

**Patient-centered transitions in care communication: Call for proposals**

**July 2008**

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The Kenneth B. Schwartz Center

*Dedicated to strengthening the relationship between patients and caregivers*

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## Introduction

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The Kenneth B. Schwartz Center's mission is to support and advance compassionate health care in which caregivers, patients and their families relate to one another in a way that provides hope to the patient, support to caregivers and sustenance to the healing process. The Schwartz Center is a growing non-profit organization dedicated to:

- Enhancing the practice of medicine and establishing medical practice norms that value communication skills, interpersonal sensitivity and cultural competence;
- Developing and evaluating specific models of care that strengthen relationships between patients and their clinical caregivers;
- Providing opportunities for clinicians to give and receive support from one another; and
- Increasing understanding of how patients define empathic care by giving them opportunities to give input directly to caregivers.

The Schwartz Center's goal in issuing this Call for Proposals is to enhance relationship-centered, coordinated care as patients transfer between different locations.

*“Practitioners’ relationships with their patients, their patients’ communities, and other practitioners are central to health care and are the vehicle for putting into action a paradigm of health that integrates caring, healing, and community.”<sup>1</sup>*

We seek creative proposals that focus on improving care for patients of all ages by enhancing the communication and coordination that occur at various transition points along the course of illness as patients transfer between different care locations. These are times when patients can be most vulnerable and in need of compassionate, caring attention and engagement. The focus of this proposal is *not* on transitions during transfers of care within acute care settings, but on transfers between different care locations.

The Schwartz Center will only accept *collaborative proposals planned by multi-disciplinary teams* from different healthcare settings in the continuum of care.

## Background

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The Institute of Medicine, in its sentinel call to action, *Crossing the Quality Chasm*, outlined six imperatives to ensure that Americans receive health care that is safe, effective, patient centered, timely, efficient and equitable. These imperatives include the redesign of care processes, effective use of information technologies, knowledge and skills management, development of effective teams, coordination of care across patient conditions, services and settings over time, and use of performance and outcome measurement for continuous quality improvement and accountability.<sup>2</sup> While healthcare systems, professionals and public advocacy groups have begun to address these imperatives within single health care settings, the challenges and problems that arise during transitions in care between locations have received far less attention.

Patients however, especially those with complex or chronic conditions, may find themselves being transferred among different providers in multiple settings including hospitals, rehabilitation, nursing and hospice facilities, assisted living, and home. Most patients are no longer followed by a single clinician during transitions among multiple settings. The increasing specialization of healthcare providers, and the complexity and dispersion of responsibility for

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<sup>1</sup> Tresolini CP, and the Pew-Fetzer Task Force. Health Professions Education and Relationship-centered Care. San Francisco, CA: Pew Health Professions Commission, 1994:24.

<sup>2</sup> Committee on Quality of Health Care in America, Institute of Medicine. Crossing the Quality Chasm. A new Health System for the 21<sup>st</sup> Century. Washington DC: National Academy Press; 2001.

patients' care across settings and persons raises real concerns about the potential for dissatisfaction and poor outcomes due to fragmentation and discontinuity. U.S. emergency and long-term care professionals identified communication problems as the largest barrier to providing optimal care to patients transferred in either direction between the two care settings.<sup>3</sup> Health care providers rarely have access to adequate information about patients' medical and psychosocial needs,<sup>4</sup> and several studies have documented an increase in errors and adverse events during transitions across care settings.<sup>2,5,6,7</sup>

In the absence of adequate inter-professional communication and systems to ensure coordination of information and care, this task may fall to patients and their family members who may lack the knowledge, skills and support needed to manage complex care transitions. Patients' and family members' perspectives will inevitably change across the trajectory of illness and care settings. This reality mandates the need for access to information, education, support and continuous dialogue among patients, family members involved in their care, and healthcare professionals to ensure that patients' values and preferences are respected, that they are involved in their care across settings according to their desire and ability, and that their medical, psychosocial, and emotional needs are addressed.

Investigators have begun to develop a variety of models and tools to address some of the needs described above, primarily during transitions from hospital to home. These have included the coordination of discharge planning and implementation of home care interventions by advanced practice nurses, implementation of patient-held tools such as a "Personal Health Record" and "Patient Care Organizer," "transition coaches" to encourage and prepare patients to take a more active role during care transitions, creation of educational materials, and linkage to community and peer support groups.<sup>8,9,10</sup> The National Transitions of Care Coalition has proposed a framework for measuring transitions of care<sup>11</sup> and instruments are under development to measure changes in patients' health and functional status after acute care discharge,<sup>12</sup> as well as patients' experiences of care transitions.<sup>13</sup>

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<sup>3</sup> Terrell KM, Miller DK. Challenges in transitional care between nursing homes and emergency departments. *J Am Med Dir Assoc.* 2006;7:499-505.

<sup>4</sup> Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians. Implications for Patient Safety and Continuity of Care. *JAMA.*2007;297:831-841.

<sup>5</sup> Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med.*2003;138:161-7.

