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Executive Summary

TITLE: The John A. Hartford Foundation

SOLE INTERMEDIARY: The John A. Hartford Foundation (JAHF)

ISSUE-BASED SIF (HEALTHY FUTURES) to disseminate the IMPACT model of depression treatment through community health clinics as subgrantees to serve low-income, rural communities in Wyoming, Washington, Alaska, Montana, and Idaho (WWAMI)

KEY MEASURABLE OUTCOMES: 1) increased access to effective depression treatment for low-income patients in rural areas, 2) decreased depression and improved social and occupational functioning among these patients, 3) improved economic well-being of individuals and families served by subgrantees

TECHNICAL ASSISTANCE AND EVALUATION PARTNER: University of Washington AIMS Center

AMOUNT REQUESTED: \$1,000,000 (100% for subgrants) for the period 09/01/2012 -- 08/31/2013

SOURCES OF INTERMEDIARY MATCH: Foundation assets

SOURCES OF SUBGRANTEE MATCH: Clinical revenues, philanthropic organizations, and/or public health funders

2012 PRIORITY: This project will improve the economic well-being of individuals and families served by subgrantees through 1) reduction of costs related to health care expenditures, 2) improvements in employment and related income, and 3) reduction in costs related to caregiving needs for patients with depression that are often borne by family members.

PROJECT OVERVIEW: Depression is one of the leading causes of disability worldwide, the number two cause of disability in the US (after heart disease) and is associated with poor health and economic outcomes, including higher healthcare costs, reduced productivity, and lower incomes. The WWAMI region is a philanthropically underserved rural area with little access to effective depression care. This project will support 5-8 nonprofit community primary care clinics in the WWAMI region over 3 years

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to implement evidence-based IMPACT depression care. In this program, primary care providers are supported by trained mental health specialists to care for the large number of patients they see with undiagnosed, untreated or ineffectively treated depression. Effective treatment using IMPACT improves depression symptoms, social and work-related functioning, and economic outcomes. Subgrantees will each identify and treat at least 600-1,000 adults over 3 years. We will conduct independent assessments of patients' depression, functional, and economic outcomes. The effects of improved treatment will benefit individual patients, their family and caregivers, the community-based health care providers developing new skills to more effectively serve a high-need population, and community organizations who will partner with participating primary care clinics to provide meaningful ways of engaging individuals in paid and nonpaid activities as they recover from depression. JAHF and UW will issue a joint solicitation for subgrantees that will be advertised to clinics in the WWAMI region. Subgrantees must be located in counties designated as medically underserved and/or health professional shortage areas, serve at least 1,500 unique patients each year, and have a patient population that is at least 50% uninsured or covered by Medicaid. Clinics must agree to participate in training, technical assistance, evaluation, financial reporting, and overall progress monitoring. Subgrantees will be selected based on criteria that include patient demographics, strength of plan for recruiting mental health providers, experience with other quality improvement initiatives, strength of plan for matching funds, and strength of plan for spread during program implementation and sustainability after grant funding ends. Subgrantees that successfully implement the program in Year 1 will be eligible to expand in Year 2 to additional patients and/or delivery sites. TRACK RECORD: JAHF is a grantmaker with over 80 years of philanthropic experience, including funding the original research trial that established the effectiveness IMPACT and the subsequent grant to disseminate the program to over 500 clinics. The AIMS Center Director was the lead researcher on the IMPACT research trial and has directed dissemination of the program for the past 8 years. In

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addition, he is an internationally recognized health services researcher who will lead evaluation of the proposed project.

ORGANIZATIONAL & FINANCIAL CAPACITY: JAHF has a staff of 16 professional and support personnel. It has assets over \$480 million and an annual grants budget between \$18 million and \$20 million.

Program Design

a. GOALS AND OBJECTIVES

The proposed project is an ISSUE-BASED social innovation that is focused on HEALTHY FUTURES. Effective care for depression can dramatically improve health outcomes, reduce unnecessary health care expenditures, and improve the productivity and economic well-being of populations through improved workforce participation and related earnings. The proposed project will help community-based primary care clinics treating underserved populations with high rates of depression in the WWAMI region (Washington, Wyoming, Alaska, Montana, Idaho) implement effective, evidence-based depression care based on the highly successful IMPACT model, which is described in detail in the Theory of Change section in this application. JAHF supports the dissemination of IMPACT for adults of all ages with the understanding that this will reach older adults who might not otherwise have access to this improved care.

SOCIAL INNOVATION FUND STRUCTURE

WWAMI is a largely rural and underserved area that comprises 27% of the land mass of the United States but contains only 3.3% of the population. On average, 43% of WWAMI residents live in non-metropolitan areas (range is 70% in Wyoming to 12% in Washington). While the overall poverty rate for the WWAMI region was 12% in 2011 (range is 15% in Montana to 9% in Alaska), in each of these states the proportion of residents living in poverty is significantly higher in rural counties (range is

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31% in Alaska and Montana to 19% in Wyoming). In the WWAMI region, Medicaid participation ranges from 13% of the state's population in Montana to 18% in Washington and the prevalence of uninsured residents is similar across all 5 WWAMI states at about 16% of the population [1]. In Washington, Idaho and Wyoming the largest ethnic minority group is Latinos who comprise about 10% of the population statewide. However, the proportion of Latinos is much higher in rural areas of these states. Latinos comprise as much as 17% of the population in rural Wyoming counties, 41% in Idaho and 59% in Washington. The largest ethnic minority group in Alaska is Native Alaskans who comprise 15% of the overall population but up to 95% of the population in rural counties. The largest ethnic minority group in Montana is Native Americans who comprise 6% of the overall state population but up to 65% of the population in rural counties. In all of these states the proportion of residents living in poverty, the proportion of older adults and the proportion of ethnic minorities is greatest in non-metropolitan areas [2].

Areas and populations are defined as MEDICALLY UNDERSERVED by the federal government's Health Resources and Services Administration (HRSA) based on the ratio of primary care physicians per 1,000 population, the infant mortality rate, the percent of the population with incomes below the poverty line, and the percent of the population age 65 and over. HRSA defines HEALTH PROFESSIONAL SHORTAGE AREAS as those with "shortages of primary medical care, dental or mental health providers and may be urban or rural areas, population groups, or medical or other public facilities." With only a few exceptions representing the largest metropolitan areas, the vast majority of the WWAMI region is identified by HRSA as medically underserved and/or a health professional shortage area [3].

Subgrantees will be rural community health clinics in the WWAMI region serving low-income,

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uninsured and Medicaid patients. They will be required to demonstrate that at least 50% of their patients are uninsured or receive Medicaid, a program that is only offered to individuals who are recognized by the government as low-income. Each subgrantee will spend the first 3 months of their award preparing to implement the Collaborative Care innovation. This includes hiring care managers and a psychiatric consultant, engaging in pre-implementation planning and technical assistance and participating in Collaborative Care training. Each subgrantee will launch the program with 2.0 FTE care manager time (supported by 0.2 FTE consulting psychiatrist) which can be distributed across more than 2 staff members and more than 2 clinical delivery sites to insure the flexibility necessary to make the program practical and sustainable in each location. Not all clinical locations, especially those serving remote areas, will have a large enough patient population to warrant a full-time care manager. We expect each subgrantee to have at least 50 patients enrolled in the program by the end of Year 1. During the first six months of Year 2, each subgrantee will continue the program with 2.0 FTE care managers. At the midpoint of Year 2, subgrantee organizations will have the opportunity to add up to 2.0 FTE additional care manager and 0.2 FTE additional consulting psychiatrist time (for a total of up to 4.0 FTE care manager and 0.4 FTE consulting psychiatrist effort). We expect subgrantees to treat 280-420 patients in Year 2, depending on care manager FTE, and 280 (2.0 FTE) to 600 (4.0 FTE) patients in Year 3. Each subgrantee is expected to treat at least 600-1,000 patients over the total duration of the program.

The University of Washington (UW) is the only medical school serving the WWAMI area and has a 40 year history of supporting quality improvement and healthcare workforce development programs in this vast region of the United States. The AIMS Center (Advancing Integrated Mental Health Solutions), as part of the Department of Psychiatry & Behavioral Sciences, has outreach experience in the WWAMI region and access to University expertise as needed.

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This SIF will produce these key measurable outcomes: 1) increased access to evidence-based depression treatment for economically disadvantaged patients in rural areas, 2) decreased depression and improved social and occupational functioning among these patients, 3) improved economic well-being of individuals and families served by subgrantees.

THEORY OF CHANGE

Mental health problems, such as depression, are among the most common and disabling health conditions worldwide. They often co-occur with chronic medical diseases and can substantially worsen associated health outcomes [4]. Rates of depression have been estimated to be 20% in Medicaid populations [5]. The World Health Organization ranks Major Depression fourth among the leading causes of disease burden worldwide and second in the United States. When depression is not effectively treated, it can impair self-care and participation in needed medical care, increase mortality, substantially increase overall health care costs, and decrease work productivity and economic well being.

Primary care practices are the "de facto" location of care for most adults in the US with common mental disorders such depression [6, 7]. Most patients prefer an integrated approach in which primary care and mental health providers work together to address medical and mental health needs in the primary care setting. Older adults, in particular, prefer treatment of mental disorders in primary care and when they are referred to mental health specialists no more than half follow through with such a referral [8]. Primary care providers, particularly those practicing in rural or otherwise underserved areas, report serious limitations in the support available from mental health specialists [9].

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Although effective pharmacological and non-pharmacological treatments exist for mental disorders such as depression, only around 40% of Americans with such problems receive treatment, and only around one-third of those (about one in seven of all those with depression) receive treatment that could be characterized as minimally adequate based on existing practice guidelines [10, 11]. Although almost 30 million Americans receive prescriptions for antidepressants each year, many of these patients do not receive an adequate trial of treatment. These problems occur because, in the typical primary care setting, the onus of responsibility for alerting the PCP that a treatment is not working lies with the patient. Patients who are depressed are often unable to advocate for themselves in this way because the symptoms of depression interfere with their ability to do so. PCPs often do not have the resources and the support to actively follow-up on patients for whom they have started treatment and miss important opportunities to adjust medications or other treatments if patients don't improve as expected. As a result, as few as 20% of patients started on antidepressant medications in usual primary care show substantial clinical improvement [12, 13]. Similarly, patients referred to psychotherapy often receive inadequate trials of such treatments and/or ineffective forms of psychotherapy so that treatment response for this type of treatment is also as low as 20% in usual specialty mental health care [14].

Efforts to improve the treatment of common mental disorders in primary care initially focused on screening, education of primary care providers, development of treatment guidelines, and referral to mental health specialty care. These approaches, alone and in combination, have not been found to improve patient outcomes [15]. Another approach to improve care for patients with mental health problems is to co-locate mental health specialists within primary care clinics. Having a mental health professional available to see patients in primary care can improve access to mental health services, but co-location has not been found to improve patient outcomes at a population level [16].

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Over the past 15 years, more than 60 randomized controlled research trials have established a robust evidence base for an approach called "Collaborative Care" [17]. In such programs, treatment is provided by a primary care-based team, including: 1) the primary care provider (PCP), 2) a care manager (typically a nurse, clinical social worker, counselor or psychologist) who supports treatment initiated by the PCP, provides evidence-based, brief, structured psychotherapy and referrals to community-based organizations that may help provide meaningful paid and unpaid activities for adults recovering from depression, and 3) a psychiatric consultant, who advises the primary care team regarding patients who are not improving.

Care managers work closely with PCPs who retain primary responsibility for patients' treatment. Collaborative Care programs have successfully used personnel with various types of professional backgrounds as care managers, including licensed clinical social workers, licensed counselors (i.e., master's level therapists), nurses, and medical assistants under the supervision of a nurse. Care manager responsibilities include: 1) screening for depression, 2) patient engagement and education, 3) pro-active follow-up focusing on treatment adherence, treatment effectiveness, and treatment side effects, 4) brief, structured counseling using established evidence-based techniques such as Motivational Interviewing, Behavioral Activation, and Problem-Solving Treatment in Primary Care, 5) regular (usually weekly) review of all patients who are not improving as expected with a psychiatric consultant, 6) facilitation of communication between the PCP and the psychiatric consultant, 7) facilitation of referrals to and coordination with community-based agencies, outside mental health or medical specialty care, substance abuse services, and social services.

Psychiatric consultants provide treatment recommendations to the primary care team, focusing on

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development of treatment plans for new patients and changes to treatment plans for patients who are not improving after 10-12 weeks with the current treatment. These consultations typically occur once per week over the telephone and are facilitated by an online patient registry that allows the care manager and consulting psychiatrist to review treatment outcomes for all patients being treated by that care manager in real time. Telephonic consultation has been used successfully in most Collaborative Care programs to date, including programs in "frontier" areas (e.g. along the Rio Grande river in Texas) where there are no psychiatrists for hundreds of miles. The Collaborative Care model is especially well suited to rural areas because it allows these areas to have access to the expertise of a psychiatric specialist who can help direct care, even if no such specialists are available locally.

