



PHASE II: INTEGRATED BEHAVIORAL HEALTH DEVELOPMENT GRANT REQUEST FOR PROPOSAL

I. INTRODUCTION AND BACKGROUND

Launched in March 2006 by The Tides Center and funded by The California Endowment, the Integrated Behavior Health Project (IBHP) seeks to increase and improve the integration of behavioral health services in community clinics statewide. Early on, IBHP engaged in an extensive program development process, identifying core integrated behavioral health program elements, strategies and treatment approaches utilized by community clinics, public mental health agencies and clinic consortia. Meetings with key stakeholders within the primary care and mental health fields were also conducted to lay the groundwork for a multi-year initiative.

In March 2007, IBHP ushered in the demonstration phase (Phase I) of its initiative by awarding one year grants to a select group of primary care clinics and clinic consortia. Grantee organizations were chosen based on their involvement with integrated behavioral care, either through provision of direct services or through their advocacy and policy work. Diversity in geographic locations and client populations was also considered in the selection, as was ensuring that a range of models was represented. The information collected during this phase will be used to accelerate and elevate promising integrated behavioral health care practices in primary care settings throughout California. For the next phase, IBHP is pleased to announce the Integrated Behavioral Health Development Grants Program to support and strengthen behavioral health integration efforts underway at community clinics and consortia.

II. OVERVIEW OF INTEGRATED BEHAVIORAL HEALTH CARE

The Hogg Foundation for Mental Health describes integrated behavioral care this way:

“In this team-based model, medical and mental health providers partner to facilitate the detection, treatment, and follow-up of psychiatric disorders in the primary care setting. It is an appropriate model for treating mild to moderate psychiatric disorders and for maintaining the treatment of severe psychiatric disorders (e.g., bipolar disorder, schizophrenia) that have been stabilized.”

Though this definition confines service delivery to primary care settings, the IBHP takes a broader view. The important distinction is not where the services are delivered, but *how they are delivered*. There must be close coordination and collaboration between behavioral health and medical service providers that supports a seamless continuum of care for the client.

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Alexander Blount, a national expert in this field, put it this way: *Integrated primary care is a service that combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to their primary medical care providers. It allows patients to feel that, for almost any problem, they have come to the right place.*

Barbara Mauer, in the background paper prepared for the National Council for Community Behavioral Healthcare entitled "Behavioral Health/Primary Care Integration Models, Competencies and Infrastructure" (May 2003), laid out reasons why states, county systems, and primary care clinics should undertake integrated care:

- It is the right thing to do.
- Many people in the broader community now receive their behavioral healthcare in a primary care setting, and the gap between medical and behavioral healthcare systems must be bridged.
- There is the opportunity for quality improvement of care within the primary care and specialty behavioral healthcare settings.
- Many people being served by public behavioral health services need better access to primary care.
- Community health centers serve people who need better access to behavioral healthcare.
- Behavioral health clinicians are a resource for assisting people with all types of chronic health conditions.
- There are changes underway in the financing of both healthcare and behavioral healthcare systems.

Additional reasons that underscore the benefits of integrated behavioral health cited in her document include:

- One-half of the individuals who receive mental health care seek services from a primary care or a family practice physician.
- Psychosocial stress is a major factor in triggering physical illness and exacerbating existing chronic illnesses.
- Many individuals seeking medical services report symptoms that may be psychosomatic, i.e., physical complaints without an identifiable medical basis. In these instances, an underlying behavioral or emotional condition can increase unnecessary medical utilization, and the client is often not referred to appropriate treatment.
- Many primary care physicians – faced with increased administrative demands and time constraints – are ill-equipped to manage patients who present with mental health or substance abuse related issues.

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- Sub-clinical and clinical depression is frequently misdiagnosed or under-diagnosed in general medical populations.
- Substance abuse problems often go unrecognized but trigger or exacerbate conditions such as accident-related injuries, gastritis, diabetes and hypertension, liver abnormalities and cardiac problems.
- Depression is a frequent complication of cancer, post-cardiac surgery, diabetes, post-partum, and in the treatment of any chronic and debilitating physical illness.
- Emotional factors are thought to play a role in triggering asthma attacks and exacerbations of autoimmune diseases (lupus, sarcoidosis, multiple sclerosis).
- Depression and substance abuse screening and referral are essential components in a primary care setting. However, medical staff has little time or expertise available to perform these functions.
- Group-oriented behavioral interventions have been found useful in addressing emotional factors in chronic and acute disease, improving adherence to medical regimens.

