

Transitions of Care for Venous Thromboembolism Request for Proposals

**Pfizer Independent Grants for Learning & Change,
Bristol-Myers Squibb Independent Medical Education
and The Joint Commission
February 10, 2015**

I. Purpose

Pfizer Independent Grants for Learning & Change (IGLC), Bristol-Myers Squibb Independent Medical Education (IME) and The Joint Commission are collaborating to offer a new grant opportunity focused on transitions of care (TOC) for patients with venous thromboembolism (VTE). VTE includes pulmonary embolism (PE) and deep-vein thrombosis (DVT). The primary goal of this request for proposals (RFP) is to accelerate the development and adoption of evidence-based approaches that have the capacity to improve the safety and effectiveness of patient movement from one care setting to another. In particular, this grant mechanism will support the development, testing and implementation of sustainable TOC strategies and programs that can be shown to improve the safety and effectiveness of care for VTE patients, and ultimately may lead to broader application of identified TOC strategies to other patient populations. The second goal of this RFP is to reduce VTE recurrence rates by:

- a) improving the care of the newly diagnosed VTE patient
- b) improving the transition-of-care of the patient from the hospital to an ambulatory care setting through healthcare professional and patient education, enhanced communication systems, and accountability
- c) improving patient adherence to prescribed oral anti-coagulation therapy for secondary-VTE risk reduction

For the purpose of this RFP, transitions of care are defined as the movement of patients between health care practitioners, settings (described below), and home as their condition and care needs change.¹ Unfortunately, these transitions do not always go smoothly. Ineffective care transition processes can lead to adverse events^{2,3} as well as higher hospital readmission rates and associated costs.³ Transition problems can occur between virtually any type of health care setting, but especially when patients transition between the hospital and other settings.

While improving transitions of care is a priority for all patients, patients who have had a VTE are often at high-risk for recurrence and therefore require a coordinated treatment transition plan from hospital to outpatient setting. VTE patients may develop an asymptomatic DVT, and die from PE even before the diagnosis is suspected. The majority of fatal events occur as sudden or abrupt death, underscoring the importance of prevention as the most critical action step for reducing death from PE.⁴ The estimated annual incidence of DVT and pulmonary embolism PE in the USA is 900,000.⁴ Hospitalization and nursing home residence together account for almost 60% of incident VTE events occurring in the community,⁵ making improvement in care transitions an important opportunity that may significantly reduce venous thromboembolism incidence.⁵

Responses to the RFP should primarily focus on transitions of care related to patient movement between and among:

- acute care hospitals (academic medical centers and community based hospitals)
- home care services
- long term care facilities and/or
- outpatient/ambulatory care facilities

Potential areas for RFP development focusing on transitions of care of VTE patients may include, but are not limited to:

- Implementation and evaluation of TOC programs
- Compliance with and impact of various TOC models
- Communication including confirmation of receipt of intended communications
- Education or training for healthcare professionals on VTE treatments and strategies for reducing the risk of secondary VTE
- Education materials for patients on VTE and medication adherence
- Monitoring of transitions and longitudinal tracking of effectiveness

Proposals should be well-balanced and focus on key aspects of transitions of care, including: multidisciplinary collaboration, early diagnosis of VTE patients, transitional planning, medication management, patient and family action/engagement and transfer of information.

This RFP has two stages. **Stage 1** is the submission of a Letter of Intent (LOI). If your letter of intent is selected you will be invited to submit a full proposal. **Stage 2** is the submission of the full grant proposal.

This RFP is being issued by the collaborating organizations. The Joint Commission will lead the application evaluation process and oversee a Proposal Review Committee that will make the final funding decision. All grant funding will be provided by Pfizer on behalf of the Pfizer/ Bristol-Myers Squibb Alliance.

II. Background

Transitions of Care

The seven *Foundations of Safe Transitions* include leadership support, multidisciplinary collaboration, patients at risk, medication management, transitional planning, patient/family education and transfer of information. For more information about the *Foundations* and a broad overview of issues and solutions associated with improving transitions of care, please refer to the following two documents and the link to additional resources:

- The Joint Commission. Transitions of Care: The need for a more effective approach to continuing patient care. June 2012.
http://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf
- The Joint Commission. Transitions of Care The need for collaboration across entire care continuum, February 2013.
http://www.jointcommission.org/assets/1/6/TOC_Hot_Topics.pdf Additional resources may also be found at The Joint Commission's Transitions of Care Portal:
<http://www.jointcommission.org/toc.aspx>

