

CALL FOR PROPOSALS



Building  
Community Supports  
*for Diabetes Care*

PROPOSAL GUIDELINES FOR  
PHASE II IMPLEMENTATION GRANTS

THE ROBERT WOOD JOHNSON FOUNDATION®

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Washington University in St. Louis  
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# INTRODUCTION

*Building Community Supports for Diabetes Care* (BCS) along with *Advancing Diabetes Self-Management* comprise The Robert Wood Johnson Foundation Diabetes Initiative. The *Building Community Supports for Diabetes Care* program is developing and evaluating innovative ways to provide community resources and self-management support for people with diabetes, and to integrate those innovations into high quality diabetes care. The Chronic Care Model provides the program with a framework for comprehensive diabetes care, including community supports for self-management.

The program has developed an ecological model of Resources and Supports for Self-Management (RSSM). The RSSM places the knowledge, skills and behavior of the individual in a broad set of influences of family, friends, health professionals, health systems and broader community influences such as social norms, access to resources and public policy. It includes:

1. Individualized assessment that includes attention to cultural and social factors.
2. Collaborative goal-setting.
3. Instruction in key skills for managing diabetes (e.g., medication management, physical activity, healthy eating); managing emotional factors and stressors; and, managing daily activities and roles. All these require skills in problem solving, decision-making and “temptation” management.
4. Ongoing follow-up and support for self-management from family, friends, health care providers, and lay health workers.
5. Access to resources for healthy diet and physical activity.
6. Linkages/coordination among pertinent community organizations and services.
7. Access to high quality clinical care.

The RSSM and the Chronic Care Model provide an organizing framework for interventions in both programs of the Diabetes Initiative. Individual projects will address the RSSM in different ways. For example, collaborative goal-setting might take place with a primary care provider or with a community health worker. Depending on the relationship between community organizations and their clinical partners, exchange of information regarding individuals with diabetes and coordination of services may take different forms. Ongoing follow-up and support may be implemented through peer and community based channels, through outreach by clinical providers, or combinations of these. Given their different resources and roles, collaborating organizations will contribute in different and complementary ways to improving resources and supports for self management in the community.

This document provides detailed instructions for preparing proposals for funding under the *Building Community Supports for Diabetes Care* program. It contains the Call for Proposals, a timetable, and related materials for Phase II grants. Only sites that have successfully completed the planning process are eligible to apply for 30-month implementation grants of up to \$370,000 to support the partnership, and programmatic, measurement and improvement activities, including attendance at the Collaborative Learning Network (CLN) meetings.

# CALL FOR PROPOSALS

## A. PURPOSE

*Building Community Supports for Diabetes Care* is a program of The Robert Wood Johnson Foundation designed to extend resources and supports for diabetes self-management beyond the clinical setting and into the communities where people with diabetes live. The Diabetes Initiative recognizes that behavior change is central to the management of diabetes and that diabetes management is every day for the rest of your life. The *Building Community Supports for Diabetes Care* program establishes collaborations between community and health care partners to develop and implement programs that improve access to and use of resources and supports for diabetes self-management, and promote linkages between community resources and the clinical care available to individuals. These should lead to enhanced quality of life for people with type 2 diabetes and their families and improved clinical outcomes.

## B. THE PROGRAM

*Building Community Supports for Diabetes Care* views self-management from an ecological perspective and encourages intervention at multiple levels including individual, family, peer, institution/organization, community/environment, and policy. Examples of intervention components that might be employed under this program include:

- Approaches that utilize peers (such as community health workers, promotoras or coaches) as channels of communication, education, advocacy or support, such as group education and skill-building classes, walking clubs, and support groups.
- Caregiver- and family-focused activities.
- Innovative community outreach and awareness activities using culturally appropriate gathering places and venues.
- Community and environmental supports for individuals with diabetes, such as available, accessible and culturally appropriate resources for healthy eating and physical activity, supportive social networks and norms; access to culturally appropriate information and skill building for diabetes self-management; linkages with primary care and with community resources to enable care, such as transportation.
- Systems or procedures to improve the quality of, or provide new access to, culturally competent diabetes-related medical services in clinic or community sites.
- Linking or coordinating community based and health care services (such as through referral, coordinated follow-up, case identification, or—with appropriate attention to privacy concerns—sharing of information regarding individuals) to guide coordinated assistance from community and clinical services.

