starting with the implementation of a data-driven revenue cycle management system (RCMS); (2) a technical platform for centralized support for standardized data flows and exchanges; and (3) support tools for practices to redesign their workflow and to effectively use these technologies.

The project involves three roles:

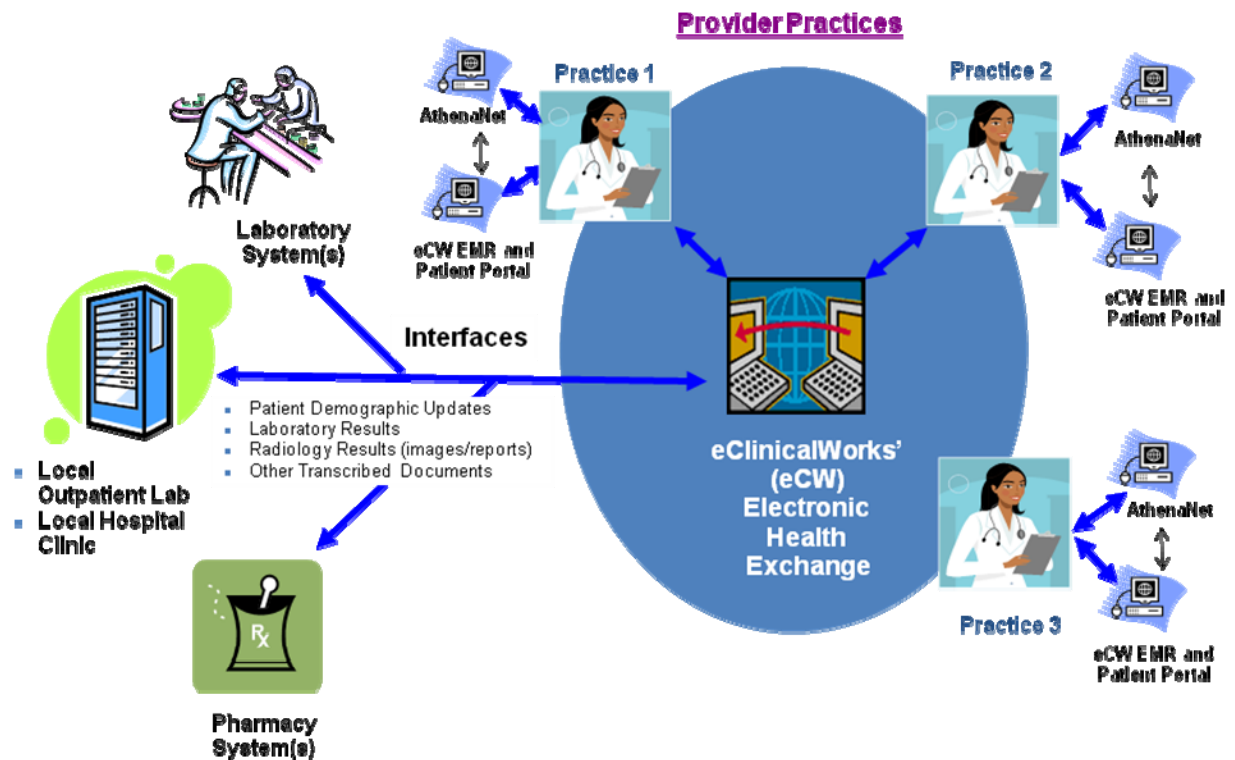
1. **The medical practice:** In addition to implementing the RCMS-EHR combination and following the project timeline, will directly contract with the vendors, purchase any needed hardware, and participate in a learning community designed to complement workflow redesign and technology implementation activities.
2. **The intermediary (a trusted entity in the community):** Serves as the first-line, primary support to the practices – maintains the master services agreement with vendors, provides local project management support, coordinates the technical components and data flows, customizes and guides end-user vendor training, and coaches practices in the use of decision support tools and overall IT adoption for quality improvement. Will be

¹ Mostashari F, Tripathi M, and Kendall M. A tale of two large community electronic health record extension projects. *Health Affairs* 2009; 28(2): 345-356.

responsible for overall management of IT implementations and outreach to new practices entering the program.

3. **The vendor:** Provides the hosted business management and EHR products and enhances the software to produce a community dashboard.