Typical treatment duration is six months, with some patients needing as little as 3 months and some needing more than 12 months, depending on how many changes in treatment are needed to achieve sufficient improvement. A typical full-time care manager carries an active caseload of 50-100 patients. Over the course of a year a full-time (1.0 FTE) care manager working in a community health clinic will treat about 150 patients. One of the key components that sets Collaborative Care apart from usual depression care is that patients are not allowed to languish indefinitely on a treatment that is ineffective or only partially effective. Treatments are actively changed every 10-12 weeks if the patient's symptoms are not at least 50% reduced since the start of care.

Collaborative Care programs follow the principles of effective care as outlined by Wagner and colleagues, in their widely accepted Chronic Care Model, including measurement-based care [18] and stepped care [19]. MEASUREMENT-BASED CARE: Every time a patient visits a primary care clinic someone takes their blood pressure. Increasingly, primary care and mental health providers are using

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this same principle to track outcomes of treatments for depression and other common mental health conditions. Once a patient has been identified as having depression and has started treatment for that condition, it's very important to re-measure the symptoms at each contact so that the treating provider has specific information about whether or not symptoms are improving and which symptoms are or are not improving. STEPPED CARE: Adjusting the treatment plan based on whether or not symptoms are improving is one of the most important components of effective Collaborative Care programs. This approach is called "stepped care" because the treating clinicians intensify the treatment step by step until patients reach a clinically significant improvement in their symptoms. Frequent measurement of symptoms is critically important in making decisions about when and how to adjust treatment. Initial adjustments can be made by the primary care treatment team, with input from the psychiatric consultant. Patients who continue not to respond to treatment, or have an acute crisis, can be referred to mental health specialty care. Such systematic treatment to target can overcome the clinical inertia that is often responsible for ineffective treatment of depression in primary care [20].

Trials of Collaborative Care have been conducted in diverse health care settings, including network and staff-model systems, and private and public providers; with different financing mechanisms, including fee-for-service and capitation; different practice sizes; and different patient populations, including both insured and uninsured/safety-net populations. Several studies have demonstrated that Collaborative Care programs are highly effective in safety net patients and patients from ethnic minority groups [21-26] and can, in fact, reduce health disparities observed in such underserved populations.

The largest trial of Collaborative Care to date, the IMPACT study (<http://impact-uw.org>) was funded

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by the John A. Hartford Foundation and the California Health Care Foundation from 1999 -- 2003. The study enrolled 1,801 older adults (age 60+) with depression from 18 primary care clinics in five US states. In addition to having depression, IMPACT (Improving Mood: Providing Access to Collaborative Treatment) patients also averaged 4 chronic medical disorders. IMPACT participants were randomly assigned to a Collaborative Care program or to usual care.

Patients receiving IMPACT Collaborative Care were MORE THAN TWICE AS LIKELY as those in usual care to experience a substantial improvement in their depression over 12 months [27]. They also had less physical pain, better social and physical functioning, and better overall quality of life than patients in care as usual. IMPACT was strongly endorsed by patients and primary care providers [28]. The IMPACT program was significantly more effective than usual care for all patients, including ethnic minorities [21] and low income patients [29]. More recent studies have demonstrated the effectiveness of the IMPACT program for adults of all ages [30], depressed cancer patients [31] and depressed diabetics [32], including low-income, monolingual Spanish-speaking diabetics [33].

The Collaborative Care approach tested in IMPACT and similar studies has been recognized as an evidence-based practice by the federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) and recommended as a "best practice" by the Surgeon General's Report on Mental Health, the President's New Freedom Commission on Mental Health, and a number of national organizations including the National Business Group on Health. In a recent evidence-based practice report by AHRQ reviewing existing literature on approaches to Integration of Mental Health/Substance Abuse and Primary Care, the IMPACT program was profiled as "the study with the strongest results" [34].

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Several large health care organizations have undertaken implementations of evidence-based Collaborative Care programs such as IMPACT. These include national and regional health plans, including Kaiser Permanente [30] and Intermountain Health. With training and technical assistance from the AIMS Center, the DIAMOND program has implemented Collaborative Care in partnership with 8 commercial health plans, 25 medical groups, and over 80 primary care clinics across the state of Minnesota [35]. However, evidence-based programs such as IMPACT are NOT YET AVAILABLE to the vast majority of primary care patients treated in rural, underserved communities that predominate in the WWAMI region. The one notable exception to this is in the State of Washington, which has the Mental Health Integration Program (MHIP; <http://integratedcare-nw.org>), sponsored by the Community Health Plan of Washington and Seattle-King County Public Health. This program has implemented Collaborative Care across more than 100 Community Health Centers for safety net patients with mental health needs. Yet even this model program leaves many rural, low-income patients without access to Collaborative Care. In King County, WA (metropolitan Seattle) the program serves uninsured and otherwise underserved clients of all ages but in rural areas of Washington, access to the program is limited to patients receiving one specific type of welfare benefit for adults with short term disability related to medical or mental health problems. Other safety net populations, including the uninsured and Medicaid recipients, do not have access to these Collaborative Care services.

While large health care organizations such as Kaiser Permanente, the VA (Veteran's Administration), and the DOD (Department of Defense) have been able to implement evidence-based Collaborative Care programs, access to such services in rural areas is still extremely limited. Barriers to widespread implementation of these programs include the lack of a workforce trained in evidence-based Collaborative Care programs, the stigma associated with depression and mental health treatment that

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is still commonly found, especially in rural areas, and financing barriers under current fee-for-service payment mechanisms in which providers are compensated for quantity of care provided rather than quality of care achieved.

The proposed project will address all of these barriers and will help community health centers caring for underserved populations in the WWAMI region implement effective depression care programs based on the evidence-based and highly successful IMPACT model.

IDENTIFICATION OF PRIORITY ISSUES

Economic benefits from improving care for depression fall into three categories: 1) reduction of costs related to unnecessary health care expenditures, 2) improvements in employment and related income, and 3) reduction in indirect costs related to caregiving needs for patients with depression that are often borne by family members and others. Depression has been shown to increase overall health care costs by 50-100% [36-38]. Several studies have demonstrated that Collaborative Care for depression is more cost-effective than usual care and a recent review concluded that Collaborative Care programs generate net social benefits at conventional valuations of quality-adjusted life years [39, 40].

Several economic evaluations have demonstrated that Collaborative Care is associated with long-term cost savings. Cost analyses from the IMPACT study found that patients in the intervention arm had substantially lower overall health care costs than those in usual care [41]. An initial investment in Collaborative Care that cost \$522 during Year 1 resulted in net cost savings per participant of \$3,363 over Years 1-4. This corresponds to a return on investment (ROI) of \$6.50 per dollar spent, with average annual savings of \$841 per participant. The IMPACT Collaborative Care intervention yielded net savings in every category of health care costs examined, including pharmacy, inpatient and

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outpatient medical, and mental health specialty care [41]. Similar cost savings have been identified in Collaborative Care studies that included patients with depression and diabetes [32] and patients with severe anxiety [42].

Depression substantially reduces employment, lowers the chance that individuals who are unemployed will reenter the workforce, and is responsible for substantial reductions in productivity (both in terms of absenteeism and presenteeism) among those who are in the workforce [43, 44]. Adults with depression have substantially lower personal income than those without depression [45]. Individuals who retire early due to depression face long-term financial disadvantages compared to people who are treated and able to remain employed [46]. This dramatic effect of depression from a human capital perspective creates a powerful case for improving depression care [43]. Fortunately, research has shown that the systematic implementation of Collaborative Care programs for depression in primary care can reduce many of these negative economic effects of depression. A large study of Collaborative Care for depression reported improved employment rates and personal income in patients who received Collaborative Care compared to those in a usual care control group [47, 48]. A similar study showed that systematic improvement of depression treatment improved both clinical and workplace outcomes. The authors concluded that many employers would experience a positive return on investment from implementing such programs [49].

We predict that in communities effectively implementing the IMPACT program, individuals will realize economic benefits through reduced health care costs, reduced costs related to caretaking for a depressed individual, and improved work related productivity and income. We will conduct independent assessments of participants to substantiate these effects.

In addition to generating these economic benefits, the initiative is designed to increase the weight of

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public and private resources mobilized to serve individuals in significantly philanthropically underserved communities, as defined by the Corporation, in the WWAMI states. The initiative also offers the added opportunity to improve the geographic diversification of the SIF portfolio by serving people in four states which have yet to announce subgrantees, according to the Corporation: namely, Alaska, Idaho, Montana, and Wyoming.

b. DESCRIPTION OF ACTIVITIES

The University of Washington (UW) is a premier research and educational institution, with the only medical school serving the vast WWAMI region. Its core values - integrity, diversity, excellence, collaboration, innovation, and respect - are evident in every aspect of this partnership. The UW School of Medicine's Department of Psychiatry & Behavioral Sciences supports the training of health professionals throughout the five state WWAMI region. A primary area of interest for the Department is the development and evaluation of programs in which mental health professionals collaborate effectively with primary care and other health care providers to care for children, adults, and older adults with common mental disorders. One of the primary reasons for this is that the vast majority of the WWAMI region has significant shortages of mental health providers, especially psychiatrists. Collaborative Care programs are especially effective at leveraging this limited resource in an efficient and effective way to affect quality of care for the largest possible number of patients.

The AIMS Center is an integral part of the Department of Psychiatry & Behavioral Sciences and is a leading center of research, training, and implementation support for integrated Collaborative Care programs such as IMPACT. Dr. Jürgen Unützer directs the AIMS Center. From 1998 to 2003, he led the coordinating center for the IMPACT Study [13] and oversaw publication of the resulting research evidence which now amounts to more than 50 peer-reviewed publications. The AIMS Center has

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since participated in a number of other studies that have extended the evidence-base for the IMPACT model, including studies in urban and rural settings and in patients with depression and arthritis [50], cancer [31, 51], and heart disease [52].

Since 2003, the AIMS Center has trained over 5,000 people and assisted over 600 clinics in several countries with implementing IMPACT-like Collaborative Care programs, including highly effective programs in Texas, Minnesota, New York, California, Oregon, and Washington. The AIMS Academy, which is the training arm of the AIMS Center, supports a variety of programs tailored to each member of the Collaborative Care team, including primary care providers, care managers, psychiatric consultants and organizational leadership (e.g. clinic manager, medical director). This proposal provides a tremendous opportunity for workforce development programs in areas designated as health professional shortage areas (most of the WWAMI region).

SUBGRANTEE SELECTION

Faculty and staff from the AIMS Center will assist JAHF in development and implementation of a transparent, competitive subgrantee selection process. The AIMS Center has 8 years experience assisting over 600 clinics with implementation of evidence-based Collaborative Care programs. That experience has resulted in a thorough understanding of factors that facilitate and hinder effective implementation. Using that experience as a guide, UW will assist JAHF with 1) advertising the SIF opportunity to potentially eligible nonprofit primary care organizations throughout the WWAMI region, 2) reviewing subgrantee applications, and 3) selecting subgrantees for participation in the program.

The SIF opportunity will be a joint JAHF and AIMS Center solicitation that will be widely advertised

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to all of the community primary care clinics in the WWAMI region. This will be accomplished by distributing information about the program through a variety of channels, including the AIMS Center contact list (nearly 5,000 contacts), Northwest Regional Primary Care Association, the dozens of WWAMI Medical Education sites operated through the UW School of Medicine, and local/regional networks of community health clinics, like the Community Health Network of Washington. The solicitation for subgrantee applications will include: 1) eligibility requirements, 2) desired characteristics, 3) how to obtain and submit an application, 4) details about the application and selection process, 5) selection criteria that will be considered in reviewing applications, 4) requirements regarding participation in training, technical assistance, financial reporting, progress monitoring and evaluation activities.

A wide variety of organizations will be encouraged to apply to ensure a portfolio of high quality subgrantees. We expect a strong group of applicants based on the level of demand that the AIMS Center currently receives for training and technical assistance from similar clinical organizations. The primary barrier for most of these organizations, especially those serving low-income uninsured and Medicaid patients, is a lack of funds to support the start-up costs necessary to implement this kind of practice change. Nearly all of the successful implementations of Collaborative Care to date have been supported by start-up funds that allowed the clinics to prepare for and launch the Collaborative Care innovation before being required to fund the program independently. It is precisely these kinds of start-up costs, which are nearly impossible to squeeze out of the budget of a non-profit health clinic serving the under- and uninsured that prevent most of these clinics from being able to implement Collaborative Care.