Many factors contribute to ineffective transitions of patient care, and these root causes often differ from one health care organization to another.⁶ The root causes most often described in medical literature and by experts include:

Communication breakdowns: Care providers may not effectively or completely communicate important information among themselves, to the patient, or to those taking care of the patient at home in a timely fashion.^{7,6} The communication method – whether verbal, recorded, or written – is sometimes ineffective. For example, the Center for Transforming Healthcare’s hand-off communication project found the following risk factors among those relating to communication:⁶

- Expectations differ between senders and receivers of patients in transition
- Culture does not promote successful hand-off (e.g., lack of teamwork and respect)
- Inadequate amount of time provided for successful hand-off
- Lack of standardized procedures in conducting successful hand-off, e.g. use of SBAR (situation, background, assessment, recommendation)

The full list of root causes and solutions is available on the Center website.

<http://www.centerfortransforminghealthcare.org/>

Patient education breakdowns: Patients or family/friend caregivers sometimes receive conflicting recommendations, confusing instructions regarding medication regimens, and unclear instructions about follow-up care. Patients and caregivers are sometimes excluded from the planning related to the transition process. Patients may lack a sufficient understanding of the medical condition or the plan or care.⁸ As a result, they may not understand the importance of following the care plan, or lack the knowledge or skills to do so.

Accountability breakdowns: In many cases, there is no physician or clinical entity that takes responsibility to assure that the patient’s health care is coordinated across various settings and among different providers.⁸ Providers – especially when multiple specialists are involved – may fail to coordinate care or communicate effectively, which may lead to confusion for the patient and those responsible for transitioning the care of the patient to the next setting or provider.

Several evidence-based transitions of care models have been developed to improve patient outcomes. These models include:

- Care Transitions Intervention (CTI)⁹ (<http://www.caretransitions.org/>)
- Transitional Care Model (TCM)¹⁰ (<http://www.transitionalcare.info/>)
- Better Outcomes for Older Adults through Safe Transitions (BOOST)¹¹ (<http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&CONTENTID=27659&TEMPLATE=/CM/HTMLDisplay.cfm>)
- The Bridge Model¹² (<http://www.transitionalcare.org/the-bridge-model/>)
- Guided Care¹³ (<http://www.guidedcare.org/>)
- Geriatric Resources for Assessment and Care of Elders (GRACE)¹⁴ (<http://graceteamcare.indiana.edu/home.html>)
- Project RED (Re-Engineered Discharge)¹⁵ (<http://www.ahrq.gov/professionals/systems/hospital/red/index.html>)
- The Joint Commission Center for Transforming Healthcare Targeted Solutions Tool (TST)TM for Hand-off Communications⁶ (<http://www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=1>)

Venous Thromboembolism

VTE treatment and reducing the risk of secondary VTE is the focus of this Transitions of Care RFP since appropriate care of a VTE patient requires in-patient and out-patient coordination.

VTE has been identified as the most common preventable cause of hospital death, and as many as three-quarters of all VTE-related deaths may be related to hospitalization.¹⁶ In a review of evidence-based patient safety practices, the Agency for Healthcare Research and Quality defined thromboprophylaxis to reduce the risk of VTE as the "number one patient safety practice" for hospitalized patients.¹⁶ Updated "safe practices" published by the National Quality Forum (NQF) recommend routine evaluation of hospitalized patients for risk of VTE and use of appropriate prophylaxis.¹⁶ While the majority of VTE cases are associated with recent hospitalization, a substantial number of these patients develop their clinical manifestations of VTE after hospital discharge.¹⁶ For some conditions such as operations for total hip replacement or in those patients undergoing surgery and subsequent treatment of malignancy, the risk for development of VTE may be present for as many as six weeks after hospital discharge.¹⁶

To achieve better patient outcomes, patient education and involvement is a vital component of an anticoagulation therapy program.¹⁷ Patients benefit from education about the potential consequences of both their disease and its treatment.¹⁸ Medication regimens with anticoagulation will continue after discharge, so hospital providers need to communicate ample information during the inpatient period and transition to outpatient care so the patient will be able to practice self-management at home.¹⁹ The provision of written instructions about discharge medications has been shown to improve patients' knowledge and decrease medication errors.²⁰ Thorough patient education on anticoagulation has been shown to decrease the risk of bleeding in older adults,²¹ and non-adherence to warfarin was the most common cause for non-therapeutic INR levels that could lead to poor outcomes.²²

