



2009B Grants Round

**Promoting Patient and Family-centered Care:
The Integration Initiative**

Request for Proposals (RFP)

- I. Advancing Patient and Family-centered Care through
Integrated Clinical Services**

- II. Systems Transformation to Advance Integrated Care**

Issue Date – May 1, 2009

Maine Health Access Foundation
150 Capitol Street, Suite 4
Augusta, ME 04330
(207) 620-8266 extension 104 or 114
(866) 848-9210 (Toll free)
(207) 620-8269 (fax)
www.mehaf.org

KEY DATES AND DEADLINES FOR 2009B INTEGRATION INITIATIVE GRANTS	
RFP Released	May 1, 2009
Bidders' Conferences: <ul style="list-style-type: none"> ▪ Portland, June 2, 2009, 9 – 11 AM ▪ Bangor, June 3, 2009, 1 – 3 PM Online Webinar Bidders' Conference <ul style="list-style-type: none"> ▪ June 2, 2009, 2 – 4 PM 	Register by e-mailing Catherine Luce at cluce@mehaf.org , or by phoning (207) 620-8266, ext. 104 on or before May 29, 2009. Details will be e-mailed to participants upon registration. Beginning May 15, responses to questions regarding the proposal will be posted on the MeHAF website: www.mehaf.org . Please check the website for regular updates. Final updates will be posted June 19, 2009.
Full Proposals Due*	June 26, 2009; 4:30 p.m. Eastern Daylight Savings
Grants Announced	On or about October 20, 2009
Grant Period (Year One)	January 1, 2010 – December 31, 2010
* Please note proposals must be <u>received</u> at MeHAF by 4:30 p.m. on the due date	

PROJECT FOCUS and FUNDING PRIORITY

The Maine Health Access Foundation (MeHAF) is issuing a request for proposals (RFP) to fund projects that advance patient and family-centered care in Maine through the integration of services across systems of care. MeHAF anticipates awarding up to four (4) grants, depending on the quality of applications and available funds.

The 2009B RFP (Round 3) offers two categories of grants for project implementation:

- Clinical Services Grants: “Advancing Patient and Family-centered Care through Integrated Clinical Services”
- Systems Transformation Grants: “Systems Transformation to Advance Integrated Care”

Funding for Clinical Services Grants and for Systems Transformation Grants will be for one to three years, with a maximum funding of \$230,000 for the three years. While a maximum of \$80,000 is allowed for year 1, applicants can determine the amounts for the balance of years 2 and 3, provided the total for the three years does not exceed \$230,000. MeHAF recommends that a smaller amount be budgeted for year 3 as part of a sustainability plan.

ORGANIZATIONAL ELIGIBILITY

501(c)(3) tax-exempt public charities, governmental or other public, non-profit entities are eligible to apply. Individuals, fiscal sponsorships, organizations with pending 501(c)(3) status, and private foundations are ineligible.

QUESTIONS

- **Technical and Logistical Questions:** Please contact Catherine Luce, Grants Manager, (207) 620-8266, ext. 104, cluce@mehaf.org.
- **Project Content or Related Questions:** Please contact Becky Hayes Boober, Program Officer, (207) 620-8266, ext. 114, bhboober@mehaf.org.

MeHAF's MISSION

The mission of the Maine Health Access Foundation is to promote affordable and timely access to comprehensive quality health care, and improve the health of every Maine resident.

MeHAF is a mission-driven and results-oriented organization that uses grants and other program support to advance strategic solutions to Maine's health care needs, particularly for persons who are uninsured and/or medically underserved.

THE MAINE HEALTH ACCESS FOUNDATION'S PRIORITY TO PROMOTE PATIENT AND FAMILY-CENTERED CARE

MeHAF is committed to transforming the current fragmented health care system into one that is patient and family-centered. The Institute of Medicine concludes that patients often are expected to adapt to the policies and procedures of health care organizations and professionals, rather than receiving services focused on their individual needs and preferences.¹ From the patient's perspective, the current health care system frequently operates in a disorganized, fragmented manner with little integration and coordination of care. Patient and family-centered care encourages people and their loved ones to define and articulate their needs, participate in decision making, and guide their care in ways that improve quality, cost-effectiveness, and outcomes.

Moving Maine's health system toward a patient and family-centered integrated approach requires a long-term focus. Improving the integration of care from a patient perspective requires restructuring our health care system to focus on results. This includes promoting easy and efficient interaction between primary care and mental and behavioral health professionals, integrating preventive services and public health goals into regular care delivery, and applying existing community resources in ways that enhance health and wellness. It also requires systems transformation that sustains integration through appropriate public policies, service delivery enhancements, or payment reforms. The Foundation's work in this area, termed the ***Integration Initiative***, continues a multi-year commitment of MeHAF funding.

Background: A variety of evidence supports MeHAF's decision to advance patient and family-centered care through improved care integration. The Institute of Medicine's recent report, *Improving the Quality of Health Care for Mental and Substance Use Conditions*, includes recommendations that "health care for general, mental and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body."² This recommendation reflects data suggesting that poor health outcomes, reduced access, and increased costs result from a separation of the mind and body in clinical practice. The mind/body separation is exacerbated by the mental health, substance use, and physical health service delivery infrastructures. The Integration Initiative strives to enhance the coordination of care across these service delivery sectors and provider groups. Emerging research suggests integrated care improves outcomes. In an analysis of over 30 studies of integrated care conducted for the Agency for Healthcare Research and Quality (AHRQ Publication No. 09-E003, *Integration of Mental Health/Substance Abuse and Primary Care*, 2008),³ investigators conclude, "The studies reviewed tended to show positive results for

symptom severity, treatment response, and remission when compared to usual care.” Further, the National Priorities Partnership convened by the National Quality Forum lists as one of the six National Priority areas: “Ensure patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care.”⁴

In 2006 MeHAF conducted an extensive assessment and visioning process to shape and define the goals of the Integration Initiative. MeHAF developed a consensus vision for integration, using a facilitated dialogue and research process which capitalized on the collective knowledge and experience of more than 60 diverse stakeholders and nearly 1,500 patients, families and community members. Two key documents resulted from these efforts. The first, *Integrated Health Care in Maine: Vision, Principles and Values, and Goals and Objectives*, is a general guide for integration of physical and behavioral health* in Maine and for the funding opportunities presented in this RFP. The second, *Maine Integrated Health Initiative: Maine People Speak about Integrated Health Care* published in 2007, summarizes the results of the discussion groups held across the state. Both documents are available on the MeHAF website. See: *Integrated Health Care in Maine* at http://208.106.187.202/pictures/integration_vision.pdf, and *Maine People Speak* at <http://www.mehaf.org/pictures/grassroots-feedback-2007.pdf>.