- Use of community-based information (such as through community advisory committees, reports of community health workers, or evaluations of community based programs) to guide needed improvements in health care services.
- Advocacy and policy activities such as media and other types of advocacy for food labeling, incentives for healthy lifestyles, access to quality health care, or medicines and supplies for people with diabetes.

Additionally, the Diabetes Initiative acknowledges the importance of organizational and community capacity to the integration and sustainability of any self-management program. Therefore, Phase II also stresses the progressive integration of diabetes self-management interventions into site's routine organizational operations and plans for both program sustainability and spread.

#### *Intended Audience*

Given the prevalence of diabetes and the broad concerns of many of the projects funded through the Diabetes Initiative planning phase, sites serve a number of groups and populations. For the purposes of the Diabetes Initiative, programs must focus on adults with type 2 diabetes. It may be important that program activities and services are available to others as well.

Applicants should define an intended audience with consideration to the needs of those they serve and their own institutional strengths and missions. The intended audience should be defined specifically. For example, “all adults with type 2 diabetes who are over 50 years of age and patients of Clinical Team B,” or “all adults with type 2 diabetes who live in the Cobbletown section of the county.” Over the course of 30 months, the projects should reach at least 300 people in their intended audience. Projects should be able to evaluate not only their ability to benefit those they reach, but also to reach those who would benefit. With this emphasis, development of innovative programs and services should include tests of approaches to reaching the intended audience as well as improvements in resources and supports for self management.

#### *Partnership*

Projects should creatively involve a wide range of strategic partners—for example, public health and environmental agencies, academic institutions, businesses, religious organizations, media, voluntary health agencies, grassroots organizations, people with diabetes, family members, and other community residents. In recognition of the essential role of quality medical care in the management of type 2 diabetes, the Phase II of BCS emphasizes the involvement of a health care provider organization as a critical member of the community partnership or coalition. For the purposes of this application, “partnership” includes coalitions or other cooperative structures for bringing together community organizations and health providers.

Projects are expected to create innovative ways through which community agencies and health care providers can interact to improve care and support for people with type 2 diabetes. The relationship between community agencies and health care provider partners should be mutual and

reciprocal. Community organizations should work with health providers to improve clinical care based on the Chronic Care Model. This may take the form of direct collaboration and community input to help guide improvements in the quality of care, or indirect approaches, such as through patient activation and increasing consumer demand for high quality clinical care. Health care providers can use their clinical perspective to identify community-based services that need improvement. The health care provider partner will also be expected to provide clinical data at regular intervals to support the cross-site evaluation and engage in improvement processes at CLN meetings.

#### *Collaborative Learning Network*

Over the course of Phase II, applicants will be expected to attend a series of CLN meetings hosted by the National Program Office (NPO), and participate in CLN workgroups to:

- Promote exchange of information among grantees.
- Identify and pursue key crosscutting issues for lessons learned from the program.
- Provide opportunities for grantees to take full advantage of available knowledge in developing their programs.
- Identify improvement objectives and guide improvement efforts to maximize the quality of programs, sustainability and spread.
- Identify innovative programs.

The CLN will promote changes or improvements that focus on clear objectives; real-world testing of methods to attain them; and, documentation of success in meeting those objectives using improvement methodologies such as the PDSA or other short cycle test-change strategies. Participation in CLN meetings is a key component of Phase II implementation.

#### *Evaluation*

There are three levels of program evaluation—two of which will be completed at the local level and the third as a cross-site evaluation.

At the local level, applicants should identify unique or key characteristic of their program or its planning that they would like to highlight for evaluation. These lessons learned will help others in similar settings do a better job of helping those with diabetes and they will later be disseminated for that purpose.

Additionally, the local evaluation will include quality improvement efforts. There may be overlap between lessons learned and quality improvement efforts. The NPO can provide consultation and technical assistance regarding local evaluation plans. Where interventions or data collection/methods are similar among sites, the NPO will facilitate communication among them so they may benefit from one another's experience, including sharing instruments. The data gathered for improvement and the sharing of lessons and instruments will be facilitated through the CLNs.

The cross-site evaluation, being managed by a separate grant to Research Triangle Institute (RTI), will include:

- Data from participant intake forms collected at each site to provide a brief set of descriptors about who is reached in each project.
- Clinical data (hemoglobin A1c, blood pressure, lipids, foot exams) submitted periodically by each site for as many of their project participants as feasible.
- Documentation of all project interventions.
- A multi-wave survey of approximately 200 participants at each site, selected from the pool of those completing intake forms. The survey will be implemented by RTI and will include measures of engagement in diabetes care, including self-management, quality of life, supportive relationship with providers of care, and access to and use of resources and support for self-management.