<sup>6</sup> Moore C, Wisnivesky J, Williams S, McGinn T. Medical errors related to discontinuity of care from an inpatient to an outpatient setting. *J Gen Intern Med.*2003;18:646-51.

<sup>7</sup> Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. *Ann Intern Med.*2005;143:121-8.

<sup>8</sup> Naylor MD, Broton D, Campbell R, Jacobsen BS, Mezey MD, et al. Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders. A Randomized Clinical Trial. *JAMA.*1999;281:613-20.

<sup>9</sup> Coleman EA, Parry C, Chalmers S, Min S. The Care Transitions Intervention. Results of a Randomized Controlled Trial. *Arch Intern Med.*2006;166:1822-1828.

<sup>10</sup> Aitken ME, Korehbandi P, Parnell D, Parker JG, Stefans V, Tompkins E, Schulz EG. Experiences from the Development of a Comprehensive Family Support Program for Pediatric Trauma and Rehabilitation Patients. *Arch Phys Med Rehabil.*2005;86:175-9.

<sup>11</sup> National Transitions of Care Coalition. Improving Transitions of Care. Available at: <http://www.ntocc.org/Portals/0/PolicyPaper.pdf>. Accessed July 5, 2008.

<sup>12</sup> Medicare Continuity and Assessment Record Evaluation Instrument. See: [http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PACPR\\_RTI\\_CMS\\_PAC\\_PRD\\_Overview.pdf](http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PACPR_RTI_CMS_PAC_PRD_Overview.pdf) Accessed July 5, 2008.

<sup>13</sup> Parry C, Mahoney E, Chalmers SA, Coleman EA. Assessing the Quality of Transitional Care. Further Applications of the Care Transitions Measure. *Med Care.*2008;46:317-322.

The Schwartz Center recognizes transitions of care as one area in which there is an urgent need to foster relationship-centered care and systems that meet the needs of patients, families and health care providers alike for communication, education, and support to enhance the quality of health care in this country.

## **The Program**

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The Schwartz Center is seeking proposals designed to enhance patient care by improving communication and coordination among patients, families, and healthcare providers during transition points along the patient's illness trajectory. These difficult transition points occur particularly as patients transfer among care settings, including hospitals, nursing homes, assisted living, rehabilitation facilities, hospice care or care in the patient's home. Transition points during transfers of care are times when patients' values, care preferences, socioeconomic, emotional and health care needs must be elicited and clearly communicated with all participants in the patients' journey.

The Schwartz Center is particularly interested in funding programs that are designed to identify and utilize critical transition points in order to encourage:

- caring, accurate, effective and timely communication with patients and families and among clinicians about care goals and options, patients' values, preferences and needs, and the benefits and burdens of various types of medications, treatments and care settings;
- care that addresses the needs of patients for physical comfort, emotional support and spiritual care;
- care that complies with the patient's wishes, particularly but not only for end-of-life care;
- communication with and support services for family members to help them cope with the care of their loved one.

The Schwartz Center will accept only collaborative proposals planned by multi-disciplinary teams of investigators who will implement the project together across a spectrum of health care settings or services. Project participants may include providers at hospitals, nursing homes, rehabilitation facilities, assisted living or other extended care facilities, hospice programs, and visiting nurse agencies. Proposals should create replicable models for communication between patients, families and clinicians about issues that arise during the course of transfers of care to different locations.

Proposals may focus on, but should in no way be limited to:

- developing training or educational programs for patients/families/providers to enhance understanding and communication about patients' values, needs and preferences during transfers of care;
- creating systems that facilitate relationship-centered care coordination;
- improving relationship-centered discharge planning;
- supporting advance care planning and communicating about the implications and appropriate use of various life-sustaining treatments.

These lists are meant to be illustrative and are not intended to limit the creativity of the proposals. The focus of the proposal should be on creating methods to incorporate within medical care plans patients' and families' values and preferences, as well as psychosocial and emotional needs during transfers of care.

Proposals should have a robust evaluation plan. Evaluation of the project should include the use of instruments designed to assess patients' perspectives of communication and care as well as other salient measurable outcomes.

## **Eligibility**

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Massachusetts hospitals, rehabilitation facilities, home health or visiting nurse agencies, community-based organizations, nursing homes, outpatient practices, assisted living and other extended care facilities, continuing care retirement communities, hospices and similar organizations are eligible to submit proposals for this grant. **Only collaboratives consisting of two or more organizations should apply for this grant.** A collaborative is defined as an affiliation of multiple organizations that will apply, plan, implement and evaluate together a program that responds to this Call for Proposals.

Applicants must be non-profit organizations that serve primarily Massachusetts residents. A for-profit company may participate in a collaborative that includes non-profit organizations as long as a non-profit organization assumes the leadership role for the collaborative. Each collaborative should designate a primary organization for purposes of communicating about the proposal. The members of the collaborative(s) chosen for this grant will need to prepare and submit a memorandum of understanding outlining the responsibilities of each participating organization. The Schwartz Center reserves the right to request that one of the participating organizations be designated as the “managing partner” if it appears that such a designation would enhance operation of the program.