Patient and Family-centered Care and Integration: MeHAF views integration as essential to the delivery of patient and family-centered care. Integration of care is one of eight core components of patient and family-centered care identified in a study commissioned by the W.K. Kellogg Foundation.⁵ The Institute of Medicine (IOM) describes integration as among the critical characteristics of patient-centered care.⁶

Defining Integrated Care: The Economic and Social Research Institute mentioned in the Kellogg study includes the following elements in its definition of integrated care: assessing the need for formal and informal services that impact health or treatment, providing team-based care and care management, advocating for the patient and family, making appropriate referrals and ensuring smooth transitions among different providers and between phases of care. These elements focus on the integration of care within a clinical setting.⁷ It is clear, however, that integration must be supported at the systems level as well to be sustainable. Advancing integration at the systems level requires addressing the funding, administrative, organizational, service delivery and clinical approaches designed to create connectivity, alignment and collaboration.⁸

MeHAF, in collaboration with current Integration Initiative grantees and stakeholders, has developed the following draft working definition of integrated care:

Integrated care is patient and family-centered and has the following desired elements:

- Patients/clients/consumers have choice regarding the setting for their care;
- Patients/clients/consumers and their family members play a meaningful and ongoing participatory role in the development and delivery of services;
- Patients’/clients’/consumers’ needs are assessed in both behavioral and primary care settings for services across the spectrum of care;
- Treatment services are provided to support both physical and behavioral conditions;

* Behavioral health includes services for individuals at risk of or suffering from mental, addictive, or other behavioral health disorders.

- Treatment is delivered by a team including physical and behavioral health providers who develop a coordinated treatment plan;
- Providers care for a common population and use common medical records;
- Solution-focused treatment is informed by evidence-based and promising-practice protocols;
- Physical and behavioral health providers engage in a fully collaborative approach to patient-centered health;
- Linkages to other specialties and referral relationships are pre-arranged; and
- Care is cost-effective.

FUNDING OPPORTUNITIES

MeHAF's long-range objective is to promote integration of health services across systems of care as one way to make care more patient and family-centered. In the near term, MeHAF supports strategic steps that are achievable and that expand integration. These may occur both at the level of clinical services delivery and at the level of transforming the systems that support integrated delivery of care (such as licensing, regulation, and reimbursement). With this in mind, MeHAF offers funding opportunities in two categories, *Advancing Patient and Family-centered Care in Maine through Integrated Clinical Services* ("Clinical Services Grants") and *Systems Transformation to Advance Integrated Care in Maine* ("Systems Transformation Grants"). A description of project requirements with specific expectations for each funding category follows.

I. Advancing Patient and Family-centered Care through Integrated Clinical Services ("Clinical Services Grants")

Clinical Services Grants should improve the care received by patients and consumers of physical and behavioral health services in Maine, with an emphasis on efforts to improve both their health outcomes and their experience of care. MeHAF is interested in advancing integration of clinical services offered within both physical health and behavioral health care settings. MeHAF also wants to expand the types of populations served. In this round of funding, MeHAF is especially interested in proposals that meet one of the following criteria:

1. Applicant has successfully completed or is completing an Integration Initiative planning grant and proposes to expand and implement integrated care; and/or
2. Applicant expands integrated care to public/community health services.

No single approach to integration or uniform level of integration can be attained across all providers and systems in Maine. Clinical Services Grants will facilitate organizations and their partners to move from less integrated to more integrated approaches, with a goal of fostering the greatest level of integration possible within their settings. *Appendix A* provides operational examples of the continuum from minimal collaboration to full integration to assist applicants in characterizing their current approach to care delivery and their proposed increased level of integration to be achieved by the end of the MeHAF grant project period. MeHAF does not expect all applicants to advance to the highest level of integration described in *Appendix A*, but does expect applicants to move toward the highest level desirable, based on the unique setting and needs of the population groups served.

Clinical Services Grants support operational changes to advance the integration of behavioral health and primary care, and with medical specialty care as appropriate. MeHAF seeks projects that focus on integrating behavioral health into primary care or on ensuring that those receiving behavioral health care receive appropriate primary care. Implementation grants are for the initiation, replication or expansion of service delivery that has been fully developed and requires only additional resources to execute.

Clinical Services Grants are offered for up to three years, with a maximum of \$80,000 for year one and a total of \$230,000 over the three years.

The following are examples of potential activities:

- 1) Enhanced collaboration among behavioral and primary care providers, including multi-disciplinary treatment teams, collaborative treatment planning, expanded referral networks, and cross-disciplinary consultation;
- 2) Expanded use of sustainable approaches to care/case management;
- 3) Introduction of evidence-based or evidence-informed screening and assessment tools and treatment approaches and pathways, particularly when implemented using clinical quality improvement approaches;
- 4) Introduction of patient/consumer-directed approaches, such as shared decision making, peer advocacy, and meaningful involvement of patient/consumer advisors;
- 5) Expansion and increased ease of access to behavioral and primary care services for underserved populations, including such approaches as co-location (or relocation) of services;
- 6) Increased integration of clinical administrative systems for medical records and data, funding, and billing;
- 7) Redefinition of existing staff and clinical practitioner roles or responsibilities in the behavioral health or primary care setting with appropriate staff training; and
- 8) Expansion of referral networks to incorporate health and social services/supports and community partners, such as Healthy Maine Partnerships, youth-serving organizations such as YMCAs and Boys/Girls Clubs, Area Agencies on Aging, housing providers, vocational providers, and churches; or to incorporate providers of effective and complementary therapies and interventions.

General Project Requirements for Clinical Services Grants

- 1) Project design must build upon and/or support the adoption of evidence-based or evidence-informed screening and assessment tools and preventive and treatment approaches and clinical pathways for integrating behavioral and primary care. Articles that describe the importance of establishing an evidence-based organizational culture and sources of evidence-based and evidence-informed practices are listed below:
 - a) US Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services <http://www.ahrq.gov/clinic/USpstfix.htm#Recommendations>.
 - b) The National Guideline Clearinghouse, a public resource for evidence-based clinical practice guidelines from the Agency for Healthcare Research and Quality (AHRQ) <http://www.guideline.gov/>. AHRQ's publication on research on integrated care, *Integration of Mental Health/Substance Abuse and Primary Care*, can be found at <http://www.ahrq.gov/clinic/tp/mhsapctp.htm>.