The following diagram provides an illustration of the community support model:



A request for information process during the planning phase led to the selection of two information technology vendors: one supporting revenue cycle management (athenahealth) and the other supporting EHR functionality (e-ClinicalWorks [eCW]). The two vendors have a proven track record of interoperability. Implementation would start first with revenue cycle management, teaching real-time skills in data-driven improvement, and move into full EHR implementation. eCW will offer the same EHR technology offered in Massachusetts and New York. The community support model will also include patient portals.

The pilot community for the model and tools is Tulare County, which is a federally designated primary care shortage area that has the highest prevalence of diabetes in California (9.9% of the population) and is one of the poorest counties in the nation. The Foundation for Medical Care of Tulare and Kings Counties (TKFMC) was identified during the planning process as the intermediary.

Up to 20 primary care practices in Tulare County would implement EHRs in two phases, beginning with a cohort of 5 to 8 sites (Wave 1) and followed by 12 to 15 sites (Wave 2). These

groups would be brought up on athenahealth first, and then rapidly on eCW, using tools (refined over the two waves) that support both the sites and the intermediary. The tools would be packaged and made freely available by CHCF so that other communities in California and nationally may use them. The tools would include template EHR contract language and terms (that allow for group purchasing of EHR, thereby significantly reducing costs), office redesign tools, standardized EHR project plans (including plans for implementing interfaces), training programs for practices and intermediaries including protocols for developing intermediary skills, definition of hardware requirements, practice application forms, business planning documents for intermediaries, and other relevant documents.

In addition to improving operational efficiency and clinical quality, the combined RCMS-EHR implementation is anticipated to improve provider and patient experience. Improved operational and clinical workflows support a better quality of work life for physicians and their staff. Similarly, changes such as improved access to care, decreased cycle times, and more satisfied providers and office staff lend to a more positive experience for patients.

Practices and clinics selected to participate would receive partial subsidies from CHCF to purchase and implement the new system, including technical assistance to redesign workflow and training in data-driven quality improvement processes through TKFMC. They would commit to engage in quality improvement activities and report quality data to TKFMC that would be aggregated and reported into an electronic community “dashboard” (no patient-level data would be shared with TKFMC).

A process of identifying additional communities and intermediaries (IPAs, hospitals, etc.) in California that could leverage the tools developed by this program is already underway. Several additional organizations have expressed interest in supporting a replication.

The following table provides an overview of major program activities:

Project Activity	Timeline
Select Wave 1 sites and begin vendor training and hardware set up	May – June 2009
Wave 1 sites implement RCMS (no longer on legacy systems by end)	June – October 2009
Evaluation begins	Mid-July 2009
Development of community interfaces	May 2009 – January 2010
Wave 1 sites implement EHR/demonstrate proof of concept for community support model	September 2009 – March 2010
Wave 2 sites implement RCMS	December 2009 – April 2010
Wave 2 sites implement EHR	April 2010 – October 2010
CHCF issue brief/summary of evaluation findings released	April 2011

IV. Evaluation Activities & Timeline

The primary goals of the evaluation are to: (1) document and assess the ability of small practices to adopt data driven improvement principles to improve patient care (both operational and clinical aspects) via the implementation and use of the revenue cycle management system and EHR; (2) document and assess how provider experience with giving care and patient experience with receiving care are impacted by the RCMS-EHR implementation; and (3) document and assess the community model in which the intermediary supports small practices in the implementation and use of the RCMS and EHR.

The target audiences for the evaluation findings include CHCF staff, small practices, potential intermediaries in California and other parts of the country (such as medical groups, IPAs, health plans), and state and federal policymakers.

