

Community and Clinical Health Bridge Project Limited Funding Opportunity

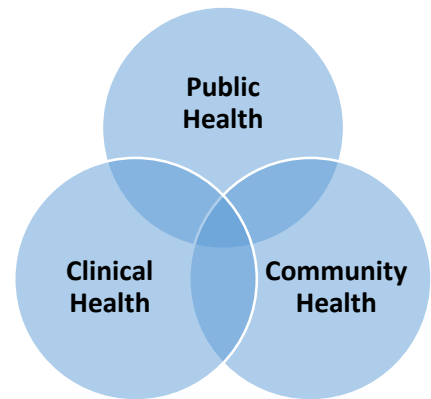
Background

The **Community and Clinical Health Bridge (CCHB) Project** aims to reduce the impact of obesity and related chronic diseases on the State of Texas by focusing on locally driven clinical and community systems-level enhancements. Example activities include: clinical quality improvement activities (e.g. promoting standardized clinical quality measures, or CQMs); enhanced training of community health workforce; and strengthening of clinical-community linkages. These efforts align with goals to improve quality of care and health outcomes, lower health care costs, and improve population health.

Scope of Work

DSHS will contract with **six (6)** local health departments (LHD), or other local public health organization, to implement the CCHB project within their local jurisdictions.

LHDs should coordinate with clinical and community partners in their communities to implement new activities associated with the CCHB priority and optional strategies outlined below.



Priority Strategies

- Enhance *health information technology* for healthcare system quality improvement;
- Develop *community-clinical referral mechanisms* for improved obesity and related chronic disease systems of care; and
- Facilitate *evidence-based education and training* for providers, patients and the community to ensure consistent messaging of reliable health information and collaboration.

Optional Strategies (please select at least one)

- Reduce *barriers to accessing healthcare* for prevention of disease, increased early detection, and reduction of complications;
- Coordinate *comprehensive data collection, analysis, and management* to evaluate implementation activities and determine overall impact on health outcomes at the population level;
- Engage community and clinical partners to *strengthen partnerships and increase sustainability*;
or
- Encourage healthy lifestyles for individuals, families, and communities through *health promotion, outreach, and marketing*.

Availability of Funds

All activities related to this funding opportunity, and potential extensions, are contingent on availability of funds.

Timeframe

The initial project period will be **March 1, 2017 to September 30, 2017**. It is anticipated that successful projects will be extended and may receive up to four additional years of funding (October 1, 2017 to September 30, 2021), dependent on available funds, sufficient progress toward year one objectives, and the submission and approval of budgets and work plans for future years.

LHDs will implement activities under their scopes of work following three phases: planning and partner development (year 1), implementation (years 2-4), and sustainability (year 5).

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
					Planning and Partner Development Phase: Year 1						
Implementation Phase: Years 2-4											
Sustainability Phase: Year 5											

Budget

The DSHS Health Promotion and Chronic Disease Prevention Section, through funding from the Centers for Disease Control and Prevention, will make multiple awards to LHDs to improve obesity and related chronic disease preventive services in accordance with the scope of work contained in this document.

LHDs will be funded up to \$125,000 each to coordinate and conduct activities associated with the strategies listed previously. Allowable expenses are: personnel, travel (in-state), and supplies as well as appropriate sub-contractor costs. Non-allowable expenses include food and equipment. DSHS will provide a complete list of allowable and non-allowable expenses during contract negotiations.

Performance Measures and Other Activities

1. Participate in monthly conference calls with the DSHS Grant Coordinator. Calls will be scheduled on or before the 15th of each month of the contract term and will cover project updates, including:
 - a. Implementation status;
 - b. Barriers to implementation and plans to address those barriers;
 - c. Opportunities to enhance activities;
 - d. Lessons learned; and
 - e. Next steps for implementation.Additional calls may be added as appropriate.
2. Submit progress reports, documentation and other information requested by DSHS on or before the due dates: May 31, 2017 and October 2, 2017. Documentation shall be submitted using the DSHS electronic reporting system, Program Management and Tracking System (PMATS), which can be accessed at www.texaspmats.org unless otherwise specified.
3. Submit preliminary health outcome data, to be specified and agreed upon during contract negotiations.
4. Maintain documentation of activities and outcomes.
5. Participate in one (1) in-person meeting in Austin, Texas during Year 1. LHDs should plan to send up to two (2) staff persons for a July/August 2017 in-person meeting.