- c) Center for Mental Health Quality and Accountability (CMHQA) Matrix of Children's Evidence-Based Interventions and other information about Evidence-Based Practices for Youth at <http://ebp.networkofcare.org/youth/index.cfm?pageName=index>.
 - d) Substance Abuse and Mental Health Administration's National Registry of Evidence-based Programs and Practices (NREPP) <http://www.nrepp.samhsa.gov/find.asp>.
 - e) The National Institute of Mental Health's Therapy Advisor website <http://therapyadvisor.org/Default.aspx>.
 - f) Maine DHHS Office of Adult Mental Health Services Evidence-Based Practices Procedural Guidelines http://maine.gov/dhhs/mh/evidence-based_practices.html.
 - g) *The Need for an Evidence-Based Culture: Lessons Learned from Evidence*, by Vijay K. Ganju, PhD. http://www.nri-inc.org/reports_pubs/2006/EBPCultureImpLessons2006.pdf.
 - h) *Behavioral Health/Primary Care Integration and The Person-Centered Healthcare Home* by Barbara J. Mauer prepared for the National Council for Community Behavioral Healthcare is available at <http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Healthcare%20Home.pdf>.
 - i) *Reimbursement of Mental Health Services in Primary Care Settings* is a U.S. DHHS SAMHSA publication by D. Mauch, C. Kautz, and S. Smith and available at <http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf>.
- 2) In proposing changes in their organizations, applicants are encouraged to use Quality Improvement (QI) approaches such as those promoted by the Institute for Healthcare Improvement (IHI), <http://www.ihl.org/ihl>. QI strategies and tools may include development of QI teams, setting aims and establishing measures, testing changes through use of Plan-Do-Study-Act (PDSA) cycles, and implementation.
- 3) Projects must expand existing capacity or develop new capacity to link high-need, underserved populations to appropriate services. Projects funded through this RFP must include or address the needs of MeHAF's priority populations. These are populations documented to need services but who have poor access due to lack of insurance or underinsurance, disability, rurality, poverty, racial and ethnic minority status, age, cultural barriers, or other significant demographic characteristics. As instructed on pages 11-12, applicants must describe the population(s) to be served.
- 4) Projects must foster new or expanded models of integrated services:
- a) Care must become more integrated. Applicants must characterize their current and proposed levels of integration using the chart of Behavioral Health/Primary Care Integration Options⁹ in *Appendix A*;
 - b) Care must be provided on a timely basis;
 - c) Patients/consumers have multiple, identifiable and accessible points of entry with no wrong door;
 - d) Service delivery should aspire to a "two-touch" standard (no more than two layers between entry point and needed services);
 - e) Care must be provided across settings and disciplines (primary care, behavioral health, and if appropriate, medical specialty care).
- Additionally, projects are encouraged to link with community supports and social services providers to assist patients with factors that often reduce access to health care, such as transportation.

- 5) Projects **must** include meaningful patient and family engagement in design and implementation. This can include ongoing patients' and their families' input into and feedback on implementation and refinement of the project.
- 6) Staff ability and capacity are critical to the implementation of evidence-based practices. Screening, assessment and treatment must be provided by professionals with the appropriate training and credentials. Applicants are encouraged to include appropriate training for staff as part of project plans.
- 7) Projects must evaluate their own work and participate in a MeHAF external evaluation.
- 8) All projects must describe how they will measure the accomplishment of project objectives. The responsible party for each evaluation task should be clearly identified. Because the Integration Initiative is focused on making care more patient and family-centered, evaluation should include specific means of obtaining patient and family input and on ensuring that patients' perception of their care improves. Evaluation of patient perspectives might use existing patient survey tools as well as qualitative methods such as interviews or focus groups. Finally, applicants must describe the frequency of review of data and procedures for making program improvements. Applicants must also indicate their willingness to participate in a state-level, external, cross-site evaluation of the Integration Initiative, including completing Client Data Elements documentation and Site Self Assessments. (Both instruments are posted on the MeHAF website at <http://www.mehaf.org/reporting-instructions.aspx>.) Grantees must agree to collect needed data, participate in the evaluation as directed by the external evaluator(s), and disseminate project results. Participation in the evaluation includes development of a project logic model and reporting of data related to number of patients/clients served, measures of patient centeredness and patient satisfaction, and may include reporting of patient outcome data. In addition, if partner provider sites are involved in delivering services, they must be willing to provide requested client outcome data as well.
- 9) All grantees will be required to attend Learning Community meetings approximately quarterly to discuss project progress and share concerns with other grantees and to participate in conference call meetings with the Program Officer approximately four times each year.

II. Systems Transformation Grants to Advance Integrated Care in Maine (“Systems Transformation Grants”)

A recent *Health Affairs* article by Berwick, Nolan, and Whittington from the Institute for Healthcare Improvement notes that the major remaining barriers to integration of care are not technical, but political. They state, “The United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals.”¹⁰

With Systems Transformation implementation grants, MeHAF will support projects that address integration at the broader system* level, while ensuring accomplishment of the over-arching goal

* “System” means either the statewide system of delivery and reimbursement for health services, or large organizations that own or manage health provider facilities or health-related subsidiaries.

of improving patient and family-centered care especially for MeHAF priority populations. Grants in this category will focus on state-level or system-wide improvements or on new linkages across systems, including changes at the funding, administrative, or organizational levels. While the Clinical Services grants focus on direct client services and on steps toward clinical and structural integration within and between health care service sites, Systems Transformation grants focus on fostering integration at a high level—for instance, by changing reimbursement and regulations for specific services or for major classes of provider type, by increasing access statewide to scarce clinical expertise (such as psychiatry), by testing new models of clinical approach or incentives (such as expanded performance reporting related to integration), or by making changes in corporate structure or relationships to support integration. Successful Systems Transformation projects should result in lasting changes that support sustainability of integrated services.

Systems Transformation Grants are offered for projects that make broad changes to advance patient and family-centered care in Maine through the integration of behavioral and primary care, and with medical specialty care as appropriate. Implementation grants are for the initiation, replication or expansion of systems-level changes that will support the broad uptake and sustainability of integration in Maine. Projects that focus on implementing integrated services for MeHAF's priority populations are preferable. Products of implementation grants can include new statewide or health system-wide policies or regulations, new broad-based strategic approaches, new workforce training systems, or new organizational structures or agreements.

Systems Transformation Grants are offered for up to three years, with a maximum of \$80,000 for year one and a total of \$230,000 over the three years. Examples of potential activities include:

- 1) Address strategic policy issues to advance integration in Maine;
- 2) Support the work of quality organizations to provide incentives for integrated care statewide or across multiple health systems (such as reporting or financial incentives);
- 3) Convene purchasers to implement strategic approaches to supporting integration;
- 4) Establish linkages with comprehensive community-based prevention strategies;
- 5) Address existing systems barriers through new reimbursement and licensing, such as a statewide effort to coordinate care/case management (which may be community-based) for high-need individuals or implementation of new evidence-based or evidence-informed screening, assessment and treatment tools and pathways across large clinical systems;
- 6) Identify and plan processes to introduce new evidence-based or evidence-informed screening, assessment and treatment tools and pathways;
- 7) Fill existing gaps in critical data or outcomes measures, or highlight specific current practices to ascertain their efficacy and to promote adoption of successful practices; and/or
- 8) Address workforce training and capacity issues to support adoption of evidence-based practices.