The evaluation will begin mid-July 2009 and continue through the duration of the project, with expected completion in April 2011 (i.e., 22 months). The evaluation team will be expected to engage in the following activities:

- Develop an evaluation workplan for the overall project to address the key evaluation questions.
- Work with project team to review already established measures on operational efficiency and clinical care, and decide whether to track additional measures related to these areas and on provider and patient experience and clinical workflow and productivity.
- Participate in ongoing data collection and analysis of trend data from the revenue cycle management system on key measures of operational/business efficiency for practices in both Waves 1 and 2.
- Participate in ongoing data collection and analysis of trend data from the EHR on key measures of clinical quality for practices in both Waves 1 and 2.
- Document and assess provider and patient experience (e.g., satisfaction, perceptions of overall care) in relation to the RCMS-EHR implementation.
- Document changes in clinical workflow and productivity resulting from the RCMS-EHR implementation.
- Conduct semi-structured interviews with the participating practices, intermediary, and possibly with the vendors.
- Create a final evaluation report for CHCF and project staff that addresses the evaluation questions and documents the outcomes associated with the project (February – March 2011).
- Summarize key evaluation findings in a brief, accessible format for public dissemination to small practices, potential intermediaries in California and other parts of the country (such as medical groups, IPAs, health plans), and state and federal policy makers (March – April 2011).

Many of the activities will be ongoing, starting with baseline data collection and observations for both Wave 1 and 2 sites. CHCF looks to the evaluator for recommendations on the frequency and intervals of the data collection. Further, given the timeliness and interest in this project, a series of interim reports/updates for wider dissemination are expected.

CHCF highly values peer-reviewed journal articles, but this is not required as part of the evaluator's scope of work. During the evaluation, it will become clearer whether to develop or commission an article on the evaluation findings.

V. Evaluation Questions

The overall evaluation will be designed to address the following key questions:

Goal 1: Document and assess the ability of small practices to adopt data driven improvement to improve patient care (both operational and clinical aspects) via the implementation and use of the RCMS and EHR.

1. How successful were the Wave 1 and 2 sites in applying/using the revenue cycle management system and EHR to improve operational efficiency and clinical care?
2. How were clinical workflow and productivity (which are separate from but relate to operational efficiency) affected by the RCMS-EHR implementation?

Goal 2: Document and assess whether the RCMS-EHR implementation impacted provider and patient experiences in care.

3. How did provider and patient experience change?

Goal 3: Document and assess the community model in which the intermediary supports small practices in the implementation and use of the RCMS and EHR.

4. How effective was the intermediary in supporting small practices in the above activities?

Two overarching questions on the replicability of the community support model apply to all three of the above goals, both from the perspective of individual small practices and potential intermediaries:

5. What are the prospects that other communities could successfully apply the community support model?
6. What factors might facilitate or serve as barriers to the replicability of this model, which could be unique to California small practices?

VI. Data Collection Requirements

A successful proposal will combine quantitative and qualitative methods to document and explore the evaluation questions described above. In the table below, we outline the types of evaluation activities that might be considered to answer each of the key evaluation questions and the sources of data that could be used for this purpose. We are providing this as guidance only and will rely on the expertise of the outside evaluation team to identify other creative evaluation

strategies, methodologies, and potential data sources. This table should be used as a template when describing your overall research design and approach in your proposal.

Evaluation Question	Evaluation Methods	Potential Sources for Data Collection	Who's Responsible for Data Collection
1 & 2. How successful were the 20 practices in improving patient care (operational efficiency and clinical quality)?	Quantitative	Dashboards for operational efficiency and clinical care, additional data collection from RCMS and EHR. To measure clinical workflow, use measures on productivity, observations, and interviews at periodic intervals throughout the Wave 1 and 2 implementations	Project team, intermediary, and evaluator
3. How did provider and patient experience change?	Quantitative and qualitative	Surveys on provider and patient experience (need development) and interviews at periodic intervals of selected practices throughout the Wave 1 and 2 implementations	Evaluator and intermediary
4. How effective was the intermediary in supporting the practices?	Quantitative and qualitative	Dashboard (see above), semi-structured interviews with intermediary staff and selected practices	Evaluator
5 & 6. Prospects for replicating the community support model?	Quantitative and qualitative	Synthesis of above data sources	Evaluator in collaboration with project team

In addition to documenting the overall impact of this project, we envision that the evaluation team will provide “real time” feedback to the project team as well as interim reports that can be more widely disseminated. Routine contact will be critical to ensuring the success of the overall project.

VII. Intent to Apply

Applicants that intend to submit a proposal may notify Caron Lee, program manager for the Better Chronic Disease Care program at the California HealthCare Foundation, at clee@chcf.org by 5:00 PM Pacific time on Friday, May 29, 2009. The submission of an Intent to Apply is optional and not doing so will not disqualify applicants from submitting a full proposal. It will, however, allow CHCF to provide potential applicants with updates about the project.

