CALL FOR PROPOSALS

Proposal Deadline: April 11, 2011

Apply Online: www.advancingcaretogether.org

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www.advancingcaretogether.org

PURPOSE

Advancing Care Together (ACT) is a four-year program sponsored by the Colorado Health Foundation. The purpose of ACT is to learn from a set of demonstration projects about what it takes to create working models of integrated care. ACT defines integration as the work involved in bringing together disparate parts of the healthcare system into a coherent whole that has meaning for healthcare systems and the people who receive care in these systems. ACT will fund demonstration projects that can achieve and extend the principles of the patient-centered medical home to integrate mental health, substance use, behavior change, and primary care services.

ACT will employ a bottom-up approach to engage people at the front lines of service to offer their best ideas for practical solutions to integrate the care of patients and clients in primary healthcare and community mental healthcare settings.

ACT will award up to 12 three-year demonstration grants of up to $50,000 per year to each participating practice. Grantees will collaborate with each other and with an embedded evaluation team to learn what works best in real-world settings to achieve integrated care.

The program welcomes applications from primary care practices and community mental health centers in Colorado by the April 11, 2011 deadline.

BACKGROUND

Our nation's healthcare system is plagued by many problems, but principal among them is the problem of fragmentation, particularly of the so-called physical from the so-called mental. This separation began almost 400 years ago as a philosophical formulation, has now grown into entirely separate systems of care that hardly communicate with one another. Such "systems of care that force the separation of *mental* from *physical* problems consign the clinicians in each arm of this dichotomy to a misconceived and incomplete clinical reality that produces duplication of effort, undermines comprehensiveness of care, hamstrings clinicians with incomplete data, and ensures that the patient cannot be completely understood."[1] In the 15 years since this IOM publication, the evidence has only grown more compelling and irrefutable. For example, the cost of care for people with major chronic diseases rises by about 50% when accompanied by a mental health diagnosis.[2] Behavioral disorders account for half as many disability days as all "physical" conditions.[3-4] Approximately 217 million days of work are lost annually to mental illness and substance abuse disorders, costing employers an estimated $17 billion per year.[3]

Our system is in need of substantial redesign, and new approaches are required that build on existing evidence.[5,6] Primary care is essential for sustainable high-performance health care[7] and is actively redesigning its methods to provide everyone a patient-centered medical home.[8-10] The patient-centered medical home is the current platform for the substantial redesign of primary care practice, nationwide. This overhaul of the primary healthcare system represents an unprecedented opportunity to improve healthcare for the entire population.

ELIGIBILITY

Primary care practices and community mental health centers in Colorado are eligible to apply.

The program will fund demonstration projects in rural, urban and suburban Colorado; as well as in diverse practice settings serving populations of all ages, ethnic, cultural and socioeconomic backgrounds.

Practices may be for-profit or non-profit; public or private-sector; federally qualified; independent or affiliated with larger organizations such as integrated health delivery systems, hospitals, patient-centered medical home trials, or practice-based research networks.

ACT is looking for practices that are experienced at various levels of achievement in the integration of mental health, substance use, behavior change, and primary care services. A population-based perspective is desired from proposed demonstration projects so that integration strategies are designed and implemented with the intent that they will be available to the practice's or center's entire population; not restricted to people with a particular condition.

Each applicant organization can submit one proposal only.

Exclusion Criteria:

- Proposals focused on a single disease or condition
- Proposals restricted to settings so unique they are unlikely to be replicable in routine primary care and community mental health settings
- Proposals submitted in a format different from specifications
- Proposals submitted after the deadline

THE PROGRAM

Advancing Care Together (ACT) is an action-oriented collaboration. This four-year program unites leaders in primary healthcare, prevention and health behavior change, mental healthcare and substance use to discover practical ways to integrate care for people whose health problems and health care needs span physical, emotional, and behavioral domains. Over the lifespan, this focus includes almost everyone. Funded demonstration projects will be organized as a set of diverse comparative case studies that are linked to support cross-project learning. ACT invites primary care practices and community mental health centers to learn what can be accomplished in real world settings to integrate care for children, adolescents and adults. To optimize learning, ACT will fund a portfolio of Colorado projects in diverse geographic areas that employ a range of care delivery models.