### *Sustainability*

Grants are intended to support the demonstration of innovations, particularly on quality improvements that are sustainable. Integral to every project component is the development of strategies to institutionalize and financially support system changes, program processes, and services that are shown to be effective in Phase II. These plans may include a range of activities both internal to applicants' organizations as well as external, such as policy advocacy. Applicants should consider which stakeholders benefit, particularly financially, from project improvements, and what would the project need to do to convince those stakeholders to help sustain those improvements (including financial support if necessary).

### *Spread*

Spread goes beyond holding the gains and addresses replication or expansion of the interventions or improvements throughout the organization or system. When developing project plans, grantees should consider the potential for spread at the local level for example, who in their department, organization or community might adopt these new methods, services or programs and who will make the decision about adoption.

### *External Dissemination*

Planning for dissemination and shaping of lessons learned should occur throughout the project. The goal is to disseminate or share lessons learned from the Diabetes Initiative to key public, provider and policy groups. Lessons learned may be presented in a variety of ways depending upon the key audiences. For example, information may be spread through mass media or through products such as protocol manuals, training materials, patient education materials, reports or papers published in professional and lay journals. The NPO and communications consultants will assist in the dissemination process.

## C. ELIGIBILITY AND SELECTION CRITERIA

Only organizations funded by RWJF under Phase I of *Building Community Supports for Diabetes Care* are eligible for Phase II Grants. In order to receive funding, applicants must successfully address the requirements of this proposal as outlined on page 11 under Detailed Instructions for Proposal Narrative. It is expected that applicants will use the key Resources and Supports for Self-Management listed in the Introduction on page 3 to demonstrate the comprehensiveness of their programs. In addition, applicants must demonstrate capacity to monitor their interventions for continuous quality improvement, to conduct a site-specific evaluation and to participate in the external cross-site evaluation.

## D. USE OF GRANT FUNDS

Grant funds may be used for project staff salaries and training, consultant fees, meeting costs, project-related travel, supplies, computer software and limited equipment purchases, information collection and analysis. In keeping with RWJF policy, funds may not be used to pay for patient care, to support clinical trials of unapproved drugs or devices, for lobbying, for personnel providing clinical services, or for the construction or renovation of facilities.

Applicants will be expected to meet Foundation requirements for the submission of six-month financial, annual, and final progress and financial reports. Project directors will be expected to submit periodic program updates and a final written evaluation report suitable for wide dissemination.



## **E. PROGRAM DIRECTION AND TECHNICAL ASSISTANCE**

Direction and technical assistance for this program are provided by the Division of Health Behavior Research, School of Medicine, Washington University in St. Louis, which serves as the NPO:

**Building Community Supports for Diabetes Care**  
**Division of Health Behavior Research**  
**School of Medicine**  
4444 Forest Park Avenue, Suite 6700  
St. Louis, MO 63108  
Phone: (314) 286-1900

Responsible staff members at the NPO are:

- Edwin Fisher, Ph.D., Program Director
- Carol Brownson, M.S.P.H., Deputy Director

Responsible staff members at The Robert Wood Johnson Foundation are:

- John Lumpkin, M.D., M.P.H., Director-Health Group
- Anne Weiss, M.P.P, Senior Program Officer
- Sara Thier, M.P.H., Program Associate
- Paul Tarini, Senior Communications Officer
- Fran Ferrara, Grants Administrator

A National Advisory Committee (NAC) will assist in the evaluation of proposals and make recommendations to RWJF staff regarding funding. Technical assistance may also be provided by the NAC and other experts participating in the CLN meetings.

RWJF does not provide individual critiques of proposals submitted.

## **F. TIMETABLE**

*January 26, 2004*

Deadline for receipt of full proposals.

*May 1, 2004*

Start date for implementation grants.

# HOW TO APPLY

## A. REQUIRED CONTENTS OF THE APPLICATION

### 1. Cover Page

### 2. One-page Project Summary

Provide a short description of the community and the geographic area for which the application is being submitted, the Intended Audience of people with diabetes, the partnership, and the proposed approach during the implementation phase.