VIII. Proposal Packet

Include the following materials in the proposal packet:

1. **Proposal cover sheet** (available at <http://www.chcf.org/grantinfo/solicited>). This does not count toward the ten-page limit.
2. **Proposal narrative.** The proposal narrative should be no more than ten pages of text, double spaced, in a 12-point font. Applicants are expected to honor the space limitations. The proposal narrative should describe:
 - a. **How you would engage the project team** to collaboratively develop an overall evaluation workplan, data collection methods, and report results.
 - b. **Overall research design and approach.** What type of study design do you propose? What would your data collection and analysis strategy be? How would your methods address each of the key evaluation questions? How would you provide formative feedback and technical assistance to the project team? Also, describe any evaluation questions or activities that you think might be missing in our description of the scope and activities. (CHCF welcomes suggestions that differ or expand on the evaluation activities described earlier.)

In addition to a narrative description, please use the Data Collection Requirements Table to outline how your methods would address each evaluation question using quantitative and/or qualitative sources such as surveys, interviews, or secondary data.

If you wish to submit a proposal but cannot complete the entire evaluation for the authorized amount, please propose a revised scope of work within the amount allocated.

- c. **Workplan for implementing the various evaluation components.** Please describe responsibilities, timeframes, and deliverables based on the evaluation activities described in 2b.
- d. **The challenges you see in this evaluation** and how to address them.
- e. **The qualifications, capacities, and roles of your key team members.** Describe individual team members' relevant experience and references from working on similar evaluations. Why are you the best team to conduct this evaluation? How will team members work together to complete the evaluation? Who will conduct each of the evaluation activities?

3. **Appendices.** Appendices do not count toward the ten-page limit.

- a. **Brief bio-sketch or CV.** Include a brief bio-sketch or CV for key team members. An NIH-type three-page bio-sketch for key team members is acceptable.
- b. **Budget form and budget narrative description.** Please submit a detailed budget and budget narrative for the entire length of the evaluation, as well as a budget for each year for multi-year evaluations. For line-item budgets (generally provided by nonprofit institutions), please use the Proposal Budget Form which can be found on <http://www.chcf.org/grantinfo/solicited/>. This form is not required for budgets based on hourly consultant rates.

Depending on scope of work and proposed deliverables, a budget range of up to \$150,000 is available, including indirect costs. How would you allocate this budget among your suggested evaluation components? Specify major budget categories such as staff, travel, data collection/analysis, evaluation technical assistance, and indirect costs.

IX. Proposal Submission

Proposals must be received by email, preferably in one file in Adobe PDF or Microsoft Word format, to Faith Wu at fwu@chcf.org no later than 5:00 PM Pacific Time on Wednesday, June 17, 2009. Proposals will be acknowledged by a return email within 24 hours or the next business day. *Hardcopies will not be accepted.*

X. Selection Criteria

The ideal evaluation team will have previous experience conducting applied research. The review committee will use the following criteria to assess proposals:

- Clarity of theoretical framework or conceptual model, project goals, hypotheses, methods, and outcomes;
- Proposed analytic methods, including quality and source of data to be used;
- Previous experience working with relevant stakeholders to collect primary data from multiple sites;
- Evaluation/research qualifications and experience of the investigator(s);
- Appropriateness of proposed budget and project timeline; and
- Plan for timely communication and dissemination of evaluation results to project staff, practitioners, health care leaders, policymakers, and other relevant stakeholders.

All funding decisions are made by CHCF, often in consultation with external experts. CHCF does not provide individual critiques of proposals submitted.

XI. For More Information

The Bidders Teleconference will be held on Tuesday, May 26 at 12:00 PM Pacific Time.

The conference call number is 1.866.270.7427 (access code *5873134*). Please submit questions about the project and evaluation in advance to fwu@chcf.org. Questions will be addressed during the teleconference.

Questions not addressed during the Bidders Teleconference can be sent to Caron Lee, program manager for the Better Chronic Disease Care program at the California HealthCare Foundation, at clee@chcf.org or 510.587.3147

If you have any questions about the proposal submission process, please contact Faith Wu at fwu@chcf.org or 510.587.3148.