ACT relies on the imagination and practical knowledge of people working day-to-day to care for people within their communities. The program recognizes that individuals' health care needs vary in severity and responsiveness to

offered and where health care is received. There should be *no wrong door* in a properly constructed system—whether people understand their problem as emotional, behavioral, or physical; their needs should be addressed in an integrated fashion.

The Program's Goals Are:

1. Identify and test promising demonstrations to provide integrated care for patients and clients in primary care and community mental health settings.
2. Evaluate processes and outcomes of demonstrations to determine what strategies work and don't work and what it takes to provide integrated care in real life settings.
3. Disseminate best practices and real-time lessons from ACT to other practices in Colorado trying to integrate care for their patients, as well as to other interested stakeholders.

The Program is Divided into Three Phases:

- **Phase 1** begins with the release of this Call for Proposals and ends with the selection and funding of up to 12 grantees.
- **Phase 2** consists of three years of active work on the implementation and on-the-ground learning and evaluation of the demonstration projects.
- **Phase 3** will encompass a period of targeted synthesis and distillation of ACT's lessons with emphasis on diffusion of best practices across key audiences in Colorado and nationally.

ACT is guided by a steering committee comprised of Colorado and national leaders in primary care, mental health care and substance use. The program office, housed in the University of Colorado Department of Family Medicine, is responsible for leading and managing all aspects of the program. The program will be evaluated by an independent evaluation team from Oregon Health & Science University.

GUIDING PRINCIPLES

The Program's Design and Goals are Grounded in the Following Principles:

1. Care and outcomes for people can be improved by working together, even in the current challenging environment.
2. Lessons from ACT can be expanded and refined to propel policies to overcome financial, social, and cultural barriers that plague our fragmented healthcare system.
3. Teamwork and creative use of technology will be required to achieve the integrated care models called for by ACT.
4. Local practical experience is a worthy source of knowledge to guide innovation and implementation of achievable approaches.
5. Learning together will require working in concert in a safe, respectful environment where participants readily share and listen to one another.

6. Models such as the Four Quadrant Model,[11] the five levels of integration,[12] the 5 A's from tobacco research,[13] and the Chronic Care Model[14] can guide local innovations.
7. Lessons from interventions such as IMPACT and DIAMOND for depression[15-16] and SBIRT for alcohol[17] as well as the development of service components like care managers and financing strategies, can inform practice innovations.
8. Features that may support integrated care models and that merit further testing include:
   - comprehensive services that include health promotion, disease prevention, acute, chronic and mental health, and substance use
   - orientation to care that takes a population-based perspective, including regular screening and measurement of established quality outcomes for a defined population
   - evidence-based interventions
   - co-located services (physical or virtual) that make collaborative care possible in real-time and not just by referral
   - a culture of collaboration to achieve common goals
   - cross-disciplinary accountability
   - shared patient records
   - case management
   - linkages to community resources and other agents within the medical/health home
   - sustainable business models

GRANTEE REQUIREMENTS

Each ACT Grantee Will:

1. Designate a qualified principal investigator and a project manager
2. Cooperate with the program office and other grantees by actively participating in phone calls, Web presentations, e-mail conversations, online discussions, surveys and interviews
3. Participate fully in the ACT evaluation
4. Identify technical assistance needs and work with the program office to respond to these needs as feasible and appropriate
5. Comply with human subjects' protection requirements, which include approval by a designated Institutional Review Board (IRB) prior to starting data collection, and when necessary acquiring patient consent for data collection
6. Identify a cohort of high utilizers that will be defined in collaboration with the evaluation to assess the effectiveness of demonstration projects
7. Collect data and report on expenses associated with the demonstration, and facilitate the collection of insurance claims data to enable cost-utilization analyses by the ACT evaluation
8. Attend up to four grantee meetings during the three-year project (principal investigator and project manager at a minimum)