General Project Requirements for Systems Transformation Implementation Grants

- 1) Applicants are encouraged to develop systems-level change projects that are relevant to integration of services and patient and family-centered care. These include, but are not limited to, projects that focus on coordinating behavioral health and public health systems, linking integrated care with public health initiatives, and/or integrating care for underserved populations.

- 2) As appropriate, projects must broadly address systems changes that promote adoption of evidence-based or evidence-informed approaches consistent with recommendations in:
 - a) IOM's *Improving the Quality of Health Care for Mental and Substance Use Conditions* (http://www.nap.edu/catalog.php?record_id=11470);
 - b) *The President's New Freedom Commission on Mental Health Strategies' Achieving the Promise: Transforming Mental Health Care in America* (<http://www.mentalhealthcommission.gov/>);
 - c) *Reimbursement of Mental Health Services in Primary Care Settings* is a U.S. DHHS SAMHSA publication by D. Mauch, C. Kautz, and S. Smith and available at <http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf> and
 - d) *SAMHSA's Evidence-Based Practices: Shaping Mental Health Services Towards Recovery* (<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/about.asp>).

- 3) Projects may focus on policy interventions that promote strategies to:
 - a) Expand existing or develop new capacity to link high-need, underserved populations to needed services; and
 - b) Accelerate the adoption and use of evidence-based or informed practices.

- 4) Projects must evaluate their own work and participate in a MeHAF external evaluation. All grantees must describe how they will measure the accomplishment of project objectives. Applicants must describe their data systems and capacity to perform the measurement described. The responsible party for each evaluation task should be clearly identified. Because the Integration Initiative focuses on making care more patient and family-centered, evaluation should include specific means of obtaining patient and family input. Finally, applicants must describe the frequency of review of data and procedures for making program improvements. Additionally, grantees will participate in an external, cross-site evaluation of the Integration Initiative. Grantees must agree to collect needed data, participate in the evaluation as directed by the external evaluator(s), and disseminate project results. Participation in the evaluation will include development of a project logic model, and if relevant, reporting of data on patient centeredness, satisfaction, and outcomes. In addition, if partner provider sites are involved in delivering services, they must be willing to provide requested data as well.

- 5) Learning community participation
 - a) All grantees under this RFP will be required to attend approximately quarterly meetings to discuss project progress and share concerns with other grantees and to participate in conference calls with their Program Officer approximately four times each year.

ELIGIBILITY REQUIREMENTS FOR ALL FUNDING CATEGORIES

Applicants must be:

- 1) 501(c)(3) tax-exempt public charities, governmental or other public, non-profit entities. Individuals, fiscal sponsorships, organizations with pending 501(c)(3) tax-exempt status, and private foundations are ineligible.
 - a) The Foundation will not consider applications from organizations whose non-profit status is pending, nor from those requiring fiscal sponsorship. Such organizations are

encouraged to form appropriate collaborations with established eligible institutions and to submit jointly.

- b) Joint applications from collaborating organizations are desirable and may include a mix of eligible and ineligible institutions. However, one eligible organization must serve as the lead agency and project applicant.
- c) Applicants need not be organizations based in Maine, but they must have established infrastructure and relationships in Maine sufficient to execute the requirements of the RFP in Maine.
- d) The Maine Health Access Foundation has specific requirements for public charity applicants that are operating under subsection 509(a)(1), (2), or are functionally integrated under subsection (3) of the Internal Revenue Code. Please closely examine your final 501(c)(3) determination letter to identify if you are affected. For more information, see *Appendix C*, page 22.

APPLYING FOR A GRANT IN ANY FUNDING CATEGORY

A. Format Requirements

- 1) Complete the Grant Summary Form (available online <http://www.mehaf.org/2009b-integration-initiative.aspx>) and use it as the Cover of your proposal.
- 2) Proposal: The proposal may not exceed 12 pages including the work plan (but excluding the mandatory grant summary form, logic model, budget page and budget justification narrative, and all required attachments).
- 3) The proposal must be submitted on 8 ½ x 11 sheets (one side only) with margins of at least ¾ inch on all sides and in a type face no smaller than 12 point.
- 4) Proposals may be single- or double-spaced.
- 5) Each page of the proposal must include a header in the upper right-hand corner with the applying organization's name and the page number.

B. Proposal Content and Scoring

The proposal must contain the following sections in the order presented here. Proposals will be scored based on the extent to which they address each element described in the general project requirements above and in each section description below. The total possible score is 100 points, with the maximum points available in each section as noted in parentheses below.

1) Needs Statement & Target Population(s) (10 points)

For Clinical Services Grants:

- a) Discuss the specific health problems or service delivery issues the proposed project will address.
- b) Describe the population(s) to be served by the proposed project in terms of relevant factors such as age, location, economic, cultural and racial/ethnic characteristics.
 - Explain how the project expands or supports the expansion of existing capacity or develops new capacity to provide integrated services to high-need, underserved populations.
 - Describe the specific number of individuals to be served and their characteristics, using the Four Quadrant Model included in *Appendix B* (page 21) and providing

additional details related to age, gender, health status, etc. as appropriate. Be specific on the types of physical or behavioral health needs of patients/consumers who will be served.

For Systems Transformation Grants:

- a) Describe the system changes that are proposed and how they will address the needs of specific populations.
 - Explain how the project expands or supports the expansion of existing capacity or develops new capacity to link high-need, underserved populations to needed services.
 - Explain how the proposed system changes will positively impact the provision of integrated care.

3) Work Plan (35 points)

For Clinical Services Grants:

- a) Describe the strategic activities you propose to undertake, relating them to the previously-identified needs and target population(s). Be specific in the number and type of services you anticipate providing to the population group(s) identified.
 - Use the template included in *Appendix D* (page 23) for your work plan. Include objectives, activities, time frames, responsible parties, and method of monitoring.
- b) Explain how your project will make care more integrated. Refer to the chart of Behavioral Health/Primary Care Integration in *Appendix A* (page 20) and describe your current level of integration and the level of integration anticipated at the end of the project. Applicants are expected to make significant gains from the lower levels of integration to the higher levels, although they are not required to achieve the highest level of integration unless appropriate for the setting and population served.
- c) Include a discussion of how you and your partners will meet the elements of the Foundation's Comprehensive Care Policy (see *Appendix F*, page 25). The project's capacity to meet this standard will be specifically reviewed and will represent 3 points of the 35 available in this category.
- d) Explain how the project will use evidence-based or evidence-informed screening, assessment and treatment tools and pathways, citing evidence sources (e.g. websites, literature citations) to provide a rationale for your approach.
 - Describe the patient/consumer entry points, clinical pathways to be used, referrals, care management, and protocols for concluding episodes of service. You may provide a patient flow chart or pathway diagram as an attachment to the proposal.
- e) Describe how the project will use QI strategies and tools to accomplish proposed organizational changes.

