Connected Care Accelerator:
Equity Collaborative
Request for Applications

This program is provided by the Center for Care Innovations and the California Health Care Foundation, with additional support from Cedars-Sinai.

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Executive Summary

In partnership with the California Health Care Foundation (CHCF) and Cedars-Sinai, the Center for Care Innovations (CCI) is launching a new program designed to reduce disparities in telehealth care called the Connected Care Accelerator: Equity Collaborative (CCA Equity Collaborative). This collaborative will improve access to telehealth for patients in historically underinvested communities.

OVERVIEW

Research shows impressive gains in telehealth during the pandemic:

- Most healthcare providers expanded the use of telehealth services.
- This expansion improved access to services and resulted in a drop in no-show rates, with people receiving services that otherwise would have been delayed or unavailable.

However, more work is needed to ensure equity in access to telehealth. There is a troubling digital divide in California and the rest of the country, with many communities not able to benefit from telehealth. We have learned that many have been left out of telehealth care, or limited to audio only services because they lack broadband connectivity, they face digital barriers or language barriers, or processes have not been implemented to provide access. The gap in access to healthcare will continue to widen if these challenges are not addressed.

OPPORTUNITY

Participating organizations will receive $75,000, access to monthly coaching, an online learning community, virtual convenings, and tools to reduce and/or eliminate disparities in access to telehealth. All participating organizations will focus on at least two of the following areas:

- Improving the use of video telehealth
- Supporting patients with digital barriers
- Expanding access to telehealth for patients with a preferred language other than English

OUTCOME

The expected outcome is that participants demonstrate increased access to telehealth for the populations they prioritize for telehealth equity interventions.

WHO CAN APPLY

- Federally qualified health centers (FQHC) and FQHC look-alikes
- Community clinics, rural health clinics, and free clinics
- Ambulatory care clinics owned and operated by county health systems or public hospitals
- Indian Health Service (IHS) clinics

Medi-Cal and uninsured patients must make up at least 50 percent of the organization's total patient population. Participants will be selected to achieve diversity in geographic location, community health center size, and patient mix.

TIMELINE

The learning collaborative will run for 13 months, from April 2022 through May 2023.

Background

The COVID-19 pandemic upended the way California delivers health care. Health care systems scrambled to restructure their services to keep both their patients and employees safe. Federal policymakers moved quickly to expand coverage and payment for telehealth. The California Department of Health Care Services dismantled previous barriers to telehealth and began paying providers for telephone and video visits at the same rate as in-person visits.

As a result, many California health care providers pivoted rapidly from in-person visits to telehealth. Despite external pressures such as the pandemic and wildfires, many health care providers made transformational changes, including adopting new technologies, overhauling workflows, and redefining team member roles, resulting in easier access to services. For example, telehealth led to a drop in patient no-show rates at many clinics, and providers were able to reach clients who lacked adequate transportation and lived in rural locations or in homeless encampments rarely visited by physicians. Telehealth is crucial to increasing access to care as well as health equity – fair, just, and inclusive opportunities for people to be healthy – during this ongoing pandemic and beyond.

While many people have benefited from the expansion of telehealth, others who need services the most have experienced barriers to access, including families with low incomes and/or little to no access to smartphones, computers, tablets or broadband as well as people who cannot read or whose primary or sole language is not English. Extensive work is needed to address barriers faced by patients to ensure that telehealth promotes equitable access to care and does not exacerbate existing health disparities.

As health care providers continue to explore different technologies and practices to meet patients' needs, there are opportunities to use human-centered design to innovate, learn together, and create a sustainable infrastructure and approach to safely care for patients using telehealth. Additional support is needed to ensure disparities aren't exacerbated by limited literacy, unequal access to internet-enabled devices, limited broadband, and lack of support and practices for patients to fully engage in their health care.