III. DIMENSIONS OF INTEGRATION:

Kirk Strosahl, Ph.D., in a 2007 presentation at the Collaborative Family Healthcare Association conference, delineated the dimensions of integration:

- Mission Integration – The extent to which the behavioral and general medical service systems are pointing toward the same health objectives, goals and strategies.
- Clinical Service Integration – The degree to which general medical and behavioral providers seamlessly engage in coordinated assessment, intervention, and follow-up activities
- Physical Integration – The degree to which the general medical and behavioral health providers work in the same space, allowing for instantaneous access to care.
- Operations Integration – The degree to which the general medical and behavioral health providers work off the same clinic “platform”.
- Information Integration – The degree to which the general medical and behavioral health provider can access real time client care information.
- Financial Integration – The degree to which general medical and behavioral health services are funded as a “basic” form of health care.

In an unpublished paper titled *Conceptualizing and Measuring Dimensions of Integration in Service Models Delivering Mental Health Care to Primary Care*

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Patients by Miles, K., Linkins, K., et al.,¹ the authors identified a continuum of variations by degree of integration with respect to the following five dimensions:

- Physical Proximity -- physical proximity of primary care providers and mental health counselors.
- Temporal Proximity (Timing) – the degree of delay or time separation between the delivery of primary care services and scheduling of mental health services.
- Communication – primary care and mental health clinicians share information about patient diagnosis and treatment.
- Mental Health Expertise and Services Available -- Models of care delivery which are more highly integrated with respect to MH expertise make it less necessary to refer patients to other mental health.
- Stigma -- where mental health care is provided in a setting not explicitly recognized as a mental health setting, such as a primary care clinic, there may be less stigma associated with receiving services.

IBHP endeavors to assist primary care clinics and consortia in moving forward along these diverse dimensions to achieve fully coordinated care for their clients.

IV. IBHP GOALS AND PRINCIPLES

IBHP's goals are threefold: (a) to improve access to behavioral health treatment services, especially for underserved populations; (b) to reduce the stigma associated with seeking such services; and (c) to improve treatment outcomes. IBHP believes that these goals can be best achieved through a cohesive, collaborative relationship between behavioral health and primary care providers sharing not only the same sites, systems and strategies, but the same vision as well.

V. GRANT COMPONENTS

Phase I of IBHP's granting process (the demonstration phase just concluded) concentrated on collecting data to better inform organizers about the current state of integrated behavioral health in California, to consider future directions, and to pilot and begin to establish a data collection infrastructure. Phase II, the focus of this RFP, will continue select data collection activities, and in addition will focus on:

- A. Expanding the *Learning Community* of providers, including training for participants, and establishing mentoring and consultation linkages for sharing integration strategies and promising practices for new sites;

¹Miles, K., Linkins, K., Chen, H., Zubritsky, C., Kirchner, J., Coakley, E., Quijano, L., & Bartels, S.

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- B.** Advocating for policy and system changes to reduce barriers inhibiting integration efforts, and to gain support for the basic tenets of integrated care; and
- C.** Fostering innovative projects at the clinics and consortia to meet specified grant objectives.

IBHP encourages the participation of clinics and consortium at all levels of integrated care, from those experienced to relatively novice. Regardless of where a clinic or consortia falls along the integration continuum, grant applicants must *participate in all three components A,B, and C*. Each new Phase II focus is explained below:

A. Learning Community

IBHP is interested in developing and evaluating a formal “mentoring” process as part of the learning dissemination strategies of the initiative. To do so, IBHP will tap into the expertise of Phase I grantees that participated in the demonstration phase and were chosen because of their comparatively advanced level of integrated care. Some Phase I clinic and consortia professional and administrative staff will be funded through this RFP by IBHP to act as mentors to new grantees (those selected from current applicants).