ELIGIBILITY REQUIREMENTS: Subgrantees will be **REQUIRED** to be nonprofit community

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primary care organizations in rural counties designated as either medically underserved or health professional shortage areas serving at least 1,500 unique patients per year across all delivery sites. In the WWAMI region there are 83 federally qualified health centers (FQHC) with 514 delivery sites [53]. Subgrantees will not be required to be an FQHC but this information about FQHCs, a common type of primary care clinic serving low-income and uninsured patients, demonstrates that most community health clinics in the WWAMI region have multiple delivery sites. Subgrantees will be required to demonstrate that at least 50% of their patient population is low-income uninsured or covered by Medicaid. Across the WWAMI region, 69% of FQHC patients meet this criterion [53].

REQUIREMENTS FOR PARTICIPATION IN PROGRAM ACTIVITIES: Clinics will be required to agree to participate in activities necessary for successful implementation and monitoring of the program. These include training, technical assistance regarding Collaborative Care, evaluation, financial reporting and overall progress monitoring. The requirements associated with each of these activities will be clearly stated in the solicitation for applications and successful applicants will be required to demonstrate the commitment of organizational leadership and the organizational capacity to participate in these activities. Training and technical assistance activities will include: 1) participation in pre-launch team building and implementation planning activities, 2) sending 5 staff (including the care manager, clinic manager, medical director, primary care provider and consulting psychiatrist) to a two-day training meeting in Seattle, WA, 3) using the online care management registry to track all patients enrolled in the program, and 4) participation in post-launch technical assistance with the AIMS Center. Clinics will be required to agree to participate in evaluation activities, including: 1) recruitment and consent of patients for data collection activities, 2) provision of data regarding match sources, and 3) provision of data regarding billing / reimbursement for Collaborative Care services. Oversight requirements from JAHF will include standardized quarterly

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financial reporting, quarterly progress reports, participation in JAHF/SIF communications efforts, and participation in annual site visits. Continued receipt of grant funds will be contingent upon adequate participation with all these requirements and this will be made clear to applicant organizations at every stage of the selection process.

DESIRED CHARACTERISTICS / SELECTION CRITERIA: Applicant organizations will also be required to describe the following characteristics in their application for funding. These characteristics are based on AIMS Center experience assisting a wide range of primary care organizations implementing Collaborative Care programs. The weight that will be given to each characteristic as part of the applicant review process is provided in parenthesis at the end of each description: 1) PATIENT DEMOGRAPHICS: clinics serving the neediest (e.g. lowest income, ethnic minority, non-English-speaking) patients will receive the highest scores in this category (10%); 2) PREVALENCE OF DEPRESSION: clinics that can demonstrate from medical record or screening data that they can identify substantial numbers of patients who have a need for depression care (e.g., at least 10 % of their patients have documented positive screens for depression or visit / claims diagnoses for depression) will receive higher scores in this category (10%); 3) CURRENT MENTAL HEALTH SERVICES: clinics without existing mental health services will be given higher scores in this category (5%); 4) RECRUITING MENTAL HEALTH PROVIDERS: clinics that can provide a convincing description of their experience and plan for recruiting care managers and a consulting psychiatrist, including strategies for overcoming workforce shortages, will receive higher scores in this category (15%); 5) OTHER QUALITY IMPROVEMENT INITIATIVES: clinics that can describe successful implementation and improved health outcomes related to other quality improvement initiatives for chronic illnesses, such as diabetes or heart disease, will receive higher scores in this category (15%); 6) IDENTIFICATION OF COMMUNITY RESOURCES AND PARTNERS: organizations that can

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describe existing or proposed collaboration with community resources and partners to identify patients who may need depression care and/or support patients in recovery from depression will receive higher scores in this category (5%); 7) ORGANIZATIONAL READINESS: clinics that can demonstrate the support and readiness of clinical and organizational leadership for practice change to improve depression care will receive higher scores in this category (10%); 8) ORGANIZATIONAL CHALLENGES AND STRENGTHS: clinics that are able to well articulate both their challenges and strengths as an organization related to implementing practice change and a well-constructed plan for addressing those challenges will receive higher scores in this category (10%); 9) PROPOSED MATCH SOURCES: clinics that are able to describe specific, realistic plans for matching funds, including demonstrated commitments from other eligible funders and/or billing data to support their plan for generating matching revenue will receive higher scores in this category (10%); 10) PLAN FOR SUSTAINABILITY AND SPREAD: clinics that are able to describe their plan for sustaining the program after the end of funding and, if applicable, spreading it to other clinical delivery locations within their organization will receive higher scores in this category (10%).

APPLICATION AND SELECTION PROCESS: Interested organizations will be required to submit a Letter of Intent that documents that they meet the minimum eligibility requirements for subgrantees. Eligible organizations will be invited to submit a full proposal. These proposals will be reviewed by a committee comprised of representatives from JAHF and the AIMS Center as well as three independent expert reviewers. The top applications will be selected for a telephone interview with the review committee. A final group of the most competitive applicants will be selected for in-person site visits. Potential subgrantees will be encouraged to invite stakeholders, including organizations offering matching funds and/or community organizations they plan to partner with regarding patient engagement and activation. Site visits will be conducted by a representative from JAHF and the AIMS

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Center before a final determination is made regarding selection of subgrantees.

JAHF and the AIMS Center will assist potential subgrantees with identifying match sources and developing match plans that are specific, detailed and realistic. JAHF will use their existing relationships with other philanthropic organizations that may be interested in supporting this work (e.g. the Rasmuson Foundation in Alaska) and their contacts through organizations like Grantmakers in Health to identify other potential sources of match funds in the WWAMI region and serve as a broker between these potential match sources and potential subgrantees. Similarly, the AIMS Center will use their existing relationships in the WWAMI region (e.g. state Medicaid directors, the Empire Foundation, the Alaska Mental Health Trust Authority, the WWAMI medical education network) to identify potential match sources for subgrantees. The AIMS Center will also provide technical assistance to potential subgrantees regarding strategies for optimizing billing and reimbursement strategies as a source for some or all of their match (depending on the clinic's payer mix and reimbursement rates).

The application and selection timeline is as follows: Advertisement of the SIF opportunity will be distributed by the end of Month 1. Potentially interested organizations will be required to submit the Letter of Intent by the end of Month 2. Applications will be due six weeks later, in the middle of Month 4. The initial review of applications will take place by the end of Month 4. Phone interviews and site visits will occur during Months 5 and 6 with final selection of grantees to occur by the end of Month 6. This is an aggressive but feasible timeline based on the organizational capacity and experience of both JAHF and the AIMS Center.

Using the selection criteria outlined above, we expect to select 5-8 subgrantee organizations to

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participate in the proposed project. We will attempt to select at least one organization from each of the 5 WWAMI states; however, the quality of the applicant organization and their readiness to participate in the proposal will be the primary selection criteria and it is possible that not all WWAMI states will have a subgrantee selected for participation.

TRAINING AND TECHNICAL ASSISTANCE: Using a Learning Collaborative approach based on the Institute for Healthcare Improvement (IHI) model, the AIMS Center will work with the subgrantees both individually and collectively. Dr. Unützer and other AIMS Center staff have extensive experience with such learning collaboratives and have participated as lead faculty in similar efforts supported by HRSA [54], the National Council of Community Behavioral Healthcare [55], and, most recently, the California Institute for Mental Health (CiMH). The AIMS Center will provide subgrantees with individual pre- and post-launch technical assistance tailored to identify their specific strengths and challenges regarding implementation of Collaborative Care. The AIMS Center will also convene the subgrantees several times over the course of the year, both by telephone and webinar, to provide opportunities for them to learn as a group from each other's experiences. The schedule of technical assistance activities will be as follows: YEAR 1, MONTH 6 - Kick-off Webinar: All subgrantees will convene via webinar for a 3 hour kick-off meeting. The purpose of this meeting will be to: 1) outline the process of the learning collaborative, 2) provide an overview of evidence-based Collaborative Care, and 3) teach participants how to use established Team Building Worksheets to develop a concrete, specific implementation plan tailored to fit their clinical setting. YEAR 1, MONTH 7 -- Individual Technical Assistance: UW will follow-up individually with each subgrantee by telephone to review their Team Building worksheets and help them make a specific, concrete and realistic Implementation Plan prior to the in-person training meeting. YEAR 1, MONTH 8 -- Learning Session #1: Subgrantees will convene in person for a 2.5 day training meeting led by the AIMS Center in Seattle, Washington

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to learn and practice the key components of the IMPACT Collaborative Care program. Each subgrantee will bring a team to this training meeting that includes at a minimum: 1 designated program coordinator (typically the clinic manager), 1 medical director or other senior leader, 2 primary care providers, 1 psychiatric consultant, 2 care managers. The training meeting will include group sessions plus break-out sessions on specific topics tailored to the different roles (e.g. care managers and primary care providers) and will use a combination of didactic, role play and skills training. This format was highly successful in training staff at each of the 18 sites participating in the original IMPACT trial [13] and has also been successfully employed in more recent large scale implementations of the IMPACT program. YEAR 1, MONTHS 9 through 12 -- Group and Individual Technical Assistance: The AIMS Center will host two group technical assistance calls each month, one focused on clinical implementation issues and one focused on operational implementation issues. The care managers and consulting psychiatrists will participate in the clinical implementation call, which will focus on how to apply the Collaborative Care principles in specific situations they encounter in clinical practice. The program coordinator/clinic manager and medical director will participate in the operational call, which will focus on organizational challenges including long-term sustainability. During the course of these calls it may become apparent that one or more subgrantees needs additional, tailored technical assistance to overcome implementation hurdles. The AIMS Center is experienced in recognizing when an organization needs additional technical assistance in order to insure implementation success and will provide this when needed. YEAR 2, MONTHS 1 through 6 -- Group and Individual Technical Assistance will continue as described above. YEAR 2, MONTH 6 -- Learning Session #2: The AIMS Center will host a 3 day meeting in Seattle that will be attended by the subgrantees. The first day will focus on progress to date, lessons learned to date from implementation and plans for expansion and sustainability at the end of grant funding. The second two days of the Learning Session will reprise the training session from the first year for the benefit of the new care

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managers hired by those subgrantees who are expanding the program in the second year. Each subgrantee will bring a team to this training meeting that includes at a minimum: 1 designated program coordinator (typically the clinic manager), 2 primary care providers who did not attend the first training, and 2 new care managers. YEAR 2, MONTHS 7 through 12 -- Group and Individual Technical Assistance will continue as described above, with special emphasis on issues related to expansion of the program from 2.0 FTE care manager time up to 4.0 FTE care manager time for those subgrantees expanding the program. YEAR 3, MONTHS 1 through 12 -- Group and Individual Technical Assistance will continue as described above, with an emphasis on expansion and sustainability of the program after grant funds end.

The AIMS Center will provide subgrantees with a variety of tools and materials to assist them with planning and implementing integrated mental health in their primary care clinic. These will include tools to assist with planning implementation (e.g. Team Building Worksheets) and tools to facilitate clinical care (e.g. clinical screening and treatment outcome measures, treatment manuals, patient education materials, clinical worksheets, etc.).

The AIMS Center will also provide an online disease management registry that includes a care plan used by all treating providers as well as symptom measures and clinical reminders designed to facilitate delivery of evidence-based care for a range of mental health conditions treated in community primary care clinics. The registry is also used for program monitoring and to facilitate the delivery of technical assistance. It tracks the total number of patients being treated, important processes of care (e.g. number of contacts, whether contact is in-person or by telephone, length of time in treatment, identification of patients not improving who have not had a psychiatric consultation) and treatment outcomes (e.g. comparison of symptom severity at baseline and most recent contact, percentage of

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patients in treatment for at least 10 weeks who are at least 50% improved since baseline). It provides this data at the individual patient level, clinician level, clinical site level, organization level and initiative-wide.

PROPOSAL FOR EVALUATION

We will conduct a thorough evaluation of the implementation, including clinical and economic effectiveness of the program, in partnership with the University of Washington AIMS Center. Our partnership with the AIMS Center provides us with considerable experience in the quantitative and qualitative evaluation of such large scale program implementations to evaluate both the implementation and the effect of the program on achieving its goals.

Our proposed analyses will examine the implementation across participating sites using an observational design that compares the numbers of clients enrolled, health care costs, and improvement in clients' depression and other health outcomes as well as changes in clients' occupational functioning (productivity) and incomes across participating study sites and compares findings from this evaluation with established benchmarks from depression care programs implemented in similar populations and practice settings [12, 27, 56]. UW's Dr. Ya-Fen Chan will serve as the project statistician / analyst and conduct the proposed analyses under the guidance of Dr. Unützer who has led several large scale studies of Collaborative Care programs in diverse practice settings and published on the effectiveness and cost-effectiveness of these programs [27, 41, 57].