There is no clear playbook and limited evidence for how to make these fundamental changes in safety net health care systems. However, we believe the answers will emerge from our community of providers who are willing to learn from and share with peers and experts, test new processes, expand the work they have already started, and develop equitable approaches to sustain telehealth as an essential component for how care is delivered into the future.

Through the CCA Equity Collaborative, California Health Care Foundation and Cedars-Sinai will provide $75,000 grants and technical assistance to up to 21 safety-net practices where the majority of patients are covered by Medi-Cal or uninsured. 12 will be funded by CHCF throughout the state and 9 by Cedars-Sinai in Los Angeles. This collaborative is designed for organizations that have already implemented both phone and video telehealth approaches in their practices and have a committed team to test, learn, and share best practices to advance equity in access to telehealth.

Program Description

The goal of the CCA Equity Collaborative is to provide a testing ground and support for organizations to rapidly design, test, scale, and share new strategies to improve equity in access to telehealth. The

lessons and best practices developed by participants will lay important groundwork for strengthening telehealth and equitable access to care throughout California's health care safety net.

Over the course of this 13-month learning collaborative (April 2022 – May 2023), participants will work on innovation projects to advance telehealth delivery for populations who face barriers to accessing care. Organizations will each dedicate a small, multidisciplinary team (3-5 people) to define, discover, design, test, and implement strategies that will improve and sustain telehealth delivery for their specified population. The program will guide teams through a process that advances the use of innovation and performance improvement methods to support rapid testing and learning. Teams will have access to virtual resources, including peers, learning events, coaches and subject matter experts, as well as tools and templates to support testing and learning. The expected outcome is that participants demonstrate increased access to telehealth for populations prioritized for telehealth equity interventions.

Participants will use data and methods to identify population groups experiencing disparities in access to telehealth, define aim statements, and design and test new strategies to improve equitable access to telehealth. Participants will be expected to focus their project on addressing at least two of three program objectives listed in the table below.

PROGRAM OBJECTIVES	ILLUSTRATIVE EXAMPLES
Improve the use of video telehealth.	▪ Developing new workflows for virtual warm handoffs between care team members ▪ Implementing new scheduling policies and scripting to encourage video use for telehealth ▪ Developing new workflows and care team models to support patients' access to video and troubleshoot technology challenges ▪ Creating new telehealth outreach and support roles (e.g., volunteers, peers, or medical assistants)
Improve access to telehealth for patients with a preferred language other than English.	▪ Developing new systems and workflows to identify and respond in patients' preferred language ▪ Improving existing or establishing new partnerships for seamless interpretation services
Support patients with digital barriers.	▪ Engaging peers or student volunteers to guide patients on how to use tools for telehealth ▪ Creating telehealth program coordinator positions focused on patient virtual visit outreach, assessing technology needs and rehearsing for video visits ▪ Establishing new partnerships to ensure connectivity and data plans for patients

Note: The scope of the CCA Equity Collaborative and participant projects will not include Remote Patient Monitoring (RPM).

Eligibility

We're looking for health care safety net organizations that provide comprehensive primary care services primarily to at least 8,000 unduplicated patients. Medi-Cal and uninsured patients must make up at least 50 percent of the organizations' total patient population. If your organization does not meet these criteria but serves a traditionally hard-to-reach or marginalized community, you may still apply as an exception. Please review the narrative questions for more details.

Eligible organizations include California-based:

- Federally qualified health centers (FQHC) and FQHC look-alikes
- Community clinics, rural health clinics, and free clinics
- Ambulatory care clinics owned and operated by county health systems or public hospitals
- Indian Health Service (IHS) clinics

Statewide associations and regional clinic consortia are not eligible to apply. If you have questions, please contact:

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Participant Expectations

This learning collaborative is intended to be flexible and responsive to the needs of participants, so we ask each organization selected for the CCA Equity Collaborative to act as a partner in shaping the program by making the following commitments:

1. Leadership Support: Successful organizations will require leadership that is committed to testing and implementing innovative approaches to advance telehealth equity and to sharing experiences and learning with others in the safety net. It will also require leaders to understand the importance of using innovation and performance improvement to spread telehealth practices across the organization and willingness to leverage organizational resources to operationalize such changes. We expect strong leadership support from the Chief Medical Officer and Chief Operating Officer at a minimum, as demonstrated through a letter of leadership support.