The Agency for Healthcare Research and Quality (AHRQ) and The Centers for Medicare & Medicaid (CMS) CAHPS® Hospital Survey are publicly reporting whether staff gave patients information about new medications, and if the patient received information in writing about what symptoms or health problems they need to be aware of post-hospitalization.²³ Additionally, the National Quality Forum's (NQF) National Voluntary Consensus Standards for Prevention and Care of VTE, call for the provision of "accurate verbal and written patient education that is appropriate to the setting and patient reading levels."²⁴ Further The Joint Commission's 2008 National Patient Safety Goal for Hospitals calls for healthcare organizations to "reduce the likelihood of patient harm associated with the use of anticoagulation therapy, by providing education regarding anticoagulation therapy to prescribers, staff, patients and families, and further enumerates the required educational criteria for patient/family education which includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions."²⁵ For patients at risk for VTE, this education is a vital component associated with the transition of care from the inpatient to the outpatient arena that can help achieve successful outcomes, and reduce hospital readmission rates.

Measuring the effectiveness of transitions

The primary goal of transitions of care processes is to provide the patient a safe, successful transition from one provider to the next. Proposals submitted in response to this RFP must evaluate the efficiency and effectiveness of transitions. This may include an evaluation of the impact on:

- readmissions data
- patient and family satisfaction scores

- measure specific components of the transitions process relating to pre-admission activities
- follow-up telephone calls
- follow-up appointments
- medication orders and management
- post-discharge activities
- home visits
- Etc.,

A growing number of nationally standardized performance measures are available on the topics of VTE and transitions of care. Whenever possible, standardized measures should be incorporated into submitted proposals.

Quality Measures Related to Transitions of Care and VTE

Organization	Measures
National Quality Measures Clearinghouse (Care Transitions) http://www.qualitymeasures.ahrq.gov/index.aspx	100
National Quality Forum (Care Coordination measures) http://www.qualityforum.org/Home.aspx	5
National Quality Measures Clearinghouse (VTE)	58
National Quality Forum (VTE measures)	17
The Joint Commission (VTE) http://www.jointcommission.org/core_measure_sets.aspx	6

III.RFP Requirements

Total Awards	<p>Up to \$2,000,000 will be disbursed across selected projects</p> <p>Expected range of funded projects will be \$50K to \$500K depending on size and scope of initiative proposed.</p> <p>Smaller community-project proposals in the \$100K range are also encouraged.</p> <p>Project plans should not exceed 24 months duration.</p>
Target Settings	<p>Hospitals, home care, long term care, and out-patient /ambulatory care settings</p>
Geographic Scope	<p>United States only</p>
Specific Area of Interest for this RFP	<p>Improving the efficiency and effectiveness of transitions in care for patients with a VTE. Proposals should address key elements of successful transition programs that include: leadership support, multidisciplinary collaboration, early identification of patients/clients at risk, transitional planning, medication management, patient and family action/engagement, and/or transfer of information</p>
Applicant Eligibility Criteria	<p>Hospitals, healthcare systems, pharmacy, medical, nursing, allied health professional schools, healthcare institutions, professional associations and others with a mission related to health care improvement may apply.</p> <p>Collaborations across providers, institutions, organizations, and associations are encouraged. Inter-professional collaborations that promote teamwork among institutions and community and state-based organizations and associations are also encouraged. Additionally, if applicant entities are accreditable by The Joint Commission (e.g., hospitals) they must be accredited; if not accreditable (e.g. professional associations) this requirement does not apply,</p>
Selection Criteria	<p>Applications will be evaluated based upon:</p> <ul style="list-style-type: none"> • Potential impact and expected outcomes of the project • Knowledge of and experience with the area • Capability of carrying out the work • Innovative approaches and applications • Collaboration if appropriate • Dissemination strategies
Key Dates/Deadlines	<p>February 10, 2015 – RFP released</p> <p>March 2, 2015 – Responses to Frequently Asked Questions posted on Pfizer IGLC website if any specific to this RFP are received</p> <p>March 31, 2015 5:00pm Eastern Time – Letters of Intent due</p> <p>May 22, 2015 – Applicants notified via email; Invited to submit full proposal</p> <p>July 9, 2015 5:00pm Eastern Time – Full proposals due</p> <p>Sept 8, 2015 – Notification of decisions</p> <p>On or after Oct 1, 2015 – Funded projects start</p>

IV. How to Apply

Letter of Intent

The Letter of Intent or LOI is a brief concept document that describes the proposed project at a high level. Refer to **Appendix A - Letter of Intent Requirements** for instructions regarding what should be included in the LOI. The Proposal Review Committee will select letters of intent that are best aligned with the purpose of the RFP. All applicants will be notified with either an acceptance or a declination. Successful LOI applicants will be asked to submit a full grant proposal for funding consideration.