A key component of the program involves real time tracking of key process and outcome variables through the web-based care management registry as a routine part of care. This information will be supplemented with patient and provider surveys and clinical billing data. We will use care

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management registry data augmented by data from independent assessments of program participants to compare program costs, health care outcomes, health care costs, and work-related productivity and incomes for individuals participating in the program. This approach has been previously used by our team in the evaluation of the IMPACT program [41, 58].

Frequency distribution of key process and quality indicators will be calculated and reported on a monthly basis at organizational, clinic, and patient levels. For implementation evaluation purposes, we will examine the performance of these indicators each month and evaluate trends within participating organizations and clinics over time. We will also examine differences in these key process measures across clinics and investigate factors that are associated with such variation. Patient satisfaction data will be analyzed using a general linear mixed model regression (GLMM) approach which allows us to examine trends, organizational and care manager contributions to the variation in patient satisfaction. Analyses of patient outcome data such as PHQ-9 depression scores, social and work functioning (using the Sheehan scale of Health Related Functional Impairment also used in the original IMPACT trial)[59] will also use GLMM to take into account the clustering of patients within clinics. Additionally, we will use survival analysis to evaluate the time from treatment entry to patient outcome improvement (e.g., the time in weeks until patient's achieve remission from depression as measured by a PHQ-9 score <5). This approach [60] was successfully used in a recent analysis of the MHIP Collaborative Care program [57].

In evaluating program effects on health care costs, we will compare mean health care costs before and after program implementation. We will examine costs aggregated in major categories such as inpatient care, outpatient care, pharmacy, and other categories and also compare total health care costs. For each participant, we will use previously validated survey methodology to determine cost

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during a 6 month period before and for as many as 24 months after enrolling in the program. We will use Generalized estimating equations (GEE) method to identify variation in cost savings across patient populations (e.g. gender, age, insurance status (e.g., specific type of Medicaid product), chronic health conditions) and participating clinics. Drs. Unützer and Chan will be assisted in these economic evaluations by Drs. Michael Schoenbaum and Yuhua Bao, two expert health economists who have collaborated with the AIMS Center on several prior large-scale evaluations of the cost-effectiveness of the IMPACT program [61] and alternative payment methods for IMPACT care [62].

PROPOSAL FOR GROWING SUBGRANTEE IMPACT

The AIMS Center has extensive experience assisting clinical organizations implementing Collaborative Care with growing the program in a sustainable manner. Their implementation experience has taught them that it is important to start the program at a manageable size and grow it only after that initial program is running smoothly for at least 6 months. This is why subgrantees will start with 2.0 FTE care manager time for the first 12 months of implementation. Only after they have shown that their program is well established and is achieving the expected clinical outcomes will they be considered a candidate for expansion up to 4.0 FTE care manager time. This approach to program expansion is compatible with the "trialability" factor of Everett Rogers' Diffusion of Innovations theory [63]. This factor recognizes that it is important for the adopter of any innovation to have an opportunity to experiment with that innovation as it is being implemented so that it can be adapted to fit with existing structures in a way that will be practical and sustainable.

This model of dissemination has been used successfully by previous implementations supported by the AIMS Center. A good example of this is an organization in New York that was initially funded by the Samuels Foundation (based on their connection to JAHF) and was one of the first organizations to

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adopt the IMPACT program following completion of the research trial. The Institute for Family Health received two years of funding to support implementation of IMPACT in 2 clinics serving older adults in New York City. This allowed them to establish the program on a small scale and work out the clinical work flows and other organizational challenges inherent with the adoption of any innovation. At the end of their grant funding they were sold on the benefits of the program for their patients and providers and went on to expand the program to adults of all ages in most of their 26 clinical locations throughout New York City and the Hudson River Valley. The start-up money that they received allowed them to try the program before making a full commitment to it. This ability to try a program before making a large-scale commitment is a critical component in enticing organizations to adopt an innovation, even if it has been irrefutably proven to produce better health outcomes.

The factors we will use to determine whether a subgrantee is ready for program expansion in Year 2 include: 1) number of patients served since implementation, 2) average number of patients receiving follow-up, 3) average number of patient contacts each month, 4) percentage of patients being discussed with psychiatrist, 5) percentage of patients experiencing at least a 5 point drop in their PHQ-9 depression score, 6) percentage of patients in treatment at least 10 weeks experiencing a 50% reduction in their PHQ-9 depression score, 7) engagement of clinic in technical assistance activities, 8) engagement of clinic in program monitoring activities, 9) strength of subgrantee plan for expansion. All of this information is available in the online care management registry. Only subgrantees who have demonstrated the ability to implement the program successfully will be considered candidates for program expansion.

If subgrantees are ready for expansion, they will be allowed to propose a plan for expansion that best

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fits their organization. This may include expansion of the program to new sites or expansion of the program at an existing site that has the patient population to support expansion. The subgrantee expansion plan will be reviewed by JAHF and the AIMS Center and may be modified based on their input. The AIMS Center will offer a second in-person training in Year 2 for clinics that are expanding the program so that they can train new staff.

From the start of the program subgrantees will be required to participate in technical assistance activities designed to help them plan for the end of grant funds so that they can sustain and expand the program after grant funding expires. This will create a cohort of self-sustaining organizations that will have the ability to expand to other clinical sites within their own organization and serve as a model for other clinics in the WWAMI region considering implementation of Collaborative Care.

Organizational Capability

JAHF is a national funder in health care focused on improving the quality of care and health of older Americans. Its board is composed of experts in foundation management, financial, legal, and healthcare domains. It has pursued this mission for 30 years and developed an exceptional professional staff team to execute its work. JAHF is currently staffed by 16 professional and support personnel. These include its executive director (EdD), finance and accounting staff (1 CPA, 1 Accountant), program team (2 PhDs, 1 MPH, 1 MSW, 1 MPA, 1 RN), grants management staff (2), office administration/HR (1), and information technology staff (1). It has an endowment of approximately \$485,000,000 annual grants payout of \$18-20,000,000 and maintains 50-100 active multi-year grants with an average size of \$750,000. It's most recent overall evaluation of organizational effectiveness from an anonymous survey conducted by the Center for Effective Philanthropy found that JAHF was rated at the 99th percentile for impact of its work as compared to ratings of other Foundations by their grantees.

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a. HISTORY OF COMPETITIVE GRANTMAKING

With over 80 years of total history, JAHF has directly run dozens of grants competitions in addition to programs run through intermediary grantee organizations. These have included both fully open calls for proposals and more selective processes. We have extensive experience in assessing readiness for clinical system change, grants administration capacity, and mission alignment. With the assistance of our technical assistance provider (AIMS Center) we will be able to draw on an extensive experience in engaging and guiding subgrantees through implementation processes specific to this model of care.

JAHF's generic processes include solicitation and review of letters of intent, screening of applicants for administrative eligibility (e.g., 501c3 status, organizational budget), solicitation of proposal and project budget, review of narrative and budget (with and without external expert consultation), narrative and budget feedback and revision, in-person site visits with stakeholder interviews, and final administrative review. The four most relevant and recent experiences (all overseen by current JAHF staff) include: 1) The semi-open call for proposals in the original IMPACT trial in 1999 of integrated depression treatment. This process resulted in seven sites selected from 11 final applicants (budgets of \$1.3 million) all of whom completed the trial and successfully implemented the clinical model. 2) The more recent semi-open call for proposals for clinical innovations at academic medical centers, Centers of Excellence Clinical Service Challenge Grants (2005). Five projects were selected for implementation from 25 applications (budgets of \$150,000 each). All successfully completed their projects and four of five sustained their innovations. 3) Open national call for proposals for Centers of Excellence in education in geriatric medicine (2007). Reviewed an initial 50 letters of intent and background descriptions, solicited full proposals from approximately 20 applicants, site visited 10 and funded 5. All continue to be satisfactory grantees, in full compliance with all policies and goals. 4) An

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open national call for proposals for Centers of Excellence in Geriatric Nursing (2007). Reviewed an initial 30 letters of intent/background descriptions, solicited full proposals from 10 applicants, site visited 8 and funded 4. All continue to be satisfactory grantees, in full compliance with all policies and goals.

The AIMS Center will assist JAHF with development of the grant solicitation and selection of subgrantees (as described in Subgrantee Selection above). The AIMS Center has experience with both activities. They have partnered with other sponsors of Collaborative Care initiatives, including Butler County (Ohio) Mental Health Board, Santa Clara County (California) Behavioral Health, Alameda County (California) Health Consortium, and the Hogg Foundation for Mental Health (Texas), to help shape grant solicitations to increase the likelihood of selecting grantee organizations ready and able to successfully implement the Collaborative Care program. AIMS Center faculty and staff also have experience assisting with the selection of grantees. They assisted with the review and selection of a grantee to implement Collaborative Care with support from the Retirement Research Foundation.

b. EXPERIENCE GROWING PROGRAM IMPACT

In its service and educational innovation work JAHF has substantial experience in sustaining and increasing the impact of models that have demonstrated increased value to beneficiaries. In service delivery models, following successful demonstration of program impact, we have supported 4 recent dissemination projects focused on scale up and spread of the models. This work has been guided by the analysis of diffusion of innovation developed by Everett Rogers [63], careful stakeholder analysis, communications and marketing efforts, business planning, and the development of on-line and remote training and technical assistance capacities. We have experience in managing the tension between fidelity to core model principles and the inevitable adaptation or reverse engineering to be

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compatible with unique organizational characteristics of the adopting organization.

These dissemination projects have included the IMPACT Implementation Center, a \$2.6M, six year effort which supported implementation of the Collaborative Care model of depression in more than 600 adopting organizations and developed modifications of the model for younger adult populations, home healthcare patients, patients with cancer, diabetes, heart disease and other co-occurring medical conditions, safety net populations and ethnic minority populations. Similarly, following successful demonstration and testing of general geriatric care management (Care Management +; <http://caremanagementplus.org/>) and post hospitalization care transitions/readmissions reduction (Care Transition Intervention; <http://www.caretransitions.org/>) we funded dissemination grants of \$1.2 and \$1.8M, respectively. Each of these projects has been extremely successful with more than 200 and 500 adoptions respectively.

In another multi-year cycle of model development and extension, Home Meds (<http://www.homemeds.org/>), a medication reconciliation model developed to address potentially dangerous medication errors in older adults recently discharged from hospitals demonstrated its benefits and was supported for dissemination into home care agencies. Subsequently, JAHF supported an adaptation of the model for Medicaid home and community-based service waiver programs where participants have similarly high levels of medical complexity and limited self-care ability. This extension of the model was evaluated and found to identify and significantly reduce high rates of problematic prescribing in this new population.

Finally, for the last 6 years JAHF has been an active funder of the Center to Advance Palliative Care, one of the nation's most successful projects to scale up and spread a clinical model (hospital-based

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palliative care teams). During its 15 years of effort, hospital-based palliative care teams have grown from non-existent to firmly embedded in over 80% of hospitals.

As part of its capacity to increase the impact of its innovative models, JAHF maintains active participation in a number of funder and healthcare association networks. These include Grantmakers in Health, Grantmakers in Aging, and the Nurse Funders Collaborative. Foundation staff are actively engaged as member/thought leaders in these organizations and have successfully used these opportunities to recruit additional funders to support JAHF projects. For example, through our Grantmakers in Aging connections, the Fan Fox and Leslie R. Samuels Foundation has funded two New York replications of the IMPACT model with training and technical assistance support from the AIMS Center. One of these implementations was undertaken by the Institute for Family Health and is described earlier in this application. The Hogg Foundation and the George Foundation have each funded regional replications of IMPACT in Texas, including in rural and frontier areas.

In addition to drawing upon relationships with other philanthropic funders, JAHF has developed valuable public-private partnerships. For example JAHF supported initial development of evidence-based models of health promotion delivered by community agencies through grants to the National Council on Aging for its Healthy Aging initiative (<http://www.ncoa.org/improve-health/center-for-healthy-aging>). These models (e.g., Healthy Moves and Healthy Ideas) were subsequently supported by the Administration on Aging through multiple federal grant cycles for national adoption by the aging services network. This public-private partnership with the Administration on Aging has been a source of great pride and value to the Foundation under multiple administrations.

From this work and other national efforts to understand scale and spread of innovation in health care,

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JAHF staff have developed substantial expertise in the field. We have worked with grantees providing external consultants to help develop sustainable business models for new activities. We have offered communications and fundraising capacity building support to grantees to enable them to identify and capture other sources of philanthropic support. And we have supported grantee engagement in regulatory policy to create environments that appropriately value grantee outcomes. We maintain active dialog with federal agencies relevant to our work including HRSA (Health Resources and Services Administration), SAMHSA (Substance Abuse and Mental Health Services Administration), CMS (Centers for Medicare and Medicaid Services), AoA (Agency on Aging), and the NIH (National Institutes of Health) to find opportunities for synergy and further support.