### 3. Proposal Narrative (Up to 15 pages 12 point font)

This section is the heart of the proposal. Information in this section should convey to the reviewers a clear sense that the proposed approach is comprehensive, feasible, and likely to improve the health and quality of life of a significant number of people with diabetes; and that the outcomes specified are reasonable and the applicant has the capacity to measure the effects of project efforts on these outcomes. The following section, III.B., “Detailed Instructions for Narrative Section” provides a detailed outline to follow.

### 4. 30-month Project Timetable

The Project Timetable should clearly illustrate start and stop dates for key implementation, evaluation, and reporting activities for the 30-month period.

### 5. Budget and Budget Narrative

Applications must include a detailed budget and accompanying budget narrative for the 30-month implementation phase. This includes a budget and budget narrative for 3 time periods—Year 01 (the first 12 months of the project starting May 1, 2004), Year 02 (the second 12 months of the project) and Year 03 (the last 6 months of the project)—and a cumulative budget. Applicants are expected to attend a total of six Diabetes Initiative meetings. Three will be held in Year 01, two in Year 02, and one in the final 6-month period. RWJF will cover the costs of travel for the first two meetings in Year 01. Therefore, proposed budgets must include travel for 2–3 people to attend the four remaining meetings. Please use the 2-night stay dollar allocation when budgeting for these meetings.

You may access The Robert Wood Johnson Foundation “Budget Preparation Guidelines” via the Web site at: <http://www.rwjf.org/applying/budgetPrepGuideinesNov03.pdf>

The proposed budget will be evaluated for correspondence between the budget and the work proposed, agreement with narrative (i.e., no unexpected or unexplained costs), clarity and completeness of budget justification, and adherence to guidelines and limits specified. Negotiations

may be held with the applicant administrative agency to identify areas requiring change or clarification to comply with Foundation policies.

## **6. Appendices**

Letters of commitment from key clinical partners must be included. These letters should clarify the role of the clinical partner and make it clear that the partners are committed to providing the required clinical data and participate in the ongoing improvement processes to be undertaken throughout Phase II. Letters should also be included from any partnership members who are new to your project since the initial proposal was submitted. Other appendices are optional and considered supplemental only. The proposal narrative should comprehensively and completely address the information required in the Call for Proposals.

## **7. Project Support Form**

Original form and accompanying documentation must be sent to Carol Brownson at the NPO in hard copy. A letter of certification must accompany the project support form. A template is provided with the Project Support form.

# **B. DETAILED INSTRUCTIONS FOR PROPOSAL NARRATIVE**

This section pertains to item 3, Proposal Narrative. The narrative section of the proposal should follow the outline below.

## **1. Partnership Progress**

A major goal of BCS is to provide support for community agencies and health care partners to develop sustainable initiatives to improve diabetes self-management. To achieve meaningful change, key stakeholders should develop and use systems thinking. The purpose of the partnership with health care providers and other community organizations is to ensure that efforts during the planning and implementation phases will be shaped, guided, and ultimately integrated into the activities of stakeholders from various sectors and systems (e.g., health care systems, providers, participants and families, and community leadership.).

Strong applications will show evidence of dynamic and committed leadership and strategic relationships among key partners, including evidence of readiness for collaborative action and the capacity to implement and sustain the proposed implementation action plan.

Given your partnership's current status, please provide the following information/answer the following questions, providing additional information as desired.

- *Partnership*  
Describe the current community health care partnership (participants and roles), including the leadership structure. Identify any changes in participation that have occurred since the planning grant proposal was submitted. Explain how the clinical partner has been formally integrated into the project.
  
- *Capacity*  
Provide examples of the capacity of the partnership. Describe how relationships among partnering agencies are different than before the project began. Give examples of how involvement in the project has influenced the work of member organizations to date.
  
- *Next Steps*  
How do you see the partners working together in Phase II? Will roles change? How will each partner's role in the project influence or inform the work of the other partners? How does this collaboration enhance the resources and supports for self-management in ways not possible for each participating agency alone? How will the partners use clinical data and program monitoring data (self-generated or from RTI) to keep improving the quality of the project?
  
- *Evolution of the Partnership*  
How do you see these partnerships contributing to the sustainability of the programmatic and quality improvement changes? Will effort toward sustainability and spread necessitate additional partners? As you work through your project development and improvement activities, how will you resolve any new conflicts or issues?
  