9. Contribute to the publication and dissemination of ACT results
10. Acknowledge ACT sponsors in presentations and publications
11. Comply with the program's monitoring and reporting requirements

SELECTION PROCESS AND CRITERIA

Applications will Progress Through a Four-step Selection Process:

Step 1: The program office will review applications for technical sufficiency and responsiveness to the Call for Proposals.

Step 2: The steering committee will conduct an initial round of reviews and prioritize projects for which additional information is necessary.

Step 3: The program office may request additional information from applicants, which may involve a site visit.

Step 4: The steering committee will make final selections for up to 12 grant awards. The program office will notify applicants of funding decisions by late July 2011.

The ACT Steering Committee Will Use the Following Selection Criteria:

- Potential for favorable impact on the community served [20 points]
- A logical explanation/rationale for how theory, evidence, and/or practical experience undergird and justify the proposed approach [10 points]
- Likelihood of reaching the intended population, and ability to accurately assess how well the intervention reaches the intended population [10 points]
- Proposal acceptability and attractiveness to critical stakeholders including patients, practice personnel, payers, purchasers, advocacy groups and key collaborators [10 points]
- Feasibility of proposal's full implementation as evidenced by its goals and strategies, complexity, leadership requirements, financial requirements and training and supervision capacity [20 points]
- Potential for adoption, sustainability and plausible dissemination of the proposed innovation [20 points]
- Stated commitment to fully participate in the ACT evaluation, learning community and dissemination strategy [10 points]

Preference may be given to applications that include a business partner positioned to support the economic evaluation and financing of the proposed demonstration.

TECHNICAL ASSISTANCE

The program office will assemble a technical assistance team to support grantees. Applicants may identify practice needs, but program assistance in those areas should not be assumed.

Possible Areas of Assistance Include:

- Institutional Review Board (IRB) application support
- Learning community opportunities and connections
- Limited on-site practice coaching for project implementation, data collection and problem solving
- Consultation with content experts for specific needs

EVALUATION

Comprehensive and meaningful evaluation is central to achieving the goals of ACT. The evaluation team, program office, and all funded grantees will work together to obtain and report necessary data, conduct analyses and report the results of the multi-method evaluation described below.

Each Project Accepts Two Primary Evaluation Responsibilities:

1. Commitment to collaborate with the evaluation team and the program office in the ACT evaluation
2. Calculation of Reach for the proposed intervention

Reach is a quantitative estimate of the proportion of the target population eligible for an intervention that received that intervention. For a definition of **reach** and tools for how to calculate it please see www.re-aim.org. Each ACT practice site must calculate Reach.

An experienced evaluation team led by Dr. Deborah Cohen from Oregon Health & Sciences University will work closely with the program office and grantees to conduct an evaluation that facilitates cross-project learning and draws out the overarching lessons of ACT.

Dr. Cohen and team will conduct a mixed-method **learning evaluation** informed by the RE-AIM framework[18] and designed to collect qualitative and quantitative data. The evaluation team intends to share the data they collect in "real time" with grantees, program leaders and other relevant stakeholders to foster learning. The ACT evaluation has two main components: a process evaluation and an outcome evaluation. The first component is a qualitative comparative assessment to monitor and examine the process of implementing ACT interventions and to identify cross-project lessons (Aim 1). The second component is a quasi-experimental study to examine the effectiveness of the ACT interventions by evaluating clinical care outcomes, health care utilization and costs attributable to ACT interventions (Aim 2).

All funded proposals should view the evaluation team as collaborators, not inspectors to be pleased. As a condition of being awarded funding, each project must commit to working with the evaluation team and collecting data necessary to evaluate the entire program. In return, project teams will be given access to evaluation data in a timely and appropriate manner.