The goals of the mentoring component will be to build networks and relationships between providers, coordinate and support ongoing communication, and to share effective strategies and problem solving aimed at improving the overall quality of integrated programs. Mentoring activities may include: (a) developing with IBHP documents that will be used to convey the core principles of an integrated behavioral health model to new grantees; (b) sharing expertise and responding to questions from new grantees and others in the field attempting to develop an integrated program; (c) participating in professional development opportunities, trainings and in-services; (d) sharing written protocols and other integrated behavioral health operational and/or clinical documents with participants; (e) documenting the mentoring process and knowledge transfer activities, and (f) participating in the evaluation of the mentoring process as developed by IBHP and its consultants during the grant period.

New grantees will be expected to utilize this valuable resource in advancing integrated care at their site(s), and will also be responsible for participating in the mentoring evaluation activities. IBHP will continue to offer training via convenings and webcasts focusing on various facets of integrated care and will nurture the Learning Community established in Phase I of the granting process. All grantees will be expected to participate in these training opportunities.

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B. Advocacy

IBHP will continue to advance the concept and practice of integrated care at the State and local level, working in collaboration with clinic organizations and government agencies. IBHP looks to grantees to further integrated care within their operations and within their communities. To that end, IBHP is interested in tracking grantee participation in local transformational processes underway within their community as a result of Mental Health Services Act (MHSA) funding, and in other integrated behavioral health activities and forums aimed at improving collaboration at local and regional levels. IBHP also would like to work with grantees in identifying ways to engage their clinic leadership (i.e. Chief Medical Officer, CEO's) as advocates for the integrated behavioral health model. These topics will be addressed as part of the Learning Community activities and processes for tracking changes will accordingly be determined.

C. Innovative Projects to Meet Grant Objectives

The final component of this RFP, Phase II, will establish a grants program that will focus on clinics and consortia across the spectrum of behavioral and primary care services integration, supporting efforts to accelerate integrated care, deepen their work in selected areas, and establish promising evidence-based best practices. The program will promote new/emerging behavioral health projects within clinics and consortia that will elevate behavioral health services to higher levels of integration and client care.

As part of this component, applicants must propose a project to address one of the following objectives, and must apply a portion of the grant funds to documenting the attainment of the objective(s) and collecting the data used to evaluate the results:

1. Expanding intra-clinic collaboration between primary care and behavioral service providers;
2. Increasing positive treatment outcomes;
3. Maximizing client engagement;
4. Advancing cross-system collaboration;
5. Enhancing the integration of primary care clinic-based substance abuse programs with primary care and behavioral health services;
6. Broadening the provision of medical services for clients with serious mental health problems; and
7. Developing a Prevention and Early Intervention (PEI) prototype, suitable for replication at other clinics, and defining a strategy for implementation that is consistent with the Mental Health Services Act (MHSA) guidelines and local mental health agency MHSA planning activities.

The following are examples of possible strategies to achieve these objectives. They are offered as guidance only; applicants can build on the examples in their application, or can choose other directions for their proposed project.

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1. Expanding intra-clinic collaboration

Possible examples of project strategies to achieve this objective could include increasing cross-training between health and behavioral health staff; increasing the frequency of and/or time allotted for team client care conferencing; heightening marketing of behavioral care services to primary care providers; integrating records; facilitating provider access to behavioral consultants; and enhancing the capacity of the behavioral program to address behavioral aspects of physical illnesses.

Outcome measures might include the rate of provider referrals to behavioral health services; provider satisfaction with behavioral services; and length of time to access behavioral consultants.

2. Increasing positive treatment outcomes

Among possible project strategies are enhancing psychiatric support (whether in-person or via telepsychiatry); initiating or augmenting client care management; following evidence-based stepped care follow-up procedures (contacting behavioral health clients at regularly scheduled intervals to assess their response to the treatment offered and adjusting medication levels and/or modifying or changing treatment approaches if the client hasn't shown the expected improvement within a prescribed period of time); systematic measures of clients' response to treatment; using evidence-based treatment algorithms; and implementing evidence-based treatment approaches.

Outcome measures could include those used during Phase I of the granting process: the Duke Health Profile, the PHQ-9 for depression, a client satisfaction survey; or instruments that measure overall quality of life or track other physical or behavior health status.

3. Maximizing client access and engagement

Projects designed to maximize client involvement and participation in treatment and recovery might include modifying scheduling practices to minimize client wait time, both for appointments and for service upon arriving for appointments; offering assistance to clients in accessing community resources like benefits, jobs and housing; following up with "no-show" clients to ascertain and, if indicated, address reasons for their failure to participate; finding ways to minimize stigma associated with behavioral health services within the clinic; involving clients in the overall care delivery system (e.g., hiring or contracting with clients to serve as peer counselors, peer behavioral specialists, care managers, or peer outreach workers); and instituting a process for identifying high-risk clients.