2. Dedicated Team: Establish a core project team that commits to testing, implementation, and learning for the organization and sharing with peers and the broader safety net community. This core team should consist of three to five clinical, administrative, and operational leads. Please note that we have seen that some teams need to add additional team members as

they go through the program, define their project, and uncover learnings in the discovery and testing phases. To begin, the core team should include:

   a. A clinical champion who has a significant role in the organization's telehealth efforts;
   b. At least one operational and/or frontline staff member who can inform and lead the operational and clinical implementation within the organization; and
   c. A quality improvement, data, or IT staff member that can help to manage data and metrics collection and reporting.

There must be a senior leader to serve as a sponsor for the project team. This senior leader can ensure protected time for team members to participate in learning collaborative activities, as well as lead change and spread successful strategies within their organizations. This individual should also have decision-making authority to move telehealth efforts forward. It should be clear how the participating team will keep the senior leader engaged in the progress of the work.

3. **Program Activities:** Teams will be expected to complete defined assignments designed to advance their telehealth equity work and to share lessons learned by presenting examples of their project successes and challenges. All project team members are invited and encouraged to participate in all program activities, but we realize that not every member will join all virtual events. Teams are expected to ensure that at least one member from the selected team participates in each of the core activities (i.e., virtual sessions, coaching sessions, and evaluation activities). We have found that when multiple team members are engaged in program activities, their team is more effective and successful. The approximate time commitment is 3-6 hours per team member and per month for program meetings and activities.

4. **Patient and Community Involvement:** With guidance provided during the program, successful organizations will actively involve patients' and community members in their plans and efforts to advance telehealth equity.

5. **Data Reporting and Evaluation Activities**: An external evaluator will support the collection of data and stories to assess the overall impact of the learning collaborative and collect data that can be used to advocate for long-term policy changes to sustain equitable access to care. Teams are expected to work closely with the evaluator to collect and submit data at the beginning, midpoint, and end of the program on a standardized set of measures; participate in two interviews and two program feedback surveys (program midpoint and end), and complete progress reports to share stories about the impact of the work. The evaluation team will support individual organizations to pull and report data. See the appendix for more information about the evaluation approach, including methods and data reporting requirements.

What Makes a Strong Application?

High number and proportion of Medi-Cal or uninsured patients: Successful applicants will meet the eligibility requirements; preference will be given to organizations that serve an even higher proportion than the minimum number of patients and demographic percentages described above.

Organization serves a unique population or need in their community: Preference will be given to organizations that provide needed care for a greater share of patients of color and/or patients with a preferred language other than English.

Prior experience and desire to expand telehealth capabilities: Successful applicants should currently provide telehealth via phone and video to patients at the time of applying. Organizations must possess an understanding of innovation and performance improvement methods, and they must be ready to measure and test changes throughout this learning collaborative. Preference will be given to organizations that clearly articulate how they plan to advance equity in access to telehealth.

Clear vision of how to sustain the efforts in this program: Successful applicants will demonstrate a keen understanding of existing challenges and articulate how they intend to further spread or enhance telehealth equity within their organization beyond this grant funding opportunity.

Data, IT, and QI Systems in Place: Successful applicants will have data, IT, and QI systems in place with the ability to track patient-level data and make improvements to telehealth approaches based upon the data. To the extent possible, data reporting for this program will build upon existing standard data collection reports.

Other preferences: Organizations that have never participated in CCI programs or only one program by CCI will be given preference. Some preference may also be given to applicants with existing practices that are important for other organizations to learn from. Nine out of the twenty-one organizations will be located in Cedars-Sinai service areas I Los Angeles so some preference may be given to organizations there.[1] Some preference may also be given to organizations that expand the geographical presence of the program in California.