- *Lessons Learned*  
Note any lessons learned to date about the process of partnering for this project.

## **2. Intended Audience**

Applications should clearly define the geographic catchment area for their project and the demographic or other characteristics that define the intended audience to be served. The aim is to reach as many of the intended audience as possible. Applications should have a well articulated plan for *reaching at least 300 people* with type 2 diabetes over the life of the project.

## **3. Phase I Progress Report**

The description of the Phase I grant period should reflect evidence of involvement of key partners and a logical planning framework for assessing needs and resources, piloting program elements, and identifying areas for improvement that will be addressed in Phase II.

- Briefly describe and summarize the findings from the Phase I assessment process. Be specific regarding information learned about the target audience, current conditions of diabetes control activities, services, practices and policies among the various sectors and systems you are working with. Indicate if your needs and resource assessment process led you to make changes from your originally proposed Phase I application.
- Briefly describe the interventions piloted through Phase I, their implementation, indicators of their success to date in reaching and helping those for whom they were intended. Discuss barriers you have encountered and how you overcame them.
- Briefly describe how findings gleaned from Phase I assessments and pilot interventions are guiding your program proposal for Phase II. The findings may include information about the needs of your target audience, barriers to care, agency or partnership readiness for the self-management interventions.
- Identify any additional improvement areas that your clinical partner has identified in regard to linking clinical care to community supports and/ or improving access to or delivery of quality medical care.

#### **4. Phase II Action Plan**

An Implementation Action Plan should include the strategies and activities/interventions you and your partners will undertake in order to improve community support for diabetes care and self-management. It should be noted that while we expect a well articulated and reasoned plan, we also intend, through the CLN, to facilitate the identification and testing of improvements in the plans. Conducting small, short-term tests of strategies will likely result in revised plans.

Strong plans will reflect awareness of and responsiveness to relevant socioeconomic and cultural factors affecting diabetes management in their intended audience. Proposed innovative strategies will flow logically from Phase I and be grounded in evidence-based practice, health behavior theory, and/or field experience. Strong applications will provide evidence of an inclusive planning and implementation process. Objectives, action plans, roles and responsibilities will be well articulated and framed in an ecological perspective with attention to the key *Resources and Supports for Self-Management*. With their clinical partnership members, applicants should demonstrate strong potential to develop a web of community supports for diabetes care and self-management and contribute to the general understanding of community supports for diabetes care. It should be clear how processes will be monitored and how data will be used to ensure improvement of programs and processes. Finally, the project timetable should be appropriate and clearly depicted.

Describe your proposed intervention action plan as indicated below.

- Using *Resources and Supports for Self-Management* as well as the Chronic Care Model as frameworks, identify the intervention strategies the applicant and partners will use to address areas of improvement. Not all programs will address each with equal attention. The application should justify the choices made. In a table or text, identify how the intervention action plan proposed addresses each of the RSSM. For each resource or support not addressed explain how it either lies outside the domain of the project or is being addressed by others in the community. Finally, identify components of the Chronic Care Model other than self management and community support that the program will address and describe strategies for addressing these to improve access to quality clinical care as a foundation for self-management.
- Provide the justification or rationale for your proposed approaches using evidence-based practice, health behavior theories and models and/ or results of your Phase I pilot testing experience. It should be clear why you chose these approaches, and how the various intervention activities support self-management. You may choose to present this information in a table, figure, narrative or logic model format.
- Outline the plan for operationalizing your project, beginning with specific goals and objectives. For each key objective, describe major activities that will be undertaken throughout the first year of the implementation period to meet the objectives (Detailed plans for the remainder of the time will be requested as part of Phase II progress reports.) Specify person(s) responsible, timetables, evaluation criteria and resources needed. You may choose to present this in narrative or table format.

## 5. Staffing Plan

Describe the staffing proposed to support your intervention plan. Clarify roles and provide descriptions of the key staff positions (hired directly by the administrative agent or through subcontract). In an appendix to the proposal, provide a resume for key staff that are new and for whom you have not previously submitted a resume.

Strong proposals will demonstrate the required skills among staff, consultants and subcontractors for partnership facilitation, project management, program implementation and evaluation.

## 6. Evaluation Plan

Your evaluation plan should address all three levels of evaluation.