Outcome measures may include an increase in the number of behavioral clients served; reductions in no-show ratios; reduction of length of time between referral and initial behavioral service; behavioral client attrition rate; amount and array of

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community resources to which clients are linked; and the number of clients involved in operational aspects of the clinic.

4. Advancing cross-system collaboration

This project strategy, appropriate for individual clinics and clinic consortia, is to move community systems towards integration. IBHP is interested in regional systems transformation activities that could include planning for better integration of primary care and behavioral health services across public and private systems, the implementation of activities that were recommended in a completed regional plan or analysis of the costs and benefits of improved regional integration. Specific projects may involve planning discussions with mental health, social service, substance abuse, and primary care agencies culminating in a specific plan for care coordination. A transformational systems project could include the development of memoranda of understanding for referring primary care clients to specialty mental health facilities and one for referring specialty mental health clients to primary care clinics or the implementation of memoranda of understanding or contractual arrangements at the operational level. The transformational projects could also include planning and execution of cross-training of mental health, primary care, substance abuse and social service clinical and program staff about the requirements, functions and client service approaches of each involved organization. Cross-system projects may also be directed at demonstrating costs and potential systems cost-savings achieved through integrated behavioral health models and/or through care coordination plans. A planning project could design the elements of a pay-for-performance pilot to document cost effectiveness of incorporating a behavioral health care model into primary care clinics and potential savings to the State Medi-Cal Program.

Outcome instruments could include measuring the volume, promptness, and ease of inter-agency referrals; evaluation of cost analyses, including the pay-for-performance analysis; satisfaction levels of clients of the respective agencies with the established arrangement; and satisfaction levels of agency service providers with the established arrangement based on a pre-and post knowledge survey.

5. Enhancing substance abuse services integration

Given the high frequency of co-occurring substance abuse and behavioral disorders, as well as substance abuse and physical disorders, collaboration among service providers is paramount. Strategies to achieve integration of substance abuse programs could include assessing the competency, attitudes and substance abuse knowledge of medical and behavioral health providers and developing a plan of action to address gaps; adding screening questions that deal with drug and alcohol use on intake forms, and establishing a clear referral and treatment pathway for those that screen positive; increasing cross-training between health and substance abuse services staff and/or time allotted for inter-

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departmental client care conferencing; and facilitating provider access to substance abuse consultants.

Outcome measures might include changes in attitudes, knowledge and behavior among primary and behavioral staff participating in training and conferencing; provider referral rates to substance abuse services; provider satisfaction with substance services; length of time to access behavioral health consultants; client satisfaction with substance abuse services; and treatment outcome measures tailored to drug and alcohol use.

6. Broadening medical services for clients with serious mental health problems

Recently published studies asserting that persons with serious mental illnesses in the United States can now expect to live an average of 25 years less than the general population have underscored the pressing need to ensure that this vulnerable population receives adequate medical care. Strategies to achieve this objective may include engaging specialty mental health clients in promoting the utilization of medical services among their peers; conducting group training and/or discussion groups among this population focusing on health lifestyle improvement, such as diet and smoking cessation; providing mental health clients with self-management skills to recognize and deal with chronic medical conditions; and offering training and consultation to mental health professionals, community mental health organizations and client groups about the detection and treatment of common co-occurring medical conditions like diabetes and COPD.

Outcome measures may include rates of hospitalizations of persons with serious mental illness before and after the project is underway; rate of emergency visits by clients; lifestyle changes in participating clients (e.g., smoking cessation, weight control, changes in exercise habits); and, demonstrated level of medical health understanding among participating clients, professionals and community members.