For Systems Transformation Grants:

- a) Describe the strategic activities you propose to undertake, relating them to your needs statement.
 - Use the work plan template included in *Appendix D* (page 23) for your work plan. Include objectives, activities, time frames, responsible parties, method of monitoring.
- b) Describe the systems transformation your project will bring about and how it will promote sustainability of integration as an approach.
- c) Provide a rationale for why the systems transformation approach you are pursuing is strategic and achievable.

4) *Collaboration and Patient and Family Engagement (15 points)*

For Clinical Services Grants:

- a) Describe how the project provides and monitors the quality of services provided in multi-institutional settings and across disciplines (primary care, specialty care, and behavioral health).
- List collaborative partners and describe the role(s) they will assume under the proposed project. Describe their current involvement and their level of commitment. Letters of commitment from all partners must be included in the Required Attachments section of your proposal.
 - Explain how the project will improve or expand linkages, and how the project complements—but does not duplicate—existing services. Describe inter- or intra-organizational linkages and how these will be managed, for example, through changes in reporting structures, memoranda of agreement, or other means.
 - Describe how projects will include meaningful patient and family engagement in design and implementation. This should include ongoing patient feedback, such as assessment of the effectiveness of services in meeting the needs of patients and their families. It may also include focus groups, family advisory groups, and involvement of patients/consumers and their families in program design, management and monitoring.

For Systems Transformation Grants:

- a) Describe how the project brings together key partners to identify or implement broad, strategic systems changes.
- List collaborative partners and describe the role(s) they will assume under the proposed project. Describe their current involvement and their level of commitment. Letters of commitment from all partners that describe the organization's role and contribution to the project must be included in the Required Attachments section of your proposal.
 - Explain how the project complements – but does not duplicate – existing activities. Describe inter- or intra-organizational linkages and how these will be managed, for example, through memoranda of agreement, or other means.
 - Describe how projects will include meaningful patient and family engagement in design and implementation. This may include focus groups, family advisory groups, and involvement of patients/consumers and their families in program design, management and monitoring.

5) *Project Leadership and Staffing (10 points)*

For Clinical Services and Systems Transformation Grants:

- a) Describe who will lead the project. **Clinical Services** applicants must name both a clinical and an administrative lead for the work.
- b) Using an organizational chart and accompanying narrative, describe the involvement of key staff members who will work on the project, noting the duties of each and how their work integrates into the project as a whole (do not include resumes). Indicate which staff members, if any, will have all or part of their salary paid by the grant. For **Clinical Services** grants, describe how the training and credentials of proposed staff are appropriate to deliver the proposed services.

- c) Additionally, for **Clinical Services** grants in which scarce workforce are required (e.g. child or geriatric psychiatrists), describe how such services will be assured.

6) Evaluation (10 points)

For Clinical Services Grants:

- a) Include a logic model, using the logic model template found in *Appendix E* (page 24).
b) Describe how accomplishment of project objectives will be measured, regularly monitored, and reviewed by project leadership.
c) Describe how patient/consumer or advocate engagement will be measured.
d) Explain how participation in the MeHAF-sponsored external evaluation will be ensured. Include a statement indicating willingness to participate in a statewide, cross-site evaluation provided by a team contracted by MeHAF.

For Systems Transformation Grants:

- a) Include a logic model, using the logic model template found in *Appendix E* (page 24).
b) Describe how accomplishment of project objectives will be measured, regularly monitored, and reviewed by project leadership.
c) Describe how patient/consumer or advocate engagement will be measured, as appropriate.
d) Explain how participation in the MeHAF-sponsored external evaluation will be ensured. Include a statement indicating willingness to participate in a statewide, cross-site evaluation provided by a team contracted by MeHAF.

7) Sustainability (10 points) For Clinical Services and Systems Transformation Grants:

- a) Projects must include a successful sustainability strategy at inception. Describe a realistic and progressive sustainability plan, or present a detailed, specific, and compelling plan to develop one over the course of the grant. Applicants must also include a statement indicating their willingness to participate in state-level efforts to support development of outcome measures, policies, reimbursements and other strategies to sustain integrated service approaches.
- How will the project be sustained beyond the term of this grant? What funding or in-kind support will be available to sustain this project after the termination of MeHAF grant funding?
 - What strategies will be used to solve non-financial sustainability concerns, such as a need for ongoing available workforce?
 - For projects that focus on systems change, the “sustainability” discussion should focus on the type of lasting changes that will be implemented and meaningful dissemination of project results.

8) Project Budget and Narrative (10 points)

For Clinical Services and Systems Transformation Grants:

- a) Use MeHAF’s Project Budget form. In addition, provide a budget narrative, not to exceed four pages.
b) The Foundation expects project budgets to be proportional to the scale of the project, in terms of both the scale of multi-institutional participation and numbers of individuals to be served. Further, grantees will be responsible for meeting budget projections and timelines. Include funds to attend the quarterly Learning Community meetings.

- c) Clinical Services grants that will involve provider sites other than the applicant organization are strongly encouraged to provide funding to partner service providers through subcontracts, stipends, or other appropriate means.
- d) Clinical Services grants are encouraged to budget funds to support data collection and aggregation for evaluation (both internally and at partner organizations).
- e) MeHAF funds dispersed through this RFP may not be used for:
 - Purchasing electronic medical or health records systems;
 - Curriculum development;
 - Direct service unrelated to an overarching systems transformation strategy;
 - Capital projects, (e.g. construction and renovation of clinic space);
 - Fundraising activities of any sort (e.g. endowment campaigns);
 - Political activity including lobbying;
 - General operating support; or
 - Scholarships.
- f) Please note that in this grants round, MeHAF will allow only limited compensation to providers to participate in project activities when there is a compelling need that cannot be met in any other way. However, applicants are encouraged to consider issues of sustainability when requesting funds to support staff.
- g) MeHAF requires all grantees to contribute or secure a minimum level of cash or in-kind support. The minimum required amount is based on the size of an organization’s annual budget and the amount of the requested MeHAF portion of the project budget (see chart below). An organization is defined as the applicant organization as a whole (if a small non-profit) or, if a large organization, the logical subdivision applying for funding (such as a department of a university or a division of a hospital).
- h) MeHAF will accept any combination of cash and in-kind to meet the requirement:
 - A cash match may be drawn from general operating funds or complementary grants received from other sources for the project proposed to MeHAF.
 - An in-kind match may be derived from contributions to the project in forms other than cash (such as employee time or supplies) supplied by the applicant or key partners on the project.
 - In compelling circumstances, a waiver of the contribution requirement may be made by MeHAF program staff. Please contact Program Officer Becky Hayes Boober (bhboober@mehaf.org) if a waiver is sought.