LOI Submission

All Letters of Intent must be submitted online via the Pfizer IGLC website by the deadline of March 31, 2015. Refer to **Appendix A - Letter of Intent Requirements** for instructions regarding what should be included in the LOI.

- Visit the website at www.pfizer.com/independentgrants and click on the button “Go to the Grant System”.
- You will be prompted to take the *Eligibility Quiz* to determine the type of support you are seeking. Please ensure you identify yourself as a first-time user.
- Submit your LOI under the dropdown selection area: **Transitions of Care VTE**.
- Complete all required sections of the online application and upload the LOI.

Full Proposals

A limited number of applicants will be invited to submit for consideration a full proposal of no more than 10 pages, accompanied by a line item budget. The full proposal format will be shared with the invitation to submit.

V. Questions

If you have questions regarding this RFP, please direct them in writing to the Pfizer Education Director for this clinical area, Jackie Waldrop, email: Jacqueline.Waldrop@Pfizer.com with the subject line “RFP Transitions of Care for VTE”. Responses to common questions will be posted on the “*Request for Proposals*” section of the Pfizer IGLC website at www.pfizer.com/independentgrants.

You may also contact The Joint Commission via the Pfizer IGLC e-mail IGLC@pfizer.com.

VI. Terms and Conditions for this RFP and submissions through Pfizer IGLC website

1. This RFP does not commit Pfizer or its partners to award a grant or a grant of any particular size if one is awarded, nor to pay any costs incurred in the preparation of a response to this request.
2. Pfizer and its partners reserve the right to accept or reject any or all applications received as a result of this request, or to cancel this RFP in part or in its entirety, if it determines it is in the best interest of Pfizer or its partners to do so.

3. For compliance reasons and in fairness to all applicants, all communications about the RFP must come exclusively to Pfizer IGLC, BMS IME, or to the Joint Commission. Applicants should not contact other departments within Pfizer or BMS regarding this RFP. Failure to comply will disqualify applicants.

4. Consistent with its commitment to openness and transparency, Pfizer reports education grants provided to medical, scientific, and patient organizations in the United States. Pfizer reserves the right to announce the details of successful grant application(s) by whatever means insures transparency, such as on the Pfizer website, in presentations, and/or in other public media. In the case of this RFP, a list of all LOIs selected to move forward may be publicly disclosed. In addition, all approved full proposals, as well as all resulting materials (e.g., status updates, outcomes reports, etc.) may be posted on the IGL&C website and/or any other Pfizer document or site.

5. Pfizer and its partners reserve the right to share with organizations that may be interested in contacting you for further information (e.g., possible collaborations) the title of your proposed project and the name, address, telephone number, and e-mail address of the applicant from the requesting organization.

6. To comply with 42 U.S.C. § 1320a-7h and 42 C.F.R. §§ 403.900-.914 (the Sunshine Act), Provider (sponsor) must provide to Pfizer specific information for the U.S.-licensed physicians and U.S. teaching hospitals (“Covered Recipients,” as defined by applicable law) to whom Provider (sponsor) furnished payments or other transfers of value from the original independent grant awarded by Pfizer. Those payments or transfers-of-value include compensation, reimbursement for expenses, and meals provided to faculty (planners, speakers, investigators, project leads, etc.) and “items of value” (items that possess a value on the open market, such as textbooks) provided to faculty and participants, if those faculty and/or participants meet the definition of Covered Recipient. Provider (sponsor) must submit the required information during the reconciliation process or earlier, upon Pfizer’s request, so Pfizer can meet Sunshine Act reporting commitments. Be advised that Pfizer will not make any payments to any individuals; grant funding shall be paid directly to Provider (sponsor).

7. No portion of a Pfizer independent grant may be used for food and/or beverages for learners and/or participants in any capacity. Provider (sponsor) will be required to certify during the reconciliation process and/or the periodic collection of Sunshine reporting that funds were not used for food and/or beverages for learners and/or participants.