We have specifically measured and tracked program expansion and replication of models we have developed. Grantees and foundation staff have shared lessons learned through professional presentations (e.g. Grantmakers in Health, Gerontological Society of America), Foundation issued annual reports, technical publications, and the peer-reviewed literature.

c. EVALUATION EXPERIENCE

JAHF employs a highly engaged approach to evaluation of its projects. There is a standing evaluation committee of the board of trustees to which staff report annually on all active projects with budgets over \$100k (over 95% of JAHF projects). Per board policy, in the first and last years of projects (and as needed) JAHF uses expert external consultants to independently review projects' progress, and report to the committee. These reports are shared with grantees and form part of the cycle of continuous quality improvement of all funded projects. Results are used to identify additional consulting assistance needs of grantees, to prioritize programs for renewal funding and, when necessary, to terminate irretrievable grants. Grantees have rated the Foundation's evaluation process as highly valuable in recent Center for Effective Philanthropy surveys.

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In addition to this level of close monitoring and operational tracking of projects, JAHF builds systematic evaluation into projects as appropriate. For example, we have funded multiple full-scale multi-site randomized clinical trials (e.g. the original IMPACT depression treatment model \$10,000,000 testing phase), complex medication management model, and primary care management, Guided Care Models [64, 65]. JAHF has also used various quasi-experimental designs including pre-post with non-randomized comparison groups, retrospective pre-post, and regression discontinuity models to assess program impact. Foundation staff include two PhD and one EdD trained researchers and a strong track record of using evaluation results in refining programs, selecting grantees/models for dissemination support and scale-up, and contributing to public literature.

For selected projects, JAHF has commissioned external, third party evaluations, including use of national consulting firms (e.g. Westat, which reviewed the Social Work Initiative) and leading experts (e.g. Shoshanna Sofaer, who conducted an evaluation of the JAHF Geriatric Nursing Initiative). JAHF is committed to appropriate measurement of program impact and transparent sharing of results and lessons. The Foundation recently published 3 comprehensive evaluations of its initiatives (Building Academic Geriatric Nursing Capacity, Hartford-RAND Interdisciplinary Research Centers, and Health-Outcome Research Scholars Program) and has budgeted resources for future efforts.

For the proposed project, JAHF will contract with the AIMS Center to conduct a patient-level evaluation of the clinical outcomes of IMPACT care as well as an evaluation of the economic benefits of the model on program participants. We will structure the grantee selection process to assess subgrantee's ability to participate in the evaluation and produce all required data. Based on our long

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experience with the AIMS Center and Dr. Unützer, as well as the very nature of the clinical intervention, which requires close tracking of patient clinical recovery and intervention processes, we are very confident that we will be able to conduct a robust evaluation. Dr. Unützer is an internationally recognized health services researcher with over 200 peer-reviewed publications. He has participated in or consulted to many of the research trials of Collaborative Care in various patient populations and settings and has led or contributed to program evaluations for many of the larger implementation projects [35, 55, 56].

While the IMPACT model of Collaborative Care is based on good evidence in those sites where it has been previously developed, its effectiveness in rural and underserved areas is an important question. The results of pre-post comparisons and other quasi-experimental designs within the subgrantee organizations will provide useful evidence of the effectiveness of the model in these contexts, building on the high level randomized trial evidence already available regarding the efficacy of the model and extending experience with the effectiveness of the program to rural and otherwise underserved sites in the WWAMI region.

d. ABILITY TO PROVIDE PROGRAM SUPPORT AND OVERSIGHT

As an engaged grantmaker, JAHF is designed to provide careful programmatic oversight and, more importantly, support to its grantees. To support this project's success JAHF proposes to allocate .40 FTE of a program officer and .05 FTE each from the Program Director and Executive Director, in addition to the technical assistance and coordination provided by the AIMS Center contractor. Average tenure of JAHF grantees is almost 10 years across multiple refinements of projects demonstrating the Foundation's preference for long-term, deep partnerships with its grantees.

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JAHF's internal evaluation and monitoring process sets a floor to oversight of its grantees (e.g., annual in-person review). As part of its standard process JAHF also requires and reviews progress reports from grantees every six months and makes routine monitoring calls and maintains an open door policy for grantee concerns and issues. Close relations between Foundation program and grants management staff (including joint approval of all budget related matters -- see further information below) means that grants management staff also support programmatic oversight. Foundation staff typically organize grantee convenings, national symposia, and publications with grantees to share lessons learned and publicize progress. For example, the Foundation convened all of its service innovation grantees in 2008 to build relationships, share lessons learned, and develop positive synergy. JAHF plans further such convenings and other forms of leadership capacity building for grantees going forward.

In addition to the invaluable support that will be provided by the AIMS Center, the Foundation's technical assistance and evaluation contractor, JAHF will provide all normal services to its SIF grantees. These include Foundation outreach on behalf of subgrantees, additional consultation from Foundation staff and contractors as needed, and the efforts of the Foundation's long-time communications firm, Strategic Communications and Planning (SCP). SCP has worked with the Foundation for more than 10 years. It provides communications capacity building through grantee workshops, an on-line resource center (www.bandwidth.com), and direct technical assistance under the Foundation's master account. They teach message development, story-telling, social media, and other techniques to help Foundation grantees leverage their accomplishments. As described under experience increasing program impact, JAHF has considerable experience in brokering its relationships to benefit grantee support from other Foundations and funders. JAHF would include SIF subgrantees in this process to benefit subgrantee sustainability as well as IMPACT and SIF brand

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awareness. JAHF also maintains a technical assistance budget item that allows it to hire consultants on behalf of grantees as the need arises. The Foundation will allocate its Technical Assistance budget to SIF grantees as needed.

KEY PERSONNEL and program staff at JAHF who will be involved in the SIF initiative include:

CORINNE H. RIEDER, EdD, Executive Director and Treasurer, oversees the Foundation's strategic direction and fiscal management. Before joining in 1996, she served as the corporate secretary of Columbia University, and earlier as the University's director of federal relations. She began her career in Washington, D.C., where she was an associate director of the National Institute of Education, a study director at the Office of Management and Budget, and an advisor in education at the former Department of Health, Education and Welfare. Currently, she is a board member of the American Federation for Aging Research; the Visiting Nurse Service of New York; and Expeditionary Learning Schools Outward Bound. Dr. Rieder earned her B.A. from the University of California, Los Angeles, and her Masters and Doctorate from Harvard University.

CHRISTOPHER A. LANGSTON, PhD, Program Director, leads the Foundation's grantmaking strategy and will oversee the implementation of the SIF initiative. Dr. Langston re-joined the Foundation in 2007 after two years at The Atlantic Philanthropies where he was a program executive managing a portfolio of grants in aging and health. While at Atlantic, he worked with the National Council on Aging in a national partnership with the federal Administration on Aging to support the national adoption of the Chronic Disease Self-Management Program. Before joining Atlantic in 2005, he worked for eight years at the John A. Hartford Foundation, where he oversaw a variety of health education and quality improvement demonstrations related to health care for older persons. Dr. Langston earned his PhD from the University of Michigan in Psychology and did a post-doctoral fellowship at the University of Pennsylvania/Philadelphia Geriatric Center on late-life physical and

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mental health co-morbidities.

WALLY PATAWARAN, MPH, Program Officer, will lead the implementation of the SIF initiative, coordinate activities with program consultants and staff, and be the point of contact for subgrantees and the Corporation. Prior to his arrival in 2011, Mr. Patawaran advised health and aging services organizations on issues of strategy, operations, and marketing. Earlier in his career, he led performance improvement initiatives for Weight Watchers International, and served as a member of the finance team directing international program expansion and replication. Mr. Patawaran has degrees from the London School of Economics and Columbia University's School of Public Health.

KEY CONSULTANTS at the AIMS Center who will be involved in the SIF initiative include:

JÜRGEN UNÜTZER, MD, MPH, MA is Professor and Vice Chair of Psychiatry & Behavioral Sciences in the UW School of Medicine, Adjunct Professor of Health Services in the School of Public Health & Community Medicine, and Director of the AIMS Center. He is a leading Health Services researcher in the area of integrating evidence-based mental health services into primary care and other medical settings with over 200 peer-reviewed publications. Dr. Unützer has been an investigator in five large multi-site Collaborative Care studies, including Partners in Care (43 primary care clinics), the IHI's Depression Breakthrough Series (21 primary care clinics) and he was Principal Investigator of the IMPACT trial (1,801 patients in 18 primary care clinics belonging to 8 healthcare systems in 5 states) which is the largest study of Collaborative Care for depression to date. Dr. Unützer will oversee all AIMS Center activities, including the program evaluation of the SIF initiative and the analysis of economic impact with the help from experts in economics and cost effectiveness analyses such as Dr. Michael Schoenbaum at NIMH and Dr. Yuhua Bao at Cornell who have previously collaborated with the AIMS Center on similar economic analyses [41, 62].

YA-FEN CHAN, PhD, is a Research Scientist in the UW Department of Psychiatry & Behavioral

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Sciences with doctoral training in psychiatric epidemiology and a Master's degree in biostatistics from Johns Hopkins University. She works closely with Dr. Unützer and the AIMS Center on the design and analysis of program evaluations for integrated care initiatives. She will assist him and JAHF with design and implementation of the evaluation plan for SIF subgrantees and will have primary responsibility for analysis of evaluation data.

DIANE POWERS, MA is a Research Scientist and Program Manager of the AIMS Center at UW. She has over twenty years experience as manager of a wide range of public health and health services research projects and programs. Over the past eight years she managed the IMPACT Implementation Center project funded by JAHF and assisted Dr. Unützer with creating and growing the AIMS Center into the successful program that it is today. Ms. Powers supervises the staff of the AIMS Center and all Center operations. She provides pre- and post-implementation technical assistance to implementing organizations, organizes and participates in training meetings and develops training and implementation materials. Ms. Powers is trained as a mental health provider and has eight years experience providing mental health services in both inpatient and outpatient settings. Ms. Powers will supervise all AIMS Center activities associated with this proposal.

e. ABILITY TO PROVIDE FINANCIAL SUPPORT AND OVERSIGHT

JAHF is a grantmaking institution with over 80 years of history. The Foundation has significant experience in managing large multi-year grants and monitoring grantee performance against specific goals and measureable outcomes. It collaborates with external funders in the philanthropic, corporate, and federal sectors. Among its federal partners in recent years are the Agency for Health Care Research & Quality (AHRQ), the Centers for Medicare and Medicaid Services (CMS), the Department of Veterans Affairs (VA), the National Institute on Aging (NIA), and the Office of the National Coordinator for Health Information Technology.

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The JAHF grants management team currently oversees over 50 active grants totaling over \$97 million in awarded funds, and has the capacity to manage more than 100 active grants per year, based on recent history of grantmaking. The grants management team reports to the executive director and treasurer. It works alongside program staff to conduct due-diligence of prospective grantees, analyze their financial soundness, assess their internal capacities for financial reporting, and monitor program activities and expenditures for size and performance against proposed budgets. The team also works with grantee administrative offices to ensure that financial and program reporting requirements are met each period. JAHF grants management uses standardized reporting forms for program budgets and expenditure reporting and provides orientation and an instruction manual to all new grantees and grantee financial management staff as needed. Grantees must report on the timing and provision of matched funds, record the amount and source of supporting funds, and explain how funds provided by JAHF have been used over the reporting period. In addition, all grantees must obtain approval from the grants management team if and when budget deviations are anticipated.

Thus, the financial oversight requirements of the SIF program are structurally similar to those JAHF already uses and it is well prepared to both manage subgrantees and discharge its own responsibilities as an intermediary. Foundation program and grants management staff have interviewed staff of three current SIF intermediary organizations to clearly understand the nature and scale of monitoring and reporting requirements. JAHF has consulted with its long-time auditing firm about the processes for the mandated A133 standard audit. The Foundation's last three audits have all been without qualification or any defects noted. The Foundation is prepared to engage additional auditing consultation to ensure that it is adequately prepared to receive an unqualified audit report for this program.

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The JAHF 2012 grantmaking budget is \$18.5 million with an overhead budget of \$6 million. The SIF intermediary grant would equal 5.4% of JAHF's 2012 grantmaking budget, or 4% of the total budget. The majority of JAHF's active grants are multi-year awards, averaging three or more years in duration.

In preparation for the SIF initiative, the grants management team will incorporate into its administrative practices the reporting requirements for subgrantees, and will prepare to provide guidance on Federal Financial Reports and the system for reporting of sub-awards. The grants manager and the grants and evaluations coordinator both have experience with the management and administration of federal grants and contracts, including the Title I of the Ryan White Care Act and the Office of the National Coordinator of Health IT. In addition, the Foundation will recruit a 0.8 FTE grants management specialist to support the administration of sub-awards and to support record-keeping, compliance, and reporting needs.

