CALL FOR PROPOSALS

Advancing Diabetes Self-Management

THE ROBERT WOOD JOHNSON FOUNDATION

Summary

Although a wide array of medications can help with the clinical control of diabetes, much of the burden of diabetes care and prevention of complications lies with patients and their families through self-management. People who have diabetes need effective self-management education programs that can offer practical skills to sustain healthy behaviors for a lifetime.

Advancing Diabetes Self-Management is a new program of The Robert Wood Johnson Foundation® (RWJF) designed to demonstrate that comprehensive models for diabetes self-management can be delivered in primary care settings and can significantly improve patient outcomes. The program will fund up to six sites to create a learning network to develop and then pilot-test multicomponent self-management programs for primary care settings. Sites will be awarded up to $300,000 each for this 15-month project. Eligible applicants include health care clinics and other primary care settings that have participated in formal quality improvement efforts, such as a Breakthrough Series Collaborative or Practice-Based Research Networks. Advancing Diabetes Self-Management is one of two new programs in The Robert Wood Johnson Foundation's $6.3 million national diabetes initiative.

Background

As the number of people with diabetes continues to rise, the health care system has begun to respond by implementing efforts to improve chronic illness care. A successful shift to optimal chronic care requires better decision-making tools, proactive clinical information systems, enhanced delivery systems, and increased involvement of patients and communities. While health care settings and providers appear to be making significant improvements in clinical care and access for those with chronic conditions, efforts to involve patients and communities in care and self-management are challenging and still lag behind.

Many studies on diabetes education programs have focused on evaluating the impact of increased knowledge and most have been of limited duration, often less than one year. Important components of

diabetes self-management, among them the development of skills in problem solving, goal setting, increasing self-efficacy and obtaining social support, as well as motivation for developing and maintaining healthy behaviors (e.g., increased physical activity, weight management and choosing healthy foods) are missing or not well integrated into these programs. Measures of intermediate and outcome variables, such as quality of life and self-efficacy, also need to be assessed in order to increase our understanding of intervention successes and challenges.

Review of the literature on self-management in chronic disease, along with consultation with several chronic disease management experts, identified several key topics and core elements of self-management programs. Key topics that should be addressed by such education programs are:

- the combination of disease and health management: disease-specific and preventive behaviors;
- patient role management: help in maintaining daily functions of life;
- patient emotional management: addressing psychological factors, adaptation to change and maintaining interpersonal relationships; and
- cultural appropriateness: addressing cultural, language, and learning styles.

In addition, core elements of self-management programs include:

- problem-solving training: enhancing the patient's ability to set goals, create solutions and monitor progress;
- follow-up: communication between providers and patients to address ongoing needs; and
- tracking: measuring health outcomes, utilization of medical resources and patient satisfaction.

More detailed information on these components and elements can be found at <www.rwjf.org/publications>.

Developing and testing educational programs that incorporate all the elements of successful behavior change and how to set up systems to maintain progress is a key step toward engaging patients in self-management.

The Program

The goal of the Advancing Diabetes Self-Management program is to demonstrate that effective multicomponent self-management programs can be delivered in primary care settings. Up to six sites will be awarded up to $300,000 each for 15 months. During this program, grantees will work for nine months in a learning network that designs the interventions and develops appropriate tools, training and systems needed to conduct a pilot. Grantees will have another six months to pilot-test these products.

Sites involved in the learning network will use conference calls, online listservs of e-mail addresses and face-to-face collaboratives to develop a consistent set of uniform measures for assessing reach, process, outcomes and cost across the program sites. Together, using rapid-change cycles and sharing of experience, the grantees will create a comprehensive set of intervention programs and protocols that can be tailored to individual sites and populations, while maintaining the key components and facilitating comparability among sites.

The key topical dimensions and core elements described in the background section provide the basis for the self-management programs to be developed and piloted in specific settings. It is expected that the blend of components will vary depending on the setting, the nature of the disease, the characteristics of the patient and other factors. If successful, the projects will result in an array of well-documented, practical self-management programs that can then be widely disseminated.

An implementation phase with the goal of further demonstrating the feasibility and effectiveness of implementing a comprehensive self-management education model in various health care settings may be funded, pending experience with this pilot program.

Communications activities will focus on working with the learning network of sites to review, create and guide the development and dissemination of material and core content. Communications assistance will be available through funds provided by the Foundation.

Proposals will be accepted from health care clinics and other primary care settings. Eligible applicants include those sites that have had previous experience in chronic disease collaboratives, evidenced by participation in Breakthrough Series, and/or participation in Practice-Based Research Networks.

Eligibility Criteria

Applicants must demonstrate that they possess existing systems to recruit, track and monitor the clinical and behavioral outcomes of at least 300 patients per year (though only 100 patients will be needed for the pilot test of the self-management program). This includes leadership support, appropriate staffing and clinical information systems.