### *Local evaluation*

The local evaluation plan should describe a central or unique aspect of your program. You may choose to explore products/materials, intervention strategies or approaches, program processes,

intermediate outcomes, partnership processes or health measures. You should articulate an evaluation question about some aspect of your program, the answer to which will be a lesson learned that will help others in similar settings do a better job of helping those with diabetes. In your description, please address:

- What is the aspect or component of your project that will be evaluated, and what is the question you want to answer?
- What will be the measurable objectives of the aspect to be evaluated, and how will this be assessed? (Please include any instrument(s) you plan to use).
- Who will be responsible for facilitating the evaluation process?
- What is the role of your partners in the evaluation process?
- How will lessons learned be disseminated (Note: May be part of the dissemination information and plans addressed below.)

The second part of the local evaluation should address routine monitoring of project components for quality improvement.

#### *Cross-Site Evaluation*

Applicants must demonstrate capacity for participating fully in the cross-site evaluation, including their ability to reach and enroll at least 200 members of their intended audience for the cross-site evaluation, and should explain their intended procedures for carrying out the site-level data collection tasks required (i.e., intake data forms, clinical data, and documentation of project activities). Applications should report the status of your IRB approval for collection of these data, if applicable, and the steps you have taken to comply with HIPAA requirements.

### **7. Sustainability**

A strong proposal will show evidence of planning for sustainability and demonstrate potential for sustainability through system and community changes. Given the multi-faceted nature of these projects, it is anticipated that some elements will be more easily sustained than others. One of the key ingredients to sustainability of any new initiative is to work toward changing policies and procedures of the environment within which the program/initiative is implemented.

Sustainability requires that projects not only institutionalize and financially support system changes, program processes, services and resources shown to be effective, but also to hold the gains already made. Steps toward sustainability should include a preliminary analysis of the burden and/or gain for the key internal and external stakeholders and partners necessary for assuring longevity of core elements of the project. We expect that you will develop and likely change portions of your sustainability plan over Phase II. However, for this proposal please:

- Identify the key stakeholders and partners needed for your program's sustainability. Stakeholders and partners may be individuals, agencies, purchasers, and policy-makers.

- Select three or four key stakeholders or partners and describe their interest in your program; and, identify what the likely burden or gain will be for each stakeholder if they are engaged in assisting you in sustaining your program. Specify the kind of burden and gain (e.g. financial, human resource, and personal time.)
- Briefly describe how the stakeholder or partners' interests, burdens or gains may affect your ability to sustain the program, and how you will address these issues.

## **8. Spread**

Spread can occur by expanding your intervention components to other community or health care organizations, expanding diabetes self-management principles to areas of health other than diabetes, or expanding current interventions in diabetes to different target audience. Please describe opportunities for expansion or spread of your self-management activities.

## **9. Dissemination**

During Phase II, applicants are expected to shape and plan for the external dissemination of lessons learned. During Phase II, each applicant will be required to develop a communications plan to disseminate lessons learned. The NPO will provide additional guidance and other resources for this plan during Phase II.

For this application, please discuss the potential audiences and provide examples of dissemination and marketing channels you may consider using to reach those audiences. Provide the rationale for your plan.



## C. PROPOSAL SUBMISSION DETAILS

Proposals must be sent via e-mail and received by the NPO no later than 10 a.m. CST on Monday, January 26, 2004. Please submit proposals to:

**Carol Brownson, M.S.P.H., Deputy Director**  
E-mail: *cbrownso@im.wustl.edu*

No fax copies will be accepted.

Two hard copies, including any appendices, the Project Support Form, and other support documentation must be sent via express or overnight mail and postmarked by Monday, January 26, 2004.

Please send hard copies to:

**Carol Brownson, M.S.P.H.**  
**Building Community Supports for Diabetes Care**  
**National Program Office**  
**Washington University School of Medicine**  
4444 Forest Park Ave., Suite 6700  
St. Louis, Missouri 63108

## D. PROPOSAL REVIEW

The principal purpose of the renewal proposal is to help RWJF, the NAC and the NPO understand the projects' accomplishments and challenges to date in broad terms. Applications will be reviewed by the NPO, RWJF program staff, and members of the NAC. After an initial review, applicants may be asked to respond to questions or to provide further clarification on some aspect(s) of their proposal. Site visits may be conducted pending direction of the NAC.

## 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 quality health care at reasonable cost.
- To improve the quality of care and support for people with chronic health conditions.
- To promote healthy communities and lifestyles.
- 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](http://www.rwjf.org)

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