MeHAF GRANT MATCH REQUIREMENT	
SIZE OF ORGANIZATION’S ANNUAL BUDGET	PROPORTION OF REQUESTED MeHAF FUNDS FOR PROJECT REQUIRED FROM CASH OR IN-KIND SUPPORT
≤ \$250,000 - \$1 million	5%
\$1 million - \$5 million	10%
\$5 million - \$10 million	15%
≥ \$10 million	20%

- i) The Maine Health Access Foundation has specific requirements for the presentation and calculation of direct and indirect cost, as described in *Appendix G* (page 26);
- j) If selected for award, grant applicants that are operating under subsection 509(a) (1), (2), or are functionally integrated under subsection (3) of the Internal Revenue Code will be required to provide additional documentation. For more information, please see *Appendix C* (page 22).

C. Required Attachments

Required attachments for complete proposals are listed below. Please do not send any additional information.

- 1) A flash drive or CD with the grant summary form, proposal narrative, work plan, logic model, project budget, and budget justification. All documents must be in a format compatible with Microsoft Word 2002 Version. Please include the name of your organization in all document titles.
- 2) Detailed letters of commitment from each key institution/partner collaborating on your project. These letters must include specific descriptions of the partner's role in the project, the resources each partner will commit to the project, the period of time over which the partner(s) will be involved, and acknowledgement of any subcontracts or other financial agreements that will be established under the grant.
- 3) If your organization/department has not applied for a MeHAF grant through another RFP process since January 1, 2009, please submit the following:
 - a) Your organization's Board of Directors list with members' affiliations. (If membership has changed since previously submitted, please resubmit this list even if you have applied for another MeHAF grant in 2009.)
 - b) Large institutions must submit their most recent audited financial statement. Small institutions that do not conduct audits may submit their most recent IRS Form 990 and unaudited financial statement.
 - c) Organizations must include a copy of their non-discrimination policy, which must verify that the organization does not discriminate on the basis of race, ethnicity, gender, sexual orientation, disability, national origin, political affiliation or religious belief. Please note that this is a more stringent standard than that currently required by the federal government; and
 - d) Organizations must include two written statements (these two statements may be submitted as one document on appropriate letterhead):
 - A statement that approval for the project has been sought and obtained by the applicant's institutional review board (IRB) or that such approval is not required for the project. An IRB is given the responsibility by an institution to review that institution's research projects involving human subjects. The primary purpose of the IRB review is to assure the protection of the safety, rights and welfare of the human subjects. In some institutions, the IRB may have a different name, such as "Human Subjects Review Committee," or another body, such as an "Ethics Review Committee," may serve the same function; and

- A statement that rigorous confidentiality procedures shall be maintained during the implementation of the project with regard to patients' medical records, consistent with HIPPA, and all other applicable state and federal regulations.

D. Submission Requirements

Submit a flash drive or CD and six hard copy sets (one original and five copies) of the proposal and attachments listed below in numbers 1 - 5. Please include one copy of items in number 6 below (if not already submitted to MeHAF since January 1, 2009) with the original (first) set. Please clip (do not staple) the original to facilitate making extra copies. Please submit the following documents in this order:

- 1) Grant summary form
- 2) Proposal, including Work Plan (maximum of 12 pages)
- 3) Logic Model
- 4) Project budget and budget justification narrative (maximum of 4 pages for narrative)
- 5) Letters of Commitment
- 6) If you have not previously submitted these documents as part of an application through another MeHAF application since January 1, 2009, please submit **one (1)** copy with your original set of application documents:
 - a) Board list
 - b) Audited financials or IRS Form 990, as instructed previously
 - c) Non-discrimination policy; and
 - d) Written statements of confidentiality and IRB approval procedures.

Submit by regular mail, overnight courier, or in person to:

Catherine Luce
Grants Manager
Maine Health Access Foundation
150 Capitol Street, Suite 4
Augusta, ME 04330

All proposals and related documents must be **received** on or before **4:30 p.m. Eastern Daylight Savings Time on June 26, 2009**. Deliveries in person must be received by a Foundation staff member by the deadline. Submissions will not be accepted electronically, by fax, or late.

E. Applicant Notification

Applicants will be notified of the Foundation's decision on or about October 20, 2009.

F. First Year Funding Period

The first year of funding will be calendar year 2010. Up to two additional years of funding are subject to annual Foundation approval.

GRANT MANAGEMENT AND REPORTING

Grantees will be required to sign the Foundation's standard grants contract. Under some circumstances, the Foundation will consider modifying contract terms to meet grantee and Foundation requirements.

Grantees will be required to participate in periodic (usually quarterly) brief telephone updates with MeHAF staff for purposes of reporting project progress. Grantees will also be required to attend day-long Learning Community meetings quarterly. Grantees are required to provide appropriate documentation for the external, cross-site evaluation, using tools provided.

The Foundation is interested in keeping its reporting and funding requirements to a minimum. Grantees will be required to provide narrative and financial reports at six-month intervals during the funding period on specific due dates; additional oral or written reports may be required, if warranted.

PROPOSAL REVIEW AND FUNDING DECISIONS

MeHAF is committed to a thorough and fair review of all applications. The Foundation has strict and comprehensive conflict of interest policies regulating the participation of its staff, Trustees, Community Advisory Committee members, and external reviewers in funding decisions. It also assures an impartial and rigorous process by including a range of qualified individuals in its grant-making decisions.

Grant proposals are independently evaluated and scored by at least two external reviewers with appropriate content expertise and qualifications, and by two MeHAF program staff. Each proposal receives four independent scores. As part of the evaluation process, MeHAF staff may contact an applicant for written clarification of particular proposal elements. Also, a site visit may be requested. Contact or lack of contact by staff should not be construed as a reflection of the likelihood of funding.

Full proposals are ranked by cumulative reviewer score and presented to the Foundation's Grants Committee. The Committee carefully reviews all scoring and written recommendations. Based on this information, the Grants Committee develops a slate of grants that is forwarded to the full Board for final approval.