Applicants should anticipate that there will be requirements for assisting with the collection of practice-level and patient-level survey and chart audit data, for participating in online diaries (confidential weekly postings that help document the process and context of each project's implementation), for hosting practice site visits and to participate in occasional key informant interviews.

USE OF GRANT FUNDS

Grant funds may be used for project staff salaries, consultants, data collection and analysis, meetings, project supplies, project-related travel and other direct project expenses including a limited amount of equipment essential for the project.

According to funder's policies, grant funds may not be used to subsidize individuals for the costs of their health care, to support clinical trials of unapproved drugs or devices, to construct or renovate facilities, for political expenditures such as lobbying, or as a substitute for funds currently being used to support similar activities.

Applicants should budget appropriately to cover travel associated with attendance at four meetings by the principal investigator and project manager. Up to two other key project collaborators may also be invited to attend these meetings at the discretion of the principal investigator. The program office will cover operational and lodging costs for these 2-day meetings. The four meetings will take place near the beginning and end of Year I and the end of Years II and III. Applicant budget allocations should also include costs associated with data collection described in the evaluation section above and for participation in learning community and dissemination activities.

MONITORING AND REPORTING

Grantees will participate in one site visit during Year II of their projects.

Grantees Will Submit the Following Reports:

- One 6-month progress report (2-page limit)
- Annual narrative and financial reports at the end of Years I and II (10-page limit)
- One final narrative and financial report (20-page limit), and a final bibliography including copies of all grant-related deliverables at the end of Year III

Five percent (5%) of the total Year III budget will be withheld until final reports have been received and approved.

HOW TO APPLY

Applications are due by 5pm MST **April 11, 2011.** Applications will be submitted electronically via the ACT online grant application system: https://www.grantinterface.com/act/Common/LogOn.aspx

E-mailed, Faxed, or hard copies **will not** be accepted.

Application Requirements:

- **Project Information**
  Title, summary, principal investigator, project manager, amount of funding requested, age groups and geographic areas served, collaborating partners
- **Practice Information**
  Name of practice, practice type, practice population characteristics, access to claims data, practice's participation in improvement activities, accreditation requirements
- **Project Narrative** (10 page limit)
  History and prior experience with integrated care
  Detailed practice description
  Description of your proposed best idea
  Implementation strategy
  Evaluation plan
  Change management strategy
  Anticipated challenges
  Sustainability plan
- **Budget**
  Line item budget
  Budget narrative
- **Supporting Documents**
  Organization's governance structure, project timeline, biographical sketches, letters of support

The ACT website — www.advancingcaretogether.org, contains important information for applicants, including frequently asked questions and resources of interest. We recommend that applicants visit this site before submitting an application.

All prospective applicants are encouraged to participate in a question and answer conference call on **February 23, 2011** from 12 noon to 1pm MT. Call instructions will soon be posted on the ACT website.

Proposals received after the deadline and that don't follow instructions or are incomplete will not be reviewed. The program office will not provide individual critiques of applications submitted.

INQUIRIES

Please Direct All Questions About ACT to:

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TIMELINE

February 14, 2011
Call for Proposals released

February 23, 2011
Applicant Q&A call (optional)

April 11, 2011
Applications due

May, 2011
Initial review by steering committee

June, 2011
Gathering of additional information from applicants

July, 2011
Final funding decision by steering committee

July, 2011
Funding notification

September 1, 2011
Projects begin

September, 2011
First grantee meeting

August, 2012
Second grantee meeting

August, 2013
Third grantee meeting

August, 2014
Fourth grantee meeting

August 31, 2014
Projects end

THE STEERING COMMITTEE

Mary Jane England pictured with Regis College students

Mary Jane England, MD - Chair
President, Regis College
Weston, MA

Rosalynn Carter - Honorary Chair
Former First Lady
The Carter Center
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