Selection Criteria

Each applicant should describe:

- the extent and demographics of those affected by diabetes in their community, and an understanding of the target population's unique needs;
- their experience with patient education and self-management in diabetes and related chronic conditions;
- their experience in working with conceptual models of self-management drawn from psychology, health education and/or public health;
- their experience in creating and adapting patient education and training programs for the patient populations served in the primary care setting, i.e., differences in culture, language and learning styles;

- their experience in evaluating innovative approaches to patient care and health education;
- the availability of adequate systems for monitoring and managing patient outcomes; and
- evidence of leadership, vision and commitment to contribute to national models and a learning network for diabetes self-management programs.

Evaluation and Program Monitoring

As a part of the learning network activities, sites will develop a uniform set of outcome and process measures that will be collected at each site. An external evaluator will help sites develop and pilot-test the evaluation tools during this phase. If an implementation phase is funded, the external evaluator will conduct a cross-site evaluation of the program.

Sites are expected to have the capacity to collect baseline data on key clinical measures of diabetes outcomes from a participating patient population of at least 100 patients during the pilot phase, with expansion to a minimum of 300 patients during the implementation phase. Examples of types of data that are likely to be needed include:

- periodic measures of blood HbA1c levels;
- providers' use of appropriate clinical procedures, such as foot and eye exams;
- intermediate outcomes, such as measures of patients' quality of life, increases in physical activity and dietary changes; and
- process indicators to document the implementation of the self-management components of the program.

The evaluative measures used to monitor and assess the program may be obtained from the available clinical information system or may be developed as a part of the current program. The evaluation will be designed to provide feedback that will help to develop effective programs and to document the success of these interventions.

Use of Grant Funds

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

Grantees will be expected to meet Foundation requirements for submission of annual and final narrative and financial reports. Project directors and staff will be asked to attend planning meetings and to provide a final written report on the project and its findings, suitable for wide dissemination.

Program Direction and Technical Assistance

Direction and technical assistance for this program is provided by Washington University in St. Louis, which serves as the National Program Office (NPO). Edwin Fisher, Ph.D., Director of the Division of Health Behavior Research and Professor of Psychology, Medicine and Pediatrics at Washington University in St. Louis, is the program director. Carol A. Brownson, M.S.P.H., is the deputy director.

This program addresses a grantmaking priority of the Clinical Care Management and Priority Populations teams at The Robert Wood Johnson Foundation. Responsible staff are Terry Bazzarre, Ph.D., senior program officer; Anne Weiss, M.P.P., senior program officer; Sara Thier, M.P.H., program associate; Doriane Miller, M.D., vice president; Fran Ferrara, program assistant; Mary Ann Scheirer, Ph.D., senior evaluation officer; Paul Tarini, senior communications officer; and Fred Hunter, financial analyst.

How to Apply

Application guidelines with complete instructions can be downloaded at <diabetesnpo.im.wustl.edu>. The program narrative, budget and budget narrative should be submitted to the NPO as attachments to the filled-out application via e-mail by 12 noon ET on September 16, 2002. Two hard copies of the program narrative, budget, budget narrative, letters of support, resumes and other attachments, must be sent by regular mail, postmarked no later than September 16, 2002. Any organization that is unable to submit required material via e-mail should contact the NPO for further instructions. Proposals that are not received by the deadline, that do not follow format instructions, or are incomplete, will not be reviewed. The Foundation does not provide individual critiques of proposals submitted.

Inquiries

Please direct all questions about the program, selection criteria or proposal requirements to:

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All applicants are encouraged to visit the Web site at <diabetesnpo.im.wustl.edu> or contact the NPO for answers to both general and specific questions on how to apply. The Web site includes a list of frequently asked questions (FAQs) about the program application process.

Timetable

The NPO will host applicant conference calls (listed below) to answer questions about the program or the application and selection process.

August 1, 2002	Applicant conference call Time: 4:00 PM-5:00 PM (ET) Dial-in number 1 800-860-2442 Guest code: Washington University *(Only necessary to participate in one call)*
August 15, 2002	Applicant conference call Time: 4:00 PM-5:00 PM (ET) Dial-in number 1 800-860-2442 Guest code: Washington University *(Only necessary to participate in one call)*
September 16, 2002	Deadline for receipt of proposals.
Early October 2002	Applicants will be notified whether they have been selected to receive a site visit.
October–November 2002	Site visits.
Mid-December 2002	Notification of awards.
February 2003	Grants begin.

About RWJF

The Robert Wood Johnson Foundation® is the nation's largest philanthropy devoted exclusively to health and health care. It concentrates its grantmaking in four goal areas:

- to assure that all Americans have access to basic health care at reasonable cost;
- to improve care and support for people with chronic health conditions;
- to promote healthy communities and lifestyles; and
- to reduce the personal, social and economic harm caused by substance abuse—tobacco, alcohol and illicit drugs.

This document, as well as many other Foundation publications and resources, is available on the Foundation's Web site:
www.rwjf.org

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