KEY FINANCE AND GRANTS MANAGEMENT PERSONNEL who will be involved in the SIF initiative include:

EVA CHENG, CPA, Finance Director and Controller, is responsible for accounting and financial reporting, monitoring investment performance of the Foundation's portfolio, taxes, budgeting, and other administrative functions. She joined the Foundation in 2001 as a Senior Accountant and was soon promoted to Assistant Controller, a position she held until 2010. Before her arrival, she served in senior finance, tax, and accounting positions at large banks and investment firms. Ms. Cheng earned a BS degree in Accounting, cum laude, from the Stern School of Business at New York University. She is a member of Financial Foundation Officers Group (FFOG).

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FRANK J. DOLL, MPA, Grants Manager, will oversee the reporting requirements, budgetary considerations, and payment schedules of subgrantees. Before joining the Foundation in 2003, Mr. Doll was a Program Coordinator at the Medical & Health Research Association of New York (now Public Health Solutions), where he managed a portfolio of federal contracts awarded to various HIV/AIDS service providers under Title I of the Ryan White Care Act. Mr. Doll earned his BA in History from Rutgers College at Rutgers University in New Brunswick, NJ and his MPA in Non-Profit Management from The Robert F. Wagner Graduate School of Public Service at New York University.

JESSIE L. WHITE, Grants and Evaluations Coordinator, will manage the administration of subgrantee awards. Prior to her arrival in 2011, Ms. White was a program coordinator at the New York City Department of Health and Mental Hygiene's Primary Care Information Project, which operated a federally-funded program increasing use of health information technology by primary care providers. Ms. White earned her BA in Global Studies and French at the University of California, Santa Barbara.

GRANTS MANAGEMENT SPECIALIST (TBD, .8 FTE) will support the administration of awards to subgrantees, and support record-keeping, compliance, and reporting needs. The ideal incumbent will have experience in accounting and federal program management.

f. STRATEGY FOR SUSTAINABILITY

We will pursue a number of specific strategies to help improve the long-term sustainability of the IMPACT Collaborative Care program among subgrantees: 1) Technical assistance provided by the AIMS Center will not only focus on initial staff training and program implementation, but will continue throughout the entire period that clinics receive SIF funding to ensure that the program is mature by the time SIF funding ends. In addition, the AIMS Center has experience recognizing implementing organizations that need additional implementation assistance and will provide

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individual, tailored technical assistance to subgrantees, as needed, to ensure program success. 2) In Years 2 and 3, the AIMS Center will support participating organizations who have succeeded with initial implementation of the program (at a level of 2.0 FTE care manager time) to expand implementation of the program up to 4.0 FTE care manager time. We will pay close attention to factors that solidify the program by incorporating its key staff and protocols into the routine staffing and clinical workflows in the participating clinics. 3) The AIMS Center will work closely with each participating organization to maximize clinical billing for IMPACT Collaborative Care services and to create a plan that will allow the program to be self-sustaining at the end of SIF funding. This will vary across participating sites based on the nature of their clinics and their local payer mix. For Federally Qualified Health Centers (FQHCs), we may work with them to make sure that their scope includes IMPACT depression care services and that they hire and train licensed staff, such as LICSWs, consulting psychiatrists or psychiatric nurse practitioners who can bill for such services under existing fee-for-service billing arrangements with the federal government. For other community health centers serving Medicaid populations, we will work with the subgrantees and their respective state Medicaid agencies to identify the best ways (either fee-for-service or capitated) in which they can be reimbursed by Medicaid for providing IMPACT services. 4) The AIMS Center has extensive experience working with health care policy makers at the local, state, and federal levels to examine how evidence-based programs such as IMPACT can be reimbursed under diverse health policy and payment settings. We feel that the IMPACT model is extremely well positioned for more widespread implementation under several health care reform developments such as Patient-centered Medical Homes (PCMH) and Accountable Care Organizations (ACOs). Although IMPACT was developed and tested before the current development of PCMHs, a recent analysis sponsored by the Agency for Health Care Quality and Research (AHRQ) cites the IMPACT model as a PCMH "forerunner" with the most compelling evidence for improvements in health outcomes [66]. The population-based focus

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and long-term cost savings observed in the original IMPACT trial [41] make it attractive to organizations trying to implement ACOs with the goal of improving health outcomes for populations while containing overall health care costs.

In addition to technical assistance from AIMS to sustain the IMPACT model through earned revenue, JAHF will use its relationships with funders, stakeholders, and affinity groups to broker opportunities for subgrantees to obtain broader support. We will coordinate and support presentations on SIF work before audiences like Grantmakers in Health, the Social Innovation Exchange, and other convenings. Such opportunities often result in new philanthropic support for continued program development and special allocations of support. In addition the opportunity for national exposure is a substantial benefit to the credibility and influence of project champions internal to subgrantee organizations.

Budget/Cost Effectiveness

a. BUDGET JUSTIFICATION

The proposed program budget for the SIF initiative is designed to support anticipated programmatic outcomes across multiple levels, spanning individual patients, clinicians, clinical sites, community health organizations, up to the initiative as a whole. It has been developed in consultation with faculty and staff from the AIMS Center, and draws on their 8 years' experience assisting over 600 clinics with large scale implementations of integrated care programs. The projections assume that 5-8 subgrantee organizations participate in implementation of the SIF initiative.

The SIF program budget for Year 1 includes a total of \$499,832 in support for the AIMS Center at the University of Washington. This will be used to provide support for Technical Assistance (\$302,261) and Evaluation (\$197,571). The total amount will be charged to the grantee share to be paid by JAHF, and incorporates a rate of 10% for indirect costs to be paid to the University of Washington.

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TECHNICAL ASSISTANCE activities include assisting JAHF with development and distribution of the grant solicitation, review of potential subgrantees (including site visits to finalist organizations), and final selection of subgrantees. It also includes pre-launch technical assistance, technical assistance materials, a two-day in-person training meeting held in Seattle, WA for all subgrantees, licensing and hosting of the online care management registry software, leading the post-launch learning collaborative and, if needed, tailored technical assistance for individual subgrantees. Personnel expenses include salary and fringe benefits for staff time, including 0.12 FTE from the director, 0.4 FTE from the program manager, 0.7 FTE from a project coordinator, and 0.3 FTE from a technical project manager. The AIMS Center director (Dr. Jürgen Unützer) will oversee the subgrantee selection process, lead the training meeting, and oversee delivery of technical assistance to the selected subgrantees. The AIMS Center manager (Diane Powers) will have primary responsibility for the coordination and timely completion of all technical assistance activities, including subgrantee selection, training, and delivery of pre- and post-launch technical assistance activities. She will also assist Dr. Unützer with the training meeting. The project coordinator (Andrea Panniero) will assist Dr. Unützer and Ms. Powers in scheduling and organizing all technical assistance activities. The technical project manager (Suzy Hunter) will oversee development and deployment of a customized iteration of the online care management software for use by the subgrantees. She will create the software functional requirements, coordinate the software development staff, coordinate completion of the software use agreement and train end users in use of the software. Also included in the technical assistance budget for the AIMS Center are travel costs for pre-selection site visits to potential grantees, venue and materials costs for the in-person training meeting, conference call and webinar fees for post-launch conference calls and webinars, and the software license and software hosting fee for subgrantee usage of the online disease management registry developed by the AIMS Center to support Collaborative Care. This online registry facilitates the delivery of evidence-based care by enabling

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program monitoring at multiple levels, including real-time tracking of key processes of care and patient outcomes, and thus guides on-going performance improvement. Together, the tools, resources, training, and technical assistance supports provided by the AIMS Center and JAHF will enable subgrantee organizations to implement the initiative successfully, grow their infrastructure and service capabilities to deliver Collaborative Care, and expand their service footprint to benefit patients of community health clinics operating in low-income, rural communities philanthropically underserved areas in the WWAMI states.

The AIMS Center has also contracted with JAHF to lead evaluation of the Collaborative Care program, including both clinical and economic effectiveness of the program. Proposed evaluation expenses amount to \$197,571 and include costs for independent assessments of patient outcomes at each subgrantee organization. The total amount will be charged to the grantee share to be paid by JAHF, and incorporates a rate of 10% for indirect costs to be paid to the University of Washington. The AIMS Center will recruit experts in economic and cost effectiveness analyses to provide consultation on the design, implementation and analysis of metrics to measure economic impact. They will also engage the services of a subcontractor to obtain individual level independent assessments from a subsample of patients participating in the Collaborative Care program to measure economic effects of the program. These assessments will be completed by telephone with a randomly selected subsample of patients participating in the program. Data on patient clinical outcomes and processes of care will be collected for all patients from the online care management registry software. AIMS Center Personnel costs include salary and fringe benefits for staff time to support the evaluation effort, including 0.08 FTE from the director, 0.1 FTE from the program manager, 0.1 FTE from a project coordinator, and 0.3 FTE from a statistician. The AIMS Center director (Dr. Jürgen Unützer) will have primary responsibility for development and implementation of the evaluation plan

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in close consultation with the economic experts and Dr. Chan, the biostatistician. The statistician (Dr. Ya-Fen Chan) will have primary responsibility for advising Dr. Unützer regarding design, collection and analysis of data for the evaluation. She will also have primary responsibility for conducting statistical analyses and for working closely with Dr. Unützer and the economic consultants regarding interpretation and reporting of results. The AIMS Center manager (Diane Powers) will have primary responsibility for coordinating independent assessments with the subcontractor hired to perform these assessments and insuring that the evaluation protocol is followed by this subcontractor. The project coordinator (Andrea Panniero) will assist Drs. Unützer and Chan and Ms. Powers with scheduling and organizing all evaluation activities. The AIMS Center has considerable experience in designing quantitative and qualitative evaluations of large scale program implementations similar in structure to the proposed initiative.

The remaining balance (\$1,500,168), which is just over 75% of the program budget, will be distributed to subgrantees to implement the program. Combined with the subgrantee match, total funds will be used by subgrantees to hire mental health care managers and consulting psychiatrists and to pay for staff time for primary care providers, and clinical administration to prepare for and implement the Collaborative Care practice innovation. Based on the experience of the AIMS Center, start-up costs for the program are expected to include the following for each subgrantee organization: 1) at least two primary care providers (0.2 FTE) to assist with pre-launch planning and participate in the training meeting in Seattle, 2) the clinic manager or similar person (0.5 FTE) to coordinate participation of the clinic in all pre- and post-launch technical assistance activities, the training meeting, and program monitoring and financial reporting activities, 3) the clinic medical director (0.25 FTE) to assist with pre-launch planning and participate in the training meeting, 4) the care managers (2.0 FTE) to participate in the training and pre- and post-launch technical assistance activities, 5) the consulting

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psychiatrist (0.2 FTE) to participate in the training and pre- and post-launch technical assistance activities, and 6) travel expenses (airfare, lodging, ground transport, and meals) for these staff to attend the two-day training meeting led by the AIMS Center in Seattle. We are confident that the program budget deploys sufficient resources to meet the required needs for start-up training, execution support, and program tracking and evaluation.

JAHF and the AIMS Center anticipate that the SIF program will obtain diverse state, philanthropic, and other non-federal resources for program implementation and sustainability through clinical billing and traditional philanthropic support. As detailed in our strategy for sustainability, JAHF and the AIMS Center will work closely with each subgrantee organization to maximize clinical billing for the evidence-based IMPACT services. We will guide them to ensure that they hire and train licensed staff that can bill for such services, and we will guide them as they work with their respective state Medicaid and other local governmental funding agencies to identify optimal reimbursement and/or match channels. JAHF also proposes to attract additional resources from local communities and beyond by harnessing its deep and extensive relationships with other Foundations and funders in the health care philanthropic sector. We are committed to assisting subgrantees, and working with the Corporation, to articulate the investment case to support the sustainability of the SIF initiative, and we will utilize our integrated communications platform (linking online and social media) for this purpose.

b. DESCRIPTION OF MATCH SOURCES AND CAPACITY

As documented in a signed statement by our Finance Director and Controller on March 20th, 2012, JAHF has investment assets of over \$480 million, including a cash balance of approximately \$34 million, which is more than sufficient to satisfy the 50% cash liquidity requirement. Required

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matching funds of \$1 million (annually) will be drawn from these assets. In addition to meeting that minimum, JAHF will allocate additional resources in the form of staff time, communications support, travel costs, and administrative costs for the A133 audit and criminal history background checks, AT NO CHARGE to the SIF program. To ensure the success of the SIF initiative, JAHF will allocate 0.4 FTE from a program officer, 0.05 FTE each from Program Director and Executive Director, 0.8 FTE from a grants management specialist to be recruited for the SIF program, 0.10 FTE from the grants manager, 0.15 FTE from the grants and evaluations coordinator, 0.05 from Finance Director and Controller. This staff time is in addition to the technical assistance and coordination provided by the AIMS Center. Other resources will also be provided AT NO CHARGE, including communications support and fundraising capacity building for subgrantees, and travel by staff to subgrantee sites or to meetings with the Corporation. Supplemental consultation from staff, contractors, and consultants will be provided as needs arise. We are confident that this allocation of staff time and resources will more than enable us to discharge our responsibilities effectively within the time lines specified in our project plan.