8. In the performance of all activities related to an independent grant, the Provider (sponsor) and all participants must comply with all applicable Global Trade Control Laws. “Global Trade Control Laws” include, but are not limited to, U.S. Export Administration Regulations; the International Traffic in Arms Regulations; EU export controls on dual-use goods and technology; Financial Sanctions Laws and Restrictive Measures imposed within the framework of the CFSP - Treaty on European Union; and the economic sanctions rules and regulations administered by the U.S. Treasury Department’s Office of Foreign Assets Control.

VII. References

- ¹ The Joint Commission. Transitions of Care: The need for a more effective approach to continuing patient care. June 2012. Accessed on May 19, 2014 at: http://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf
- ² Forster AJ, et al: Adverse drug events occurring following hospital discharge. *Journal of General Internal Medicine*, April 2005;20(4):317-23
- ³ Medicare Payment Advisory Commission, *Report to the Congress: Reforming the Delivery System*, Washington, D.C.: MedPAC, June 2008
- ⁴ Heit JA. The epidemiology of venous thromboembolism in the community. *Arterioscler Thromb Vasc Biol*. 2008;28(3):370-372.
- ⁵ Heit J, O'Fallon W, Petterson T, Lohse C, Silverstein M, Mohr D, Melton L. Relative impact of risk factors for deep vein thrombosis and pulmonary embolism: a population-based study. *Arch Intern Med*. 2002; 162: 1245–1248.
- ⁶ Joint Commission Center for Transforming Healthcare, Improving Transitions of Care: Hand Off Communications, http://www.centerfortransforminghealthcare.org/assets/4/6/CTH_Hand-off_commun_set_final_2010.pdf (accessed May 20, 2014)
- ⁷ Solet DJ, et al: Lost in translation: challenges and opportunities in physician-to-physician communication during patient hand-offs. *Academic Medicine*, 2005;80:1094-9
- ⁸ Snow V, et al: Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine. *Journal of Hospital Medicine*, July/August 2009;4(6):364-370
- ⁹ Coleman EA, et al: The Care Transitions Intervention: results of a randomized controlled trial. *Archives of Internal Medicine*, 2006;166(17):1822-1828
- ¹⁰ Naylor MD, Sochalski JA: Scaling up: bringing the Transitional Care Model into the mainstream. *The Commonwealth Fund*, November 2010; Pub. 1453, Vol. 103
- ¹¹ Project BOOST – Better Outcomes for Older Adults through Safe Transitions. Implementation guide to improve care transitions. Society of Hospital Medicine, 2010.
- ¹² The Bridge Model. Illinois Transitional Care Consortium, <http://www.transitionalcare.org/the-bridge-model> (accessed May 23, 2014)
- ¹³ The Johns Hopkins Bloomberg School of Public Health: Guided Care, <http://www.guidedcare.org> (accessed May 23, 2014)
- ¹⁴ Counsell SR, et al: Geriatric Resources for Assessment and Care of Elders (GRACE): A new model of primary care for low-income seniors. *Journal of the American Geriatrics Society*, 2006;54(7):1136-1141, <http://www.medscape.com/viewarticle/541536> (accessed May 23, 2014)
- ¹⁵ Agency for Healthcare Research and Quality: Preventing avoidable readmissions: information and tools for clinicians. Project RED, <http://www.ahrq.gov/professionals/systems/hospital/red/index.html> (accessed May 23, 2014)
- ¹⁶ Bratzler, Dale W. "Development of National Performance Measures on the Prevention and Treatment of Venous Thromboembolism." *Journal of Thrombosis And Thrombolysis* 29, no. 2 (2010): 148-54.
- ¹⁷ The Joint Commission. "2014 National Patient Safety Goals." The Joint Commission Resources, http://www.jointcommission.org/assets/1/6/ncc_npsg_chapter_2014.pdf.
- ¹⁸ Institute for Clinical Systems Improvement (ICSI). Anticoagulation therapy supplement. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2006 Apr. 49p.
- ¹⁹ Leino-Kilpi, H., K. Johansson, K. Heikkinen, A. Kaljonen, H. Virtanen, and S. Salanterä. "Patient Education and Health-Related Quality of Life: Surgical Hospital Patients as a Case in Point." *Journal of Nursing Care Quality* 20, no. 4 (2005): 307-18.
- ²⁰ National Council on Patient Information and Education, Enhancing Prescription Medicine Adherence: A National Action Plan, White Paper, Bethesda, MD; August 2007.