## **Application Process**

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The first step in the application process will be a Bidders Conference that is scheduled for **August 15, 2008**, 9:30-11:00 am at Harvard Pilgrim HealthCare, 93 Worcester Street, (Rt. 9), Room 1007, Wellesley. At that time, we will review the Call for Proposals and respond to questions. For directions, please visit [www.harvardpilgrim.org](http://www.harvardpilgrim.org), click on Contact Us, and follow directions for the corporate offices in Wellesley. We encourage interested organizations who intend to apply for this grant to attend. Please RSVP about your intention to attend the Bidders Conference to 617-724-4746. Following the Bidders Conference, we will prepare a list of many of the questions and our answers on our website. Before you call with questions, please check our website to see if we have answered your questions. If not, please contact Marjorie Stanzler (617) 726-0914.

We will then accept **Letters of Intent** to apply for this grant that do not exceed three double-spaced pages. Letters of Intent with 12 copies should be submitted to:

Marjorie Stanzler, Director of Programs  
The Kenneth B. Schwartz Center  
205 Portland Street, 6<sup>th</sup> floor  
Boston, MA 02114

Letters of Intent must be received at the Schwartz Center by 5pm on **September 19, 2008**. Each Letter of Intent should include:

- A brief description of each organization in the collaborative proposing the project;
- A summary and brief description of the proposed project;
- A preliminary program budget (may be changed for the final proposal)
- A brief description of how the program will be evaluated; and
- The name, email address, street address, and phone number of the person we should contact if we have any questions concerning the Letter of Intent.

Based on our review of the Letters of Intent we receive, we will invite a selected group of applicants to submit **full proposals** for our consideration. We will notify applicants by **October 17, 2008** whether they have been selected to submit a full proposal or not. Full proposals are due by **December 8, 2008**.

Please direct all inquiries to:  
Marjorie Stanzler, Director of Programs (mstanzler@partners.org)  
Phone: (617) 724-4746 Fax: 617-643-5490

## **Application Content**

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If asked to submit a full proposal, it should include:

1. A cover letter stating support from the chief executives of the organizations applying as part of the collaborative.
2. A summary sheet that includes the name, address, telephone number, fax number and email address of each applicant organization/institution that is participating in the collaborative. Please identify the program director, principal investigator or primary contact person for the program.
3. Brief Narrative (maximum of 5 double-spaced pages):
  - A. Describe the problem and the transition point(s) you intend to address, the population you intend to serve and why you chose that problem and population;
  - B. Describe the proposed program and how it meets the goals of the grant (please focus a majority of your narrative on this description);
  - C. Describe your plans for program implementation, including a timetable;
  - D. Describe how you anticipate the program will be sustained over time (both administratively and financially); and
  - E. Describe how you plan to disseminate the content and/or results of your program.
4. A description (maximum of two double-spaced pages) of your primary goals/anticipated outcomes along with quantifiable objectives for the proposed program and of your plans to evaluate performance both during and at the end of the grant. How will you define, document and assess program impact along with lessons about program implementation?
5. A description (maximum of one double-spaced page) of the collaborative's capacity to undertake the proposed program along with past experience and qualifications. Before making a final award, the Schwartz Center anticipates that it may need to request additional information about the collaborative's organizations and budgets.
6. An itemized program budget and a budget justification for each of the 2 years. What portion of existing staff do you anticipate using? Please indicate whether you have or also anticipate receiving other sources of funding for the proposed program.
7. A CV for the program director, principal investigator or primary contact person.
8. A list of the people serving on applicants' Board of Trustees or other governing body
9. A copy of applicants' federal tax-exemption ruling and, if an applicant has a total budget of under \$500,000, a copy of applicant's most recent federal tax return on Form 990.
10. Up to three letters of support for your proposal.

If asked to submit a full application, please submit 12 copies to:  
Marjorie Stanzler, Director of Programs  
The Kenneth B. Schwartz Center  
205 Portland Street, 6th floor  
Boston, MA 02114

Complete applications must be received **by 5pm on December 8, 2008**. Late proposals cannot be considered. Faxed or emailed proposals will not be accepted.

## **Selection Criteria**

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The funded proposal will be selected based on the following criteria:

- responsiveness to the listed program objectives (see page 3);
- demonstrated ability of the collaborative to meet the program objectives;
- degree of collaboration among providers in different settings and likelihood of successfully promoting collaborative strategies across treatment settings;
- involvement of patients, family members and/or patient advocates or representatives in planning and/or implementation of the program;
- inclusion of objective performance measures;
- clarity of evaluation methods and plans;
- feasibility of replicating the program or using it as a model at other institutions; and
- overall merit, clarity, innovation, feasibility, potential impact, and sustainability of the proposal.

## **Review Process**

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The Schwartz Center Program Review Committee will include members of the Center's Programming Committee as well as outside experts. The Schwartz Center Board of Directors will ratify the final selection. Funding decisions will be finalized by **January 23, 2009**. An announcement will follow the final decision.

## **Amount and Duration of Grants**

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The Schwartz Center is making \$100,000 per year for two years available under this grant. There may be one or two collaboratives selected for the grant in which case the money will be divided in amounts to be determined by the Schwartz Center.