Strategies and Example Activities

	Strategy	Example Activities
Priority	Enhance health information technology for healthcare system quality improvement	<ul style="list-style-type: none"> • Develop processes to track, report and improve clinical quality measures (CQM) related to obesity. CQM includes documented adult body mass index (BMI) and, when appropriate, development of a follow-up plan. • Increase adoption and use of electronic health records to improve performance. • Implement decision support tools to assist physicians in gathering and using data to improve quality of care and promote strategies for maintaining good health. Decision support tools include required BMI measure field, prompts to counsel on nutrition and/or physical activity, and follow-up plan documentation. • Implement Health Information Exchange (HIE) modules that facilitate tracking and reporting of standard CQM at the facility and Healthcare System level for quality improvement and performance feedback. HIE is the mobilization of healthcare information electronically across organizations within a region, community or hospital system. May also refer to the organization that facilitates the exchange. • Implement recognition program based on performance feedback from CQM tracking and reporting activities. • Develop payment and reimbursement mechanisms that encourage clinical preventive services such as bundled payment systems, reimbursement for non-traditional services, and generic medications.
	Develop community-clinical referral mechanisms for improved obesity and related chronic disease systems of care	<ul style="list-style-type: none"> • Facilitate Bi-directional Referral System, or two-way, data sharing through standardized referral system protocols and feedback integration into electronic health records. • Implement Bi-directional Referral System to ensure community providers can connect individuals to medical homes and/or close the feedback loop on clinical referrals. • Implement a team-based care model for disease management within the Healthcare System that include traditional and non-traditional members. Team-based care model is the provision of health services by at least two health providers who work collaboratively with patients and their caregivers. Traditional members include physicians, physician’s assistants, nurse practitioners; non-traditional members include Healthcare Extenders (e.g. CHWs), health educators, and registered dietitians. • Provide training on community-clinical referral mechanism to increase use by traditional and non-traditional professionals. • Market a standardized referral system for community and clinical use to increase efficiency and effectiveness for disease management.
	Facilitate evidence-based education and training for providers, patients and the community to ensure	<ul style="list-style-type: none"> • Implement guidelines-based training opportunities for traditional and non-traditional professionals working in community and clinical settings. • Adopt a team-based care model that utilizes traditional and non-traditional members; include other professionals as needed. Traditional members include physicians, physician’s assistants, and nurse practitioners; non-traditional members include patient navigators, care coordinators, Healthcare Extenders (e.g. CHW), health educators, and registered dietitians. Other professionals may include community pharmacists, nurses, social workers, or behavioral health specialists. • Utilize nutrition and physical activity assessments and tools that are guidelines-based and do not require extensive time to conduct or review.

	<p>consistent messaging of reliable health information and collaboration</p>	<ul style="list-style-type: none"> • Communicate in an appropriate, culturally-competent, and health literate manner to ensure individuals can understand and act on advice and directions. • Support use of schools, workplaces, community centers, and other facilities for the provision of Evidence-based preventive services. • Offer community education for the prevention and self-management of obesity or related chronic diseases. • Schedule community Health Education classes so that they are accessible to individuals. Examples include providing classes in convenient locations, scheduling during evening or weekend hours, providing childcare, and offering in multiple languages. • Implement follow-up mechanism for community Health Education so physicians or referring professionals are informed whether the patient follow-up on the referral, what services were received, and any additional comments.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Optional (please select at least one)</p>	<p>Reduce barriers to accessing healthcare for prevention of disease, increased early detection, and reduction of complications</p>	<ul style="list-style-type: none"> • Reduce or eliminate out-of-pocket costs by ensuring individuals are connected to care coordinators. • Establish patient reminder systems for preventive services. This includes email, text message, phone call, and post card reminders. • Expand hours of operation and/or provide childcare to accommodate working individuals and families. • Offer preventive services in convenient locations such as co-location of services, offering near schools, workplaces, community centers, or other facilities. • Offer innovative clinical preventive services, such as telemedicine or home-based care. Telemedicine is the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data, and Health Education, using interactive audio, video or data communications.
	<p>Coordinate comprehensive data collection, analysis, and management to evaluate implementation activities and determine overall impact on health outcomes at the population level</p>	<ul style="list-style-type: none"> • Develop a common data portal for standardized CQM monitoring and complementary community-based measures that can enhance coordination and allow for more robust data analysis. • Develop and adopt policies/protocols for secure, HIPAA-compliant data sharing between Healthcare Systems and community-based providers. • Conduct routine data analysis to identify quality improvement opportunities and successful interventions. • Facilitate presentation of the findings to those community and clinical providers involved as well as the general public. • Utilize the data findings to develop improvement plans, form new partnerships, and inform marketing and outreach efforts.
	<p>Engage community and clinical partners</p>	<ul style="list-style-type: none"> • Assess availability of community resources for treatment and prevention of obesity and related chronic diseases.

	<p>to strengthen partnerships and increase sustainability</p>	<ul style="list-style-type: none"> • Facilitate coordination and support among diverse care providers, including traditional and non-traditional professionals, through coalitions, committees, or local associations. Diverse care providers include physicians, Healthcare Extenders (e.g. CHW), health educators, fitness trainers, registered dietitians, and public health workers. • Create a network of community and clinical partners that will support the connection of individuals to community resources, family support and education programs. • Coordinate marketing and outreach of community education opportunities to promote Community-Clinical Linkages. • Utilize data findings to develop coordinated funding requests for continuation and expansion of Community-Clinical Linkages for chronic disease prevention and management.
	<p>Encourage healthy lifestyles for individuals, families, and communities through health promotion, outreach and marketing</p>	<ul style="list-style-type: none"> • Develop sustained, targeted physical activity and nutrition health promotion campaigns with a media-based social marketing plan. • Promote health literacy by empowering individuals to be informed and proactive about their health. • Educate community and clinical providers on how to ensure appropriate messaging and comprehension. • Market community-based Health Education classes to encourage and expand participation beyond individuals referred by the Healthcare System. This includes families, other support systems, and the general public. • Develop nutrition or physical activity policies for school, workplace, community and/or clinic settings. Examples include food service/nutrition standards, healthy vending, menu labeling, shared use agreements and employer-based exercise facilities. • Enhance the built environment through community environmental changes. Examples include farmers markets, community gardens, walking trails, and bike lanes. The built environment includes all of the physical parts of where we live and work (e.g. home, building, streets, open spaces, and infrastructure). The built environment influences an individual's level of physical activity.