QUESTIONS

Applicants are strongly encouraged to contact MeHAF staff as they develop their proposals. Guidance and clarification of RFP requirements can help ensure a stronger application.

- **Technical and Logistical Questions:** please contact Catherine Luce, Grants Manager, (207) 620-8266, ext. 104, cluce@mehaf.org.
- **Project Content or Related Questions:** Please contact Becky Hayes Boober, Program Officer, (207) 620-8266, ext. 114, bhboober@mehaf.org.
- Beginning May 15, responses to questions will be posted on the website www.mehaf.org. Please refer frequently to the website for updates. The final update for questions will be posted no later than June 19, 2009.

APPLICATION CHECKLIST

- Application **received** by MeHAF on or before 4:30 p.m. June 26, 2009. Include a flash drive or CD with the grant summary form, proposal narrative including the plan of work (maximum 12 pages), logic model, project budget, and budget justification narrative.
- Six hard copy sets (one original and five copies) of materials listed below **in order**. Please securely clip the original and staple the copies.
 - Grant summary form
 - Proposal, including Work Plan (maximum 12 pages)
 - Logic model
 - Project budget and budget justification narrative (maximum of 4 pages for narrative)
 - Letters of commitment
- One set of the following required attachments to be included with the original if not already submitted as part of another MeHAF RFP application since January 1, 2009:
 - Board list
 - Nondiscrimination policy
 - Audited Financials or IRS Form 990
 - Written statements of confidentiality and IRB approval procedures
- Submit by regular mail, overnight courier, or by hand.
 - Applications, including in-person deliveries, must be **received** by a Foundation staff member no later than 4:30 p.m. on June 26, 2009. Submissions will not be accepted electronically, by fax, or late.
- Submit to: Catherine Luce
Grants Manager
Maine Health Access Foundation
150 Capitol Street, Suite 4
Augusta, ME 04330
207-620-8266 ext. 104

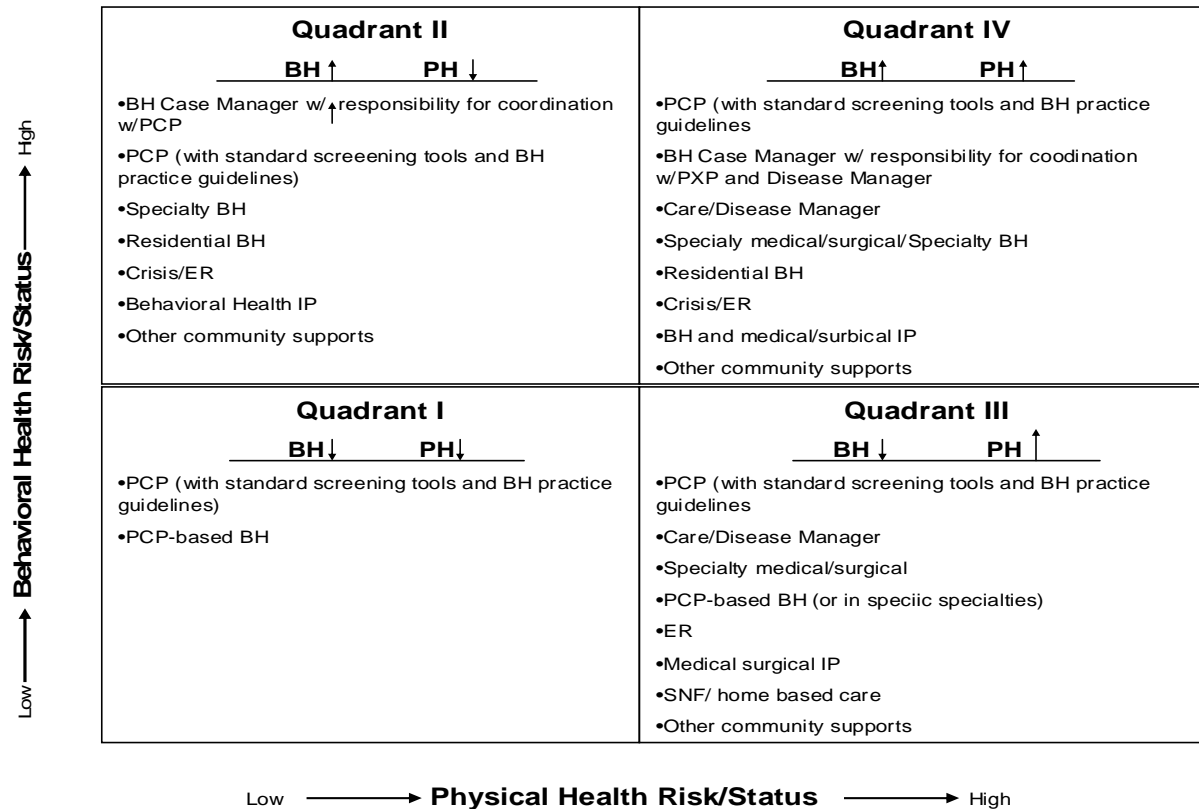
APPENDIX A
Behavioral Health/Primary Care Integration Options[†]
Operational Examples

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/ Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for service	Two front doors; cross-system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for patient/consumers with high physical and behavioral health needs	Two providers working in consultation; two treatment plans but routine sharing on individual plans, probably serve patients/consumers with all levels of physical and behavioral health needs	Individuals with low behavioral health needs will have all needs met by single provider; those with high behavioral health needs will interact with two providers who work from a single treatment plan in some cases, but not consistently with all consumers	One treatment plan with all patients/consumers, one site for all services, one physician prescribing for all patients/consumers except for some with high physical and behavioral health needs, one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding with resources shared across organizational needs, maximization of billing and support staff, potential new resources and staffing flexibility
Governance	Separate systems with little or no collaboration; patient/consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for specific groups of patients/consumers	Two governing boards that meet together periodically to discuss mutual issues	One governing Board with equal representation from each partner
EBP	Individual Evidence-Based Practices (EBPs) implemented in each system	Two providers, some sharing of information but responsibility for care located in one clinic or the other	Some sharing of EBPs around patients/consumers with high physical and behavioral health needs; some sharing of knowledge across disciplines	Sharing of EBPs across systems; joint monitoring of health conditions for patients with all levels of behavioral physical health needs	EBPs like PHQ-9, chronic disease self-management across all patients/consumers
Data	Separate systems, often paper-based, little if any sharing of data	Separate data sets, some discussion with each other of what data are shared	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; may be some aggregate data sharing on population groups	Fully integrated (electronic) health record with information available to all practitioners on need to know basis, data collection from one source

[†] Adapted from MH/Primary Care Integration Options, developed by Kathleen Reynolds, Director, Washtenaw Community Health Organization, Washtenaw County, MI; Based on Doherty, McDaniel and Baird, 1996.