As noted in the description of activities and in experience growing program impact, JAHF is committed to assisting subgrantees identify resources for the required match. Moreover, as we have shown, JAHF has the capacity and means to organize and execute such a campaign. To realize the potential of the SIF opportunity, JAHF will broker funding connections between individuals, organizations, and institutions in the philanthropic and state government sectors. We will recommend investment in the SIF program to our broad network of funding partners and health care associations. These include affinity groups such as Grantmakers in Aging, Grantmakers in Health, and the Nurse Funders Collaborative. Furthermore, we will invite the participation of major, prospective stakeholders early on in the site visit and review processes. We are confident that our joint

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efforts with subgrantees will enable them to capture other sources of philanthropic support and secure their required match.

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Clarification Summary

I. PROGRAMMATIC ISSUES FOR CLARIFICATION

DESCRIBE KEY CHARACTERISTICS THAT DISTINGUISH IMPACT AS A SPECIFIC TYPE OF COLLABORATIVE CARE. WHAT ELEMENTS ARE MOST CRITICAL TO ENSURE DESIRED PATIENT OUTCOMES?

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The 7 core tasks necessary for effective implementation of IMPACT are: 1) Patient Identification and Diagnosis, in which patients are identified using valid screening instruments; 2) Engagement and Education, in which patients (and families as appropriate) are effectively engaged in treatment and educated about symptoms, treatments and self-care strategies; 3) Evidence-based Treatment, in which patients collaborate with providers to develop and implement treatment plans that use treatments proven effective for the conditions being treated; 4) Systematic Follow-up and Treatment Adjustment, in which providers use a population-based registry to proactively track treatment outcomes for all patients and adjust treatments as necessary to achieve established quality standards; 5) Communication and Care Coordination, in which all providers work collaboratively as a team using a shared care plan; 6) Population-focused Psychiatric Consultation, in which psychiatric specialists conduct regularly case reviews for patients who are not improving as expected and make suggestions for treatment adjustments or changes, 7) Program Oversight and Quality Improvement, in which clinic leadership regularly review provider-level and program-level outcomes and use this information to manage the program.

EXPLAIN THE ROLE OF FOUNDATION STAFF RELATIVE TO AIMS CENTER STAFF IN THE FOLLOWING PROCESSES:

A. SUBGRANTEE SELECTION

Foundation staff will lead the subgrantee recruitment and selection process, including making all final decisions about subgrantee selection. Foundation staff will have responsibility for advertising the funding opportunity, reviewing letters of intent to determine eligibility, inviting eligible organizations to submit a proposal, convening and coordinating the proposal review committee, conducting telephone interviews and in-person site visits, assisting applicants with identification of match sources, and notifying applicants of the results of the selection process. Foundation staff will assess the

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administrative capacity and organizational commitment for all potential subgrantees.

AIMS Center staff will assist the Foundation with advertising the funding opportunity throughout the five state WWAMI region by partnering with the University of Washington WWAMI Program office. AIMS Center staff will also review applications as part of the proposal review committee and provide advice and guidance to the Foundation on each applicant organization's readiness for model adoption and implementation and their capacity for sustaining the program at the end of funding.

B. TECHNICAL ASSISTANCE (TA)

Under Foundation contract, the AIMS Center will lead provision of training and TA regarding clinical model implementation to each individual organization and to all subgrantees collectively. JAHF and AIMS Center staff will jointly provide TA regarding organizational development, long-term financial sustainability for the program, and development of specific, detailed and realistic plans for matching funds.

C. EVALUATION

Under Foundation contract, the AIMS Center will lead evaluation activities, including development of analytic plans in collaboration with CNCS, data collection, data analysis and preparation of reports. The Foundation will have primary responsibility for communicating results of the evaluation with assistance from the AIMS Center.

D. PLAN FOR GROWTH IMPACT

As described above under TA, planning for further growth of the clinical model within subgrantee organizations will be the principal responsibility of Foundation staff with support from the AIMS

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Center, especially regarding billing for integrated care services and other topics where AIMS Center expertise is needed.

EXPLAIN THE FOLLOWING IN YOUR SUBGRANTEE SELECTION PLAN:

A. PROCESS IF A CONFLICT OF INTEREST IS IDENTIFIED

The subgrantee selection committee will include representatives of The Foundation, the AIMS Center and 3 independent expert reviewers. This is designed to insure a breadth of opinion regarding applications and will allow individual members of the selection committee to recuse themselves from the review process if they have a prior relationship with applicant organizations or the leadership at applicant organizations. If a conflict is identified with a member of the selection committee, that member will be excluded from discussions of that organization's application for funding and will not participate in determining whether or not that organization is selected as a subgrantee. Similarly, members of the selection committee will be instructed not to provide information, advice or other information to potential subgrantees so as to insure a level playing field for all applicants.

B. DIFFERENT STAGES OF REVIEW PROCESS AND WHAT EACH ENTAILS? HOW WILL DETERMINATIONS BE MADE REGARDING TELEPHONE INTERVIEWS AND SITE VISITS?

LETTER OF INTENT: Interested organizations will be encouraged to submit a letter of intent to the Foundation that states their interest in being considered for selection as a subgrantee and that documents evidence of their eligibility for participation. These eligibility requirements are: non-profit community primary care organization, located in a rural WWAMI county designated as either medically underserved or a health professional shortage area, serving at least 1,500 unique patients each year, and at least 50% of patient population is low-income uninsured or covered by Medicaid. Eligible organizations will be contacted by the Foundation and offered the opportunity to submit a full

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proposal.

FULL PROPOSAL: Interested and eligible organizations will submit an application for funding that documents their understanding, willingness and ability to participate in required activities as well as information about their organization's characteristics that will be used during the selection process. It will be made clear to applicants that funding is contingent upon adequate participation in required activities, including clinical implementation activities and organizational reporting and compliance activities. Full proposals will also include ten selection criteria. Applicants will be asked to describe the extent to which each of these ten criteria fit their organization.

TELEPHONE INTERVIEW: The purpose of the telephone interview is to allow the applicant organization to provide additional information to the selection committee about their capacity, willingness and appropriateness as a subgrantee. At least 3 members of the selection committee will conduct each telephone interview, including a representative of the Foundation, a representative of the AIMS Center and one of the three independent expert reviewers. Following each interview, this subgroup of the selection committee will discuss the application and re-score the proposal, as applicable, based on the outcome of the interview and will make a recommendation to the full selection committee regarding whether the organization should receive a site visit. The full committee will convene by conference call after all telephone interviews have been completed to determine the final list of organizations who will receive site visits.

SITE VISIT: The purpose of the site visit is to allow Foundation and AIMS Center staff the opportunity to visit potential subgrantees to see firsthand their clinical and administrative operations and to address any remaining questions about their capacity to participate in the program.

Organizations will be required to demonstrate the ability to provide data from their administrative systems that will be required for evaluation. They will also be encouraged to invite stakeholders, including organizations offering matching funds and/or community partners, to participate.

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Following each site visit, the selection committee representatives will summarize and score the site visit.

SELECTION: Information from all stages of the application process will be provided to the full selection committee which will convene by conference call to review it and make a final determination regarding which organizations will be selected as subgrantees. All subgrantee applicants will receive a summary of the evaluation of their proposal, including strengths and weaknesses, and a final determination regarding selection.

C. WHAT ARE THE CRITERIA FOR PHONE INTERVIEWS AND SITE VISITS?

Prior to receipt of applications, the selection committee will develop a review matrix and scoring system that will be used to evaluate each applicant's capacity to participate in required activities and their strength in each of the ten selection criteria categories. Members of the selection committee will review and score each application independently. These assessments will be combined into a summary evaluation for each applicant that retains the individual scores of each reviewer and also shows aggregate scores. The selection committee will meet via conference call to discuss applications and summary evaluations and determine which applications are deemed strong enough to warrant a telephone interview. Prior to the telephone interview, potential subgrantees will receive a summary of the selection committee's review of their proposal, including strengths, weaknesses and specific questions the reviewer's would like to address in the interview. The number of applicants selected for a telephone interview will be determined by the quality of the overall applicant pool. Only applications from organizations providing credible documentation of their ability and willingness to participate in all program activities and their appropriateness as a subgrantee will be invited to participate in a telephone interview.

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A scoring system will be used during the review of full proposals and these scores will determine who is invited to participate in a telephone interview. This score will be amended based on the outcome of the telephone interview and used to determine which potential subgrantees are invited to participate in a site visit.

Applicants will be selected for a site visit based on the outcome of the telephone interview; specifically, the adequacy with which they address the weaknesses and questions identified by the selection committee during the review of full proposals.

D. WHAT CRITERIA WILL BE USED TO ASSESS SUBGRANTEE CAPACITY FOR EVALUATION?

The majority of evaluation data will be collected in the online care management registry, which all sites will be required to use. This registry data will be supplemented by patient and provider surveys and clinical billing data. Capacity for evaluation will be determined at each stage of the review process to insure subgrantee ability to participate in evaluation activities. At the letter of intent stage, this will be determined by their ability to provide specific information about the number and type of patients they treat. At the proposal stage this will be determined by their response to required program activities and the ten selection criteria. Organizations that are unable to provide specific information from their existing record keeping systems (e.g. medical records, billing systems) will not be able to participate in evaluation. Site visits will require potential subgrantees to describe and demonstrate their ability to extract the information necessary for evaluation from their record keeping systems.

E. HOW WILL SUBGRANTEE AWARD AMOUNTS BE DETERMINED?

Award amounts will be determined based on patient volume, estimates (or data, if available) on prevalence of depression in the clinic's patient population, and the subgrantee's proposed budget for

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program implementation. Based on AIMS Center experience assisting a wide variety of organizations with implementation of collaborative care, subgrantee costs are expected to vary based on their organizational structure, the acuity of the patients they serve, their payer mix, prevailing wages for clinical staff and local workforce availability. This experience will be instrumental in evaluating the reasonableness of budget requests.

F. GIVEN THE HARTFORD FOUNDATION'S TRACK RECORD IN GRANTEE SELECTION, WHY WOULD THESE DUTIES BE MANAGED BY AIMS CENTER?

Foundation staff will lead the subgrantee selection process with assistance from the AIMS Center. It is correct that the Foundation has a stronger track record in selection of grantees. However, the AIMS Center has experience with the organizational characteristics and processes that affect successful implementation of IMPACT. The proposed partnership between the Foundation and AIMS Center in selection of subgrantees will increase the likelihood that organizations with both the organizational and clinical capacity to participate in the program will be selected.

CLINIC RECRUITMENT OF KEY PERSONNEL IS A MAJOR CONSIDERATION IN THE SELECTION PROCESS. WHAT IF SELECTED CLINICS HAVE DIFFICULTY HIRING QUALIFIED STAFF?

One of the strengths of the IMPACT model is its flexibility. The key components of the program can be adapted to suit the scope of practice for a range of clinical staff, including vocational nurses, registered nurses, clinical social workers, professional counselors, marriage and family therapists, clinical psychologists and (when paired with a one of the preceding professionals) medical assistants. The AIMS Center has seen successful implementations using each of these kinds of professionals in the care manager role and will work closely with subgrantees to adapt the program to fit their local

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environment, including their local workforce capacity. Similarly, psychiatric consultation can be provided by either a psychiatrist or a psychiatric nurse practitioner. Specialist consultation is typically provided by telephone, even in urban areas, to use the consultant's time as efficiently as possible and this is facilitated by use of the online care management registry that allows the care manager and consultant to review patient information in real time while talking on the telephone. The AIMS Center has supported several implementations in which the psychiatric consultant is physically located hundreds of miles away from the clinical delivery site. This ability to extend the reach and capacity of specialists to underserved areas is another strength of the IMPACT model.

EXPLAIN HOW THE AIMS CENTER WILL AID SUBGRANTEES IN GROWING THEIR PROGRAMS ON AN ONGOING BASIS.

The AIMS Center will work with subgrantees during regularly scheduled individual technical assistance calls to identify opportunities for spreading the program that fit each specific organization. Experience has taught the AIMS Center that it is important to tailor program expansion to the local capacity and opportunities of each organization, rather than trying to implement a pre-determined plan. Readiness for growing the program will be determined by how well the program is operating in the initial site(s). It is important for the program to be fully implemented and functioning well at the initial site(s) before considering expansion.

II. EVALUATION ISSUES FOR CLARIFICATION

THE APPLICATION SAYS THAT EVALUATION WILL FOCUS ON IMPLEMENTATION USING OBSERVATIONAL DESIGN BUT ALSO STATES THAT PRE-POST COMPARISONS AND OTHER QEDS THAT BUILD ON PREVIOUS RCT EVIDENCE WILL BE USED. PLEASE CLARIFY.