7. Developing PEI models of service delivery

The Mental Health Service Act (MHSA) Plan provides for funding for mental health prevention and early intervention (PEI) services. Although the State Department of Mental Health has summarized national programs that may serve as models, few primary care clinic models have emerged at the local level. IBHP is interested in funding projects that result in replicable PEI models or that identify integrated behavioral health care practices in primary care clinics upon which prevention/early intervention models and prototypes can be built. PEI projects could be proposed by clinics and/or consortia on behalf of their members and could include developing an integrated primary care / behavioral health school based clinic model; adding behavioral health screening questions on clinic health intake forms and/or administering evidence-based instruments like the PHQ-9 at intake, and creating clear treatment paths and approaches for those

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who register positive scores. These projects must include a PEI program design consistent with PEI guidelines and detail all the elements needed to implement a PEI project at a community clinic, including evidence-based intervention, expected patient outcomes, data to be collected and tracked, required staffing and budget.

Outcome measures might include written materials, training and technical assistance needed to implement models; identification of potential systems savings to be achieved through implementation of models and dissemination of model results; number of potential screenings, persons identified as needing behavioral health services and percent of those persons who would receive prompt treatment in the proposed PEI model; and assessment of clinic policies and procedures that specifically address prevention and early intervention.

VI. EVALUATION EXPECTATIONS FOR INNOVATIVE PROJECTS

Because IBHP wishes to advance the field and develop evidence-based best practices, it is important that clinics and consortia select a project that either has not been undertaken by them to date; *or*, that will move their current practices into a new direction consistent with best practice approaches in behavioral health care. Applicants must be able to explain how obtaining this funding will propel their practices to a higher level of behavioral health integration. IBHP may conduct site visits or telephone interviews during the funding decision period as part of its due diligence in validating the applicant's current developmental level.

Applicants should exercise imagination within the limits of feasibility to develop a workable plan to initiate and execute the project they've chosen, mindful of the full range of grant deliverables and expectations. Applicants will be selected in part on the basis of their proposed project's (a) potential to reach its objective, as well as the project's practicality; (b) sustainability; (c) evidence-backed substantiation of its approach; (d) relative need; (e) ability to produce quantifiable results; (f) replication potential to other similarly-situated clinics or consortia throughout California; (g) innovation; and (h) contribution to the project diversity of the initiative.

Because IBHP wishes to expand and elevate best practices that approach evidence-based assessment rigor, and because clinics benefit from feedback about utility of their practices, Phase II grantees will be responsible for selecting outcome measures for their project that gauge impact. Instruments can be either self-constructed (e.g., agency developed survey or assessment tool) or already in the public domain or proprietary.

Based on their proposed project, grantees will be required to identify baseline data for comparison with anticipated results. A preliminary assessment plan is required as part of the Phase II application. Finalization of design and methods will be determined upon discussions with evaluation consultants provided by IBHP. Since the type of baseline data required will be contingent on the specific

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project proposed, IBHP consultants will work with grantees to tailor their methodology to their project. It is also anticipated that consortia applicants' approaches to baseline data may be different from clinics.

VII. GRANT APPLICATION REQUIREMENTS

After examining its own operations, needs, motivation and readiness, interested applicants should choose one project to address one of the seven broadly described objectives. To be considered for a grant, clinics and consortia must respond to the following guidelines. Please use 12 point type and single space your responses.

1. Complete, as accurately as possible, the Integration Level Survey included with these funding guidelines. Applicants should be mindful that IBHP seeks to award grants to primary care clinics and consortia falling all along the integration continuum, providing that applicants meet the minimum threshold criteria (see VIII. Applicant Qualifications Section). Thus, there are no "correct" or desired responses.
2. Describe in a maximum of four type-written pages:
 - a. a brief overview of your community and the patient population that your clinic or consortia serves;
 - b. the current status of IBH within your organization and the proposed project, including the goals and the specific objectives to be achieved as a result of the project;
 - c. the activities that will enable you to reach the objectives;
 - d. how the project is unique or different from the work the applicant is currently doing in this area;
 - e. how the clinic's/consortia progress toward these objectives will be measured; what parameters will be used; how baseline and project outcome data will be collected and tabulated; and what measurement instruments or source will be used;
 - f. how the project will be carried out; what the projected timelines will be for all phases of implementation; who, by name, title, and background (if known), will be involved, including the project leader with responsibility for implementation, data collection and reporting; and
 - g. how the project could be sustained at the conclusion of the granting period.
3. Complete the budget form at the last page of the IBHP cover sheet. If matching funding is being provided, please identify the source and amount.
4. Submit your most recently filed UDS or OSHPD report.
5. Include the signed Proposal Cover Sheet. The signature of the clinic CEO / Executive Director and Chief Medical Officer/ Medical Director is required

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to ensure that the clinic meets all the applicant criteria specified in Section VIII. For consortia, a signature of CEO/Executive Director of participating consortia member-clinics is required. If the consortia applicant is proposing a clinical project, the signature of the CMO/ Medical Directors should also be obtained.