²¹ Gorski, L. A. "Venous Thromboembolism: A Common and Preventable Condition. Implications for the Home Care Nurse." [In eng]. Home Healthc Nurse 25, no. 2 (Feb 2007): 94-100, quiz 01-2.

²² Waterman, A. D., P. E. Milligan, L. Bayer, G. A. Banet, S. K. Gatchel, and B. F. Gage. "Effect of Warfarin Nonadherence on Control of the International Normalized Ratio." American Journal of Health-System Pharmacy 61, no. 12 (2004): 1258-64.

²³The Center for Medicare & Medicaid Services. CAHPS® Hospital Survey. January 2007. Retrieved from the world wide web on September 2007.

²⁴ National Quality Forum. National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism: Policy, Preferred Practices, and Initial Performance Measures. A Consensus Report. 2006. Washington, DC.

²⁵The Joint Commission. "National Patient Safety Goals." In 2008 Hospital Accreditation Standards. 113-131: The Joint Commission Resources, 2007.

Appendix A - Letter of Intent Requirements

LOIs should be single-spaced using Calibri 12-point font and 1-inch margins. Note there is a 3-page limit in the main section of the LOI. ***LOIs not meeting these standards will not be reviewed.***

LOIs should include the following sections

Main Section (not to exceed 3 pages):

- A. Title
- B. Goal - Briefly state the overall goal of the project. Also describe how this goal aligns with the focus of the RFP and the goals of the applicant organization(s).
- C. Objectives - List the overall objectives you plan to meet with your project.
- D. Assessment of Need for the Project
 1. Please include a quantitative baseline data summary, initial metrics (e.g., quality measures), or a project starting point (please cite data on gap analyses or relevant patient-level data that informs the stated objectives) in *your* target area. Describe the source and method used to collect the data.
 2. Describe the primary audience(s) targeted for this project. Also indicate whom you believe will directly benefit from the project outcomes.
- E. Project Design and Methods
 1. Describe the planned project and the way it addresses the established need.
 2. If your methods include educational activities, please describe succinctly the topic(s) and format of those activities.
- F. Innovation
 1. Explain what measures you have taken to assure that this project idea does not duplicate other projects or materials already developed.
 2. Describe how this project builds upon existing work, pilot projects, or ongoing projects developed either by your institution or other institutions related to this project.
- G. Design of Outcomes Evaluation
 1. In terms of the metrics used for the needs assessment, describe how you will determine if the practice gap was addressed for the target group.
 - Identify the sources of data you anticipate using to make the determination.
 - Describe how you expect to collect and analyze the data.

- Explain the method used to control for other factors outside this project (e.g., use of a control group or comparison with baseline data).
2. Quantify the amount of change expected from this project in terms of your target audience.
 3. Describe how the project outcomes might be broadly shared or disseminated.

H. Anticipated Project Timeline

I. Requested Budget Amount

1. A total amount requested is the only information needed for the LOI stage. Full Budget is not required. This amount can be adjusted at the Full Proposal stage as applicable.
2. While estimating your budget please keep the following items in mind:
 - Institutional overhead and indirect costs may be included within the grant request. Examples include human resources department costs, payroll processing and accounting costs, janitorial services, utilities, property taxes, property and liability insurance, and building maintenance as well as additional project expenses such as costs for publication, IRB / IEC review fees, software license fees, and travel. Please note: Pfizer does not provide funding for capital equipment.
 - It should be noted that grants awarded cannot be used to purchase therapeutic agents (prescription or non-prescription).
 - The maximum allowed overhead rate is 28%.

Organizational Detail (not to exceed 1 page)

Describe the attributes of the institutions/organizations/associations that will support and facilitate the execution of the project and the leadership of the proposed project. Articulate the specific role of each partner in the proposed project. Letters of support from partner organizations will be required at the Full Proposal stage only and should not be included with the LOI.

LOIs should be single-spaced using Calibri 12-point font and 1-inch margins. There is a 3-page limit for the main section and a 1-page limit for organizational detail. If extensive, references may be included on 1 additional page. **Final submissions should not exceed 5 pages in total** (3 pages for the main section, 1 page for organizational detail, and 1 page for references).

Make every effort to submit as **few** documents as possible—you are encouraged to include all required sections in one document. There is no need to submit the organization detail or references in a document separate from the main section of the LOI.

*Please note the formatting and page limit for the LOI. The LOI is inclusive of additional information of any kind. A submission exceeding the page limit **WILL BE REJECTED** and **RETURNED UNREVIEWED**.*