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More than 60 randomized controlled trials (RCT) have been conducted in the United States and Europe over the past 20 years to establish the effectiveness of the collaborative care model for depression which underlies the IMPACT program. This literature is well summarized in two sets of recent meta-analyses (one focusing on clinical outcomes and one focusing on economic outcomes) that were sponsored by the Centers for Disease Control and published in the American Journal of Preventive Medicine (67,68). The IMPACT study, an RCT conducted by the team at the AIMS Center, was the largest of these RCTs and its findings were consistent with the overall findings of the studies reviewed in the recent meta-analyses. Given the strong RCT evidence for collaborative depression care (e.g., the IMPACT model), we do not feel it necessary to use an RCT design to establish the effectiveness of the IMPACT program for this grant.

Instead, we propose an observational design that will track key clinical outcomes (e.g., depression severity), functional outcomes (family, social, and work functioning) and economic outcomes (e.g., workforce participation, household income) in patients served by the clinics implementing the IMPACT program as part of this initiative. We will compare these outcomes to national benchmarks established by IMPACT and other RCTs of collaborative care as well as more recent studies of implementations of such programs in real world health care systems (30,31,33,35,56,57).

We also plan to conduct comparisons in which we will compare clinical and health outcomes from a sample of patients before and after the participating clinics implement the IMPACT program. This will provide some ability to use participating sites as their own controls. We propose to collect such pre-post-implementation data on a minimum of 100 randomly selected patients seen at each grantee organization.

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In our proposed evaluation, we will use well established and validated outcome measures that were successfully used in the original IMPACT trial (27).

CLARIFY EVALUATION CRITERIA SUCH AS THE SELECTION OF CONTROL GROUPS, SAMPLING METHODOLOGY, AND DATA COLLECTION METHODS FOR SOME MEASURES.

A. CONTROL GROUPS:

Because we will not use an RCT design, there will not be a randomly assigned control group. We will compare clinical, functioning, and economic outcomes from patients in participating organizations before and after implementation of the IMPACT program. In this way, each participating clinical site will serve as its own control.

B. SAMPLING METHODS: We will use screening methods developed and tested in the original IMPACT trial (13) to identify a random sample of depressed adult patients seen at each of the participating clinic sites. These methods use a 2-item depression screener called the PHQ-2 (69) which has been extensively validated and is widely used in primary care. The screener will be administered to adults visiting the participating primary care clinics and patients who screen positive for depression will be administered the full PHQ-9 (70) to see if they meet criteria for clinically significant depression and would benefit from depression care management. Eligible patients will be asked to provide informed consent to participate in a survey (described below) at baseline and at 6-month follow-up.

C. DATA COLLECTION METHODS: We will use two primary methods of data collection:

CLINICAL TRACKING SYSTEM / REGISTRY DATA: In all participating clinics, depression care managers will track intervention activities (e.g., number of clients served, and for each client number of in-person and telephone contacts, visits with care managers, psychiatric consultations) as well as key clinical outcomes (e.g., depression severity as measured by the PHQ-9 and workforce participation) in real time using a well-established web-based electronic registry / tracking system that

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was originally developed for the IMPACT study. This system has also been used extensively by organizations implementing collaborative care programs based on IMPACT and is currently being used to track quality of care and health outcomes for over 25,000 patients. (71, 57, 35).

SURVEY DATA: We will also conduct surveys of a random sample of at least 100 participating subjects at each grantee organization at baseline and six-month follow-up. These surveys will be based on surveys that were successfully administered to over 1,800 participants in the original IMPACT and will contain validated and established measures of clinical and functional outcomes including questions about overall health, quality of life, depression severity (measured by the PHQ-9), workforce participation, health and income / household wealth.

We will compare the results of these surveys with clinical outcome measures collected by participating clinicians in the web-based registry (see above). Our experience with the original IMPACT study suggests that there is a high degree of correlation between these two sources of data / measurement (72) but the surveys will be able to provide more detailed information on such economic outcomes as health care utilization, costs, and workforce participation / productivity.

When possible, we will augment the above data on health care utilization obtained from patient surveys with clinic billing / claims data that capture the extent and cost of services provided to participating patients during a 12 month period after initiating the program. Because the availability of such claims data often varies from site to site, we will rely primarily on patient survey data which will be comparable across sites but we will augment these analyses with analyses of available practice claims and billing data.

We have detailed analytic methods for the data collected in the original proposal but would be happy

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to provide additional information about this as well.

THE APPLICATION PROVIDES TWO DIFFERENT APPROACHES FOR MEASURING HEALTH AND ECONOMIC OUTCOMES; FURTHER DESCRIBE THE RELATIONSHIP BETWEEN THE TWO.

Please see above for a more detailed description of the two primary approaches to measuring health and economic outcomes and their relationship.

III. BUDGET ISSUES FOR CLARIFICATION

THE BUDGET DOES NOT LIST PROJECT PERSONNEL EXPENSES, PERSONNEL FRINGE BENEFITS, TRAVEL, EQUIPMENT, AND SUPPLIES THAT ARE INCLUDED IN THE BUDGET JUSTIFICATION. PLEASE CLARIFY.

Given the Foundation's resources and capacity, and its intention to maximize the funds available for subgrantee distribution, and thus the number of individuals served, the Foundation will contribute as an additional in-kind the staff time, personnel fringe benefits, and staff travel as detailed in the budget justification. The Foundation has allocated 1.6 FTE in total staff time, and will recruit a grants management specialist to support the program's administrative requirements. The Foundation has also allocated resources from its administrative budget to cover staff travel for subgrantee selection, subgrantee site visits, mandatory training sessions with CNCS, and conferences and meetings to support this SIF initiative. Our budget for supplies for training and technical assistance is itemized under the contractual and consultant services line item. Further details on the budget are given below.

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THE APPLICATION LISTS THE AIMS CENTER PARTICIPATING IN AND/OR MANAGING SUBGRANTEE SELECTION, TECHNICAL ASSISTANCE, EVALUATION AND PLAN FOR GROWTH IMPACT. A NUMBER OF STAFF ARE LISTED AT LESS THAN AN FTE. EXPLAIN HOW THESE VERY ARDUOUS TASKS WILL BE MANAGED FOR 5 TO 8 SUBGRANTEES WITH LESS THAN AN FTE.

The AIMS Center staffing plan is informed by nearly 9 years of experience training over 5,000 people and helping over 600 sites in 31 US states implement collaborative care. They have supported individual organizations of all sizes and large-scale multi-organization initiatives involving over 100 participating sites. They have supported implementations in urban, suburban, rural and frontier areas and with patient populations that run the gamut from well-educated, middle class, insured to low-income, illiterate, and uninsured. Similarly, they have encountered organizations at every stage of readiness for practice change and with a wide range of management styles. This breadth of experience has given them a well-developed understanding of: 1) the amount of effort it requires from them and from implementing organizations to be successful, 2) the organizational characteristics that serve as barriers and facilitators to practice change, and 3) the most efficient and effective ways to work with implementing organizations.

The AIMS Center maintains a pool of consultants who supplement the core staff at the University of Washington. These consultants are experts in various components of collaborative care (e.g. care management, billing and reimbursement strategies, program evaluation) and allow the AIMS Center to flex their staffing as needed to support multiple simultaneous implementations and many concurrent training, technical assistance and program evaluation activities. AIMS Center staffing for technical assistance activities (e.g. site selection, training, pre- and post-launch assistance) includes 1.52 FTE at the University of Washington and 160 hours of consultant time (0.08 FTE). Staffing for

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evaluation activities includes 0.58 FTE at the University of Washington plus 160 hours of consultant time (0.08 FTE) and \$80,000 to collect survey data that will supplement the data available in the online care management tracking system. The original IMPACT study used computer assisted surveys administered in person or by telephone to collect survey data from patients and providers and a similar survey method will be used for this project. AIMS Center staff will focus their effort on design of the survey instruments and methods as well as analysis of the data.

In addition to staffing and consultant resources from the AIMS Center, the Foundation has allocated 0.8 FTE for a Grants Management Specialist to provide administrative support to this program. Additional Foundation staff time includes 0.4 FTE from the Program Officer, 0.05 FTE each from the Program Director and Executive Director, 0.10 FTE from the Grants Manager, 0.15 FTE from the Grants and Evaluations Coordinator, and 0.05 FTE from the Finance Director. All of this effort (1.6 FTE) will be provided as an in-kind contribution from the Foundation's administrative budget to maximize the resources available to subgrantees. These staff resources were allocated based on our experience managing grants to spread IMPACT and the advice of federal grants management experts and prior year SIF awardees.

Combined Foundation and AIMS Center staffing totals 3.86 FTE (1.6 FTE from JAHF, 1.6 FTE from UW for technical assistance, and 0.66 FTE from UW for evaluation) and additional time for survey data collection that will either be performed via contract by a professional survey research group or by AIMS center staff designated for this purpose. We are confident these staffing resources will ensure the success of the SIF initiative.

REQUIRED CRIMINAL HISTORY CHECKS DO NOT APPEAR ON THE BUDGET.

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In order to maximize the funds available for subgrantee distribution and, thus, the number of patients served by this initiative, the cost to conduct criminal history checks will be made as an in-kind contribution from the Foundation's administrative budget. Based on our prior experience, we estimate a cost of \$75 per person. Criminal history checks will be conducted for 7 Foundation staff, 5 AIMS Center staff, and subgrantee staff.

COSTS FOR TRAVELING TO CNCS FOR MANDATORY TRAININGS ARE NOT INCLUDED.

As described above, travel to CNCS for mandatory trainings will be contributed by the Foundation as an administrative budget item.

ITEMIZE COSTS UNDER THE CONTRACTUAL AND CONSULTANT SERVICES LINE ITEM (TECHNICAL ASSISTANCE AND EVALUATION COSTS).

Technical assistance and evaluation costs are now listed on the contractual and consultant services line items on the budget.

EXPLAIN THE DESIGNATION OF FOUNDATION AND AIMS CENTER STAFF TIME BETWEEN PROGRAM, TECHNICAL ASSISTANCE, AND EVALUATION DUTIES.

The Foundation and the AIMS Center have a long-standing relationship upon which the proposed program is built. They successfully collaborated on the IMPACT research trial, with the Foundation serving as the primary funder and Dr. Unutzer as the Principal Investigator. Based on this success the Foundation provided seed money to launch the IMPACT Implementation Center, which became the AIMS Center. Most recently, the two organizations hosted a national summit on collaborative care in which thought leaders and stakeholders from public and private organizations convened to create a national roadmap for furthering dissemination.

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Division of responsibility for key program activities between the Foundation and AIMS Center is designed to play to the strengths of each organization. Each key area will be led by either the Foundation or the AIMS Center with considerable input from the other partner. Foundation staff will take the lead on programmatic activities (including subgrantee selection, compliance with program requirements, and planning for growth impact) allowing them to utilize their considerable expertise as a grantmaker to insure the success of these areas. AIMS Center staff will take the lead on technical assistance and evaluation, allowing them to focus on the activities that best suit their expertise.

HOW WILL AIMS CENTER PARTICIPATION IN THE RECENTLY ANNOUNCED CMS INNOVATION PROJECT AFFECT THEIR ABILITY TO PARTICIPATE IN THIS PROJECT?

As described above in #8, the AIMS Center is comprised of faculty and staff based at the University of Washington who are supplemented by an existing network of training, technical assistance and evaluation consultants. This has allowed the AIMS Center to successfully support a large number of implementing organizations in an efficient and effective manner.

Since submitting this proposal for consideration, the AIMS Center added a full-time faculty member (Dr. Marc Avery) to their core team based at UW. Dr. Avery is a seasoned community psychiatrist with over 20 years of clinical experience in consultation-liaison psychiatry and more than 4 years of experience as a consulting psychiatrist to rural community health centers. He will expand Dr. Unutzer's capacity by taking over many of his responsibilities for supporting existing collaborative care programs supported by the AIMS Center. Upon learning of the CMS Innovation award, the AIMS Center began the process of hiring a new full-time staff member to expand their project management capacity. Additionally, within the past year, the AIMS Center has expanded their pool of

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experienced training and technical assistance consultants to insure that they have the staffing they need to meet their commitments. We feel confident that the AIMS Center is fully capable of participating fully in this project if awarded.

REFERENCES

Numbers through 66 correspond to the original application. Additional references provided here.

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70. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med.* 2001;16(9):606-13.

71. Unützer J, et al. A web-based data management system to improve care for depression in a multicenter clinical trial. *Psychiatr Serv.* 2002;53(6):671-3, 8.

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Continuation Changes

N/A

Required Documents

Document Name

Status

Match Verification

Sent