VIII. APPLICANT QUALIFICATIONS

A. Primary Care Clinics:

To qualify for a Phase II grant under this RFP, primary care clinical operations must have, at a minimum, the following:

1. Behavioral health services (sometimes referred to as mental health services) are currently staffed by qualified personnel with behavioral health-related experience and appropriate professional discipline backgrounds, including any of the following: psychiatrists, psychologists, LCSW's, psychiatric nurses and/or MFT's. Behavioral health personnel must perform clinical assessments, provide therapeutic interventions and monitor their clients' treatment progress;
2. Co-located primary care and behavioral health services in close proximity within the clinic site(s);
3. A data collection system potentially capable of tracking client contacts and clinical outcomes;
4. A systematic and time-limited approach to behavioral therapy and intervention that meets professional standards of care;
5. The demonstrated organizational capacity and infrastructure needed to participate in required data collection/evaluation tasks, program-related activities, Learning Community convenings, and other grant requirements;
6. A demonstrated commitment to the principles of integration by the agency's leadership and a willingness on the part of leadership to advance the integrated care beyond the internal practices of their own organization;
7. A CEO and CMO with willingness to lead transformational projects that enhance service effectiveness and improve client outcomes;
8. A history of providing culturally competent services to underserved communities and a clientele that reflects the diversity of California's ethnic populations;
9. A willingness to work with IBHP staff and evaluators in assessing operational processes and outcomes and to allow access to facilities, personnel and written materials that inform the evaluation effort;
10. Good standing and compliance with applicable licensing, certification and other local, state and federal governmental requirements;
11. For previous IBHP grantees, demonstrated compliance with all IBHP previous requirements for participation; and

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12. Clinic corporations must provide comprehensive primary care services; family planning clinics, school based clinics, and American Indian Health Centers are eligible to apply. Clinics must also meet the following eligibility criteria:
 - a. Licensed by the State of California as a community clinic or tribally-designated clinic;
 - b. Provide direct medical care to underserved populations;
 - c. Free standing and community based;
 - d. Non-profit, 501(c)(3) or a tribally chartered/sanctioned organization; and
 - e. Provides services regardless of ability to pay

B. Consortia:

To qualify for a Phase II grant, consortia operations must have, at a minimum, the following (please note that consortia led transformational projects may be exempt from some of the data collection requirements expected of clinics):

1. Demonstrated history of partnership with county health systems to deliver effective primary care services to the uninsured/underserved;
2. Established history of leadership in integrative behavioral health among consortium members;
3. Proposed or current partnership with county department of behavioral/mental health, (or multiple counties, including CMSP) to design and/or execute a new system or model of integrated primary care and mental health services that includes a consortia led a) uniform standard of care; b) data collection; c) quality improvement process; d) training; or e) evaluation of cost/benefit of integrated model;
4. Ability to lead case study processes documenting the development, challenges, successes and outcomes of new integrated system/model that will demonstrate potential replicability to other regions of the state;
5. Demonstrated organizational capacity and infrastructure needed to participate in required data collection/evaluation tasks, program-related activities, participation in the project convenings and other demonstration grant requirements;
6. Demonstrated commitment to the principles of integration by the organization's leadership, as exemplified by a willingness to advance the integrated care beyond the internal practices of their own regional consortium;
7. Demonstrated experience in leading and implementing change/transformation processes on a system/countywide basis;
8. Representation of and advocacy for diversity of populations and cultural competency within participating primary care sites;

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9. Agreement to work with IBHP staff and evaluators in assessing operational process and outcomes, and agreement to allow access to the participating member sites, personnel and written materials;
10. Pre-existing memoranda of understanding with the participating member organizations;
11. For previous IBHP grantees, demonstrated compliance with all IBHP previous participation requirements; and
12. Consortia eligible to receive grants must have at least 80% of their membership consisting of community clinics or demonstrate that they have been designated by a network of community clinics to act on their behalf in a management capacity.