APPENDIX B

National Council for Community Behavioral Health Four Quadrant Integration Model[‡]



Source: National Association of State Mental Health Program Directors, Integrating Behavioral health and Primary Care Services, January 2005

[‡] Each quadrant represents a category of patients defined by their level of behavioral and physical health status and includes the type of providers and services that would be appropriate.

APPENDIX C

Requirements for Public Charity Grantees Operating Under Subsection 509(a)(3)

The Maine Health Access Foundation has the following requirements for public charity grantees that are operating under subsection 509(a)(3).

MeHAF will rely on its own research through a current GuideStar search to determine whether the grantee derives its public charity status under section 509(a)(3) of the Code. Each section 509(a)(3) grantee must establish to MeHAF's satisfaction its status as a Type I, Type II, or Functionally Integrated Type III supporting organization. MeHAF's policy is not to make grants to Type III supporting organizations that cannot establish functional integration with their supported organization(s). Therefore, any grant applicant whose IRS determination letter indicates section 509(a)(3) status must provide the following additional information:

Type 1 and Type 2 supporting organizations must submit the following documents:

- Written representation, signed by an officer, director or trustee of the grantee, stating that the organization is a Type 1 or Type 2 supporting organization and including:
 - A description of how the grantee's officers, directors or trustees are selected with references to any provisions in governing documents that establish a Type 1 or Type 2 relationship between the applicant and its supported organization(s); and
 - Copies of such governing documents. [The Foundation is then required to review these documents, in accordance with instructions from our attorney, to be sure that they support the written statement.]

Functionally Integrated Type 3 supporting organizations must submit the following documents:

- Written representation, signed by an officer, director or trustee, stating that the grantee is a Functionally Integrated Type 3 supporting organization including:
 - Identification of the one or more supported organizations with which the grantee is functionally integrated; and
 - Copies of any governing documents relevant to the relationship of the grantee to its supported organization(s), and
 - Written representation(s), signed by an officer, director or trustee of each supported organization, representing that the grantee is functionally integrated, describing the activities of the grantee, and stating that but for the involvement of the grantee engaging in activities to perform the functions of, or to carry out the purposes of, the supported organization, the supported organization would normally be engaged in those activities itself. [The Foundation is then required to review these documents, in accordance with instructions from our attorney, to be sure that they support the written statement.]

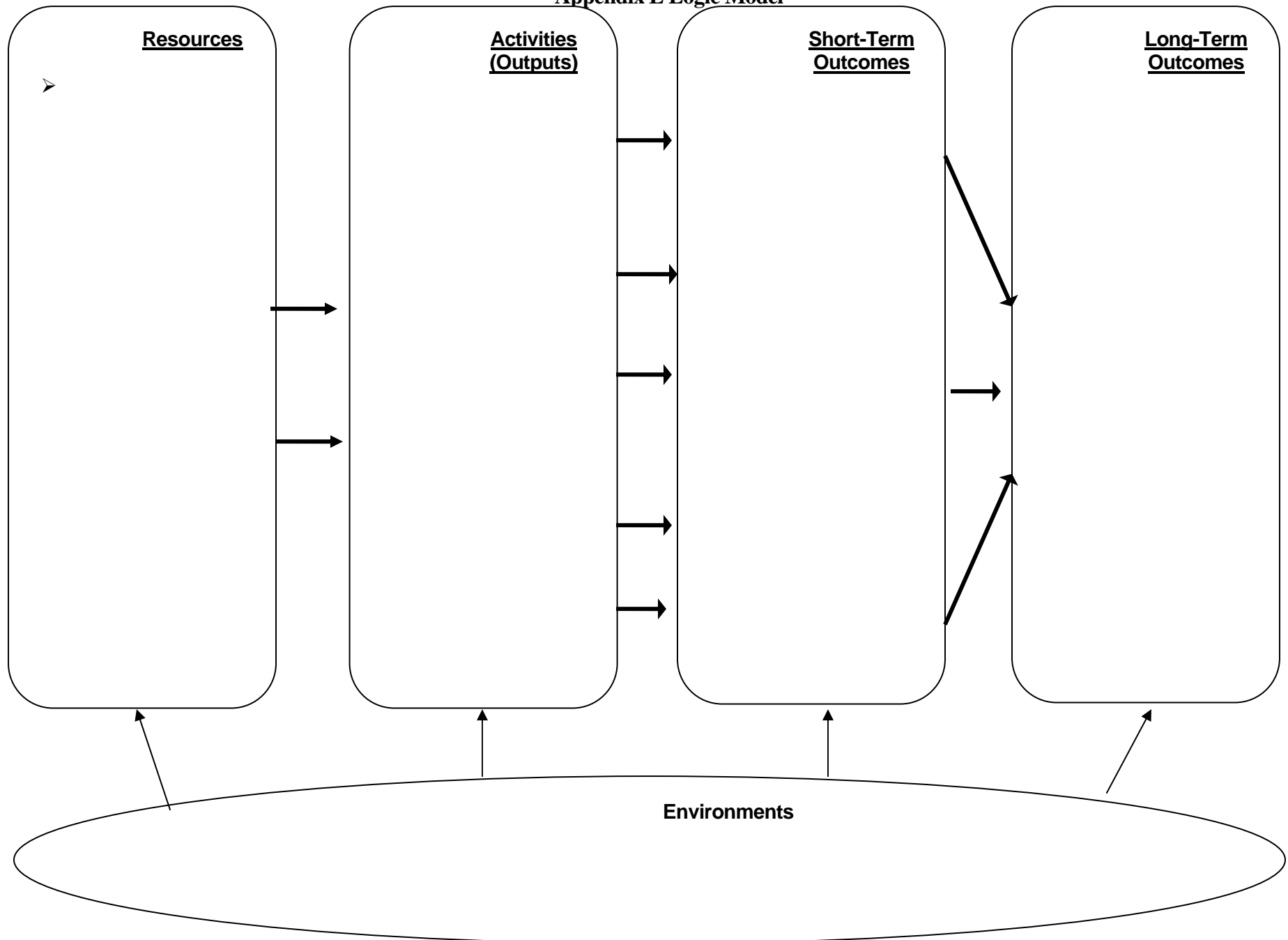
Required documents must be submitted with grant proposals.

These requirements are based on current legal advice, and may change in light of subsequent IRS rulings.

**APPENDIX D
Work Plan Template**

<p align="center">Objectives</p> <p>(Describe what you want to accomplish in terms that are specific, measurable, achievable, realistic, and time-framed)</p>	<p align="center">Activities</p> <p>(List the