How to Apply

STEP 1: ATTEND INFORMATIONAL WEBINAR (OPTIONAL)

Interested partnerships are encouraged to participate in an informational webinar on February 10, 2022 at 12:00 pm to hear a program overview and ask any clarifying questions. Register here.

STEP 2: APPLY ONLINE

Applications must be submitted online by March 16, 2022 by 5:00 pm PT. The online form is available here. The program cohort will be announced by April 8, 2022.

Applications should include the following:

- Application Submission Form
- Application Narrative: Includes responses to the eight questions below.
- Budget Proposal: Outlines how you intend to use the grant funds.
- Most recent W-9 form.
- Letter of Leadership Support: This letter should demonstrate organizational commitment to implement or expand upon telehealth capabilities and collect data as needed. This includes dedicated time for the core team to fully participate in program activities and implement

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[1] Service Planning Areas (SPAs) 2, 3, 4, 5, 6 and 8.

changes at the clinical and organizational level. The letter should be submitted by either the Chief Medical Officer, Chief Operating Officer, or Chief Executive Officer.

APPLICATION NARRATIVE QUESTIONS

Please limit your response to a maximum of five pages, using at least 11-point font and 1-inch margins.

1. **Overall Goals:** Why is your organization interested in participating in this learning collaborative? What objectives would your organization focus on to improve equity in access to telehealth (see the program objectives under program description)? What do you hope to accomplish with this program?

2. **Telehealth Leadership:** Who in your organization is leading your telehealth (video and audio) infrastructure efforts? What is their role and how do you intend to spread learnings and practices within your organization?

3. **Telehealth Experience:** In thinking about your organization's experience with delivering telehealth, what are your organization's strengths? And what do you see as your organization's main opportunity for improving access to telehealth services?

4. **Telehealth Equity:** How does your organization identify patients at greatest risk for care gaps or poor health outcomes? What do you know about differences in use of telehealth services across population groups you serve? How do you address their needs and preferences? Please share if you screen patients for digital barriers, and/or if you support patients to address digital barriers. If you serve people with a preferred language other than English, please comment on your experiences of providing telehealth services for them.

5. **Priority Patient Population:** What priority patient population do you plan to focus on in the Equity Collaborative? This can be groups based on ethnicity, race, language preference, common barriers to care, or your entire patient population. (Note: during the program, you will have a chance to revisit your telehealth data and affirm or change this population based on your data about disparities.)

6. **Quality Improvement Experience:** Please describe a clinical or operational improvement project you implemented in your organization. What data (outcome measure, processes measures, qualitative measures) did you collect and how often? What is an example of one change you made based on what you learned from the tests and/or data (telehealth example preferred but not required)?

7. **Data Reporting Capabilities:** Please describe: (a) What tools or instruments do you use to collect patient and provider experience and have you included questions about telehealth. (b) Do you collect and can you report on patient-level data by visit modality (i.e., in-person, phone, video). (c) Are you able to report this data segmented by patients' race/ethnicity and preferred language? d) Do you measure disparities in access to telehealth, if yes, how?

8. **Site Selection:** What site or sites will you test telehealth practices and why did you select this site or sites? What are key characteristics about the site or sites (e.g., patient demographics, number of providers, and prior telehealth capabilities) that fit the program goals?

For organizations that do not meet all the outlined criteria and serve traditionally hard-to-reach or marginalized communities (250 words or less): Please describe the community your organization

serves. Include details about which criteria your organization does not meet and why (e.g., this practice has two full-time providers that serve 6,000 patients in total). We will only select participants from this group if we are unable to achieve our health equity goals from applicants who meet the full criteria.