IX. GRANT DELIVERABLES AND PARTICIPANT EXPECTATIONS

1. Clinic and/or administrative staff participation in behavioral integration-related training at least semi-annually and in monthly conference calls as part of the IBHP Learning Community activities.
2. Clinic and/or administrative staff participation as advisors to the IBHP team on policies, procedures, protocols, problems and outcomes related to establishing and maintaining integrated primary care behavioral care programs.
3. Participation in the mentoring activities -- experienced IBHP Phase I grantee personnel will serve in a mentoring capacity that will offer free training and consultation to new grantees who will avail themselves of the same as part of this funding.
4. Collection of comparative and/or baseline data to be used to gauge the impact of the project, as mutually agreed upon by the grantee and IBHP. The type of baseline data to be collected will be dictated by the specific project(s) chosen. IBHP consultant staff will assist in the direction, collection and analysis of the data. While IBHP hopes that projects will produce successful results, successes as well as failures are useful in informing future courses of action.
5. At specified intervals during the grant period, IBHP may institute universal outcome measures, screening instruments, and/or surveys to track treatment effectiveness for behavioral health care clients, and all grantees will be expected to participate. Data collected will be submitted to IBHP for compilation, analysis and feedback. Appropriate confidentiality provisions will be adhered to and stipulated in grant award contracts.
6. Cooperation with periodic IBHP surveys of primary care providers, behavioral staff, and administrators regarding the integrated behavioral program, cultural competence, and integration levels.
7. Designation of staff person who will assume responsibility for facets of the grant, including project implementation, data collection and reporting,

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liaison to staff within the agency, and participation in required IBHP meetings.

X. TECHNICAL SUPPORT:

A consulting firm has been engaged to assist grantees in meeting the data sharing requirements, which may include the compilation of demographic, service and survey data in addition to IBPH customized and pilot instruments. A customized evaluation plan will be developed for each site. Telephone and on-site consultation will be provided throughout the demonstration period. Grantees, in consultation with the evaluation consultants, will manage the compilation of baseline and new data, and customized and standardized survey instruments based on agreed upon timeframes. Grantees are also responsible for providing data in a format prescribed by the evaluation consultants.

XI. APPLICATION PROCESS:

Proposal narrative and all supporting documents must be submitted to IBHP by e-mail at ibhp@tides.org no later than **WEDNESDAY June 25, 2008 at 5:00 p.m.** Failure to submit by the required deadline could result in the applicant's elimination as a potential recipient. IBHP will notify applicants of grant awards by August 11, 2008. Grant award amounts will range up to \$75,000. Grant periods will be September 1, 2008 to August 31, 2009. Funding will be disbursed in three installments: one-half at initiation; one quarter at midpoint and the final quarter upon completion of all required grant deliverables.

XII. GRANT REPORTING REQUIREMENTS:

Each applicant will be required to submit a mid-term and final narrative progress report detailing successes and challenges of grant implementation. Guidelines will be forthcoming. In addition, each applicant will be required to submit a financial expenditure report at the close of the grant reflecting the expenditure of funds as proposed in the approved budget.

XIII. GRANT-MAKING TIMELINE:

June 3, 2008	Release of Application
June 25, 2008 by 5:00 PM	Deadline for Submission of Applicant Information. They must be submitted electronically to ibhp@tides.org
August 11, 2008	Agency notifications by IBHP Team
September 1, 2008	Implementation of Grants
September 11/12, 2008	Mandatory Learning Community Meeting (Location to be determined)
August 31, 2009	End of Demonstration Grant Period

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XIV. OVERALL PROJECT EVALUATION:

The California Endowment has commissioned a global, initiative-wide evaluation to assess the project's impact and to inform future initiatives. Each grantee also will be required to participate in this evaluation process, which will likely involve reviews of written materials, interviews and/or site visits.

XV. CONTACT INFORMATION:

Programmatic questions: Mary Rainwater, IBHP Project Director (mary@ibhp.org) and Barb Demming Lurie, IBHP Assistant Project Director (barb@ibhp.org). Both can be reached at (323) 436 7478.

Grant administration questions: Olivia Nava (ibhp@tides.org); (415) 561 6387

Evaluation questions: Gary Bess Associates (gary@garybess.com); (530) 877 3426

APPENDICES:

1. Integration Level Survey – Clinics
2. Integrated Level Survey – Consortia
3. Grant Application Cover Sheet and Budget Form