Appendix: CCA Equity Collaborative Evaluation Approach

The purpose of the Connected Care measures is to support teams in understanding their progress in implementing telehealth over the course of the program, assess changes in telehealth utilization over time, describe changes in telehealth access for sub-populations of interest (e.g., BIPOC patients and patients with PLOE), and assess the learning collaborative's contribution to expanding access to telehealth and improving quality of telehealth services. This information will also be helpful in making a case to sustain these services into the future.

The Connected Care measurement approach will collect a mix of qualitative and quantitative data from all participating organizations, described in tables 1-2 below.

Table 1. Evaluation Methods	
Data Type	Description
Clinical data reporting*	Reporting from all participating organizations on key quantitative metrics related to utilization of telehealth throughout the organization (see Table 2) and on 2-3 project-specific metrics based on proposed projects. Reporting would be required three times during the initiative, at intervals of approximately four months.
Participant interviews	Two reflective interviews with each organization will be conducted to collect qualitative data on progress and lessons related to project implementation, facilitators and barriers, and emerging promising practices. Interviews may include: 1. Interviews with key leaders at each participating organization at mid-point and the end of the learning collaborative 2. Interviews with front line staff from a sample of organizations (e.g., clinicians, other members of the care team)
Program participant survey	Surveys will be conducted to obtain participant feedback and support program improvement at midpoint and end of the program.

Table 2. Clinical Data Reporting	
Measure Description	Required numbers to report (3 times during initiative):
Distribution of primary care visits by visit type	1. Total number of primary care encounters 2. Number of face-to-face encounters in primary care 3. Number of audio-only (telephone) encounters in primary care 4. Number of video encounters in primary care
Patients reached by telehealth in primary care	5. Total number of patients seen for primary care 6. Number of patients seen for primary care with at least one face-to-face encounter

	7. Number of patients seen for primary care with at least one audio-only (telephone) encounter
	8. Number of patients seen for primary care with at least one video encounter
Distribution of behavioral health visits by visit type provided by own credentialed staff	9. Total number of behavioral health care encounters since last report
	10. Number of face-to-face behavioral health encounters in their clinic
	11. Number of behavioral health audio-only (telephone) encounters
	12. Number of behavioral health video encounters
Patients reached by telehealth in behavioral health	13. Total number of patients seen by behavioral health
	14. Number of patients seen by behavioral health with at least one face-to-face encounter
	15. Number of patients seen by behavioral health with at least one audio-only (telephone) encounter
	16. Number of patients seen by behavioral health with at least one video encounter
Utilization by race & ethnicity for primary care and BH visits	17. Overall race/ethnicity distribution of patient population
	18. Race/ethnicity distribution of patients who have at least one face-to-face visit
	19. Race/ethnicity distribution of patients who have at least one audio-only (telephone) visit
	20. Race/ethnicity distribution of patients who have at least one video visit
Utilization by age for primary care & BH visits	21. Overall age distribution of patient population
	22. Age distribution of patients who have at least one face-to-face visit
	23. Age distribution of patients who have at least one audio-only (telephone) visit
	24. Age distribution of patients who have at least one video visit
Utilization by language for primary care & BH visits	25. Overall language distribution (e.g., patients with preferred language of English and patients with preferred language other than English) of patient population
	26. Language distribution of patients who have at least one face-to-face visit
	27. Language distribution of patients who have at least one audio-only (telephone) visit
	28. Language distribution of patients who have at least one video visit

NEXT STEPS

CCI, CHCF, and Cedars-Sinai will review applications. Our intent is to select an engaged group of up to 21 health care safety net organizations (at least 9 of these within Cedars-Sinai's service areas in Los Angeles County). Organizations will be informed of the status of their application via email by April 8.

In the meantime, please hold April 26, 2022 (12:00 - 2:00 pm) for the CCA Equity Collaborative Kick-Off Webinar.

You should invite your core team and senior leader sponsors from each organizational partner. Once you have been accepted, we will send webinar registration information to join the call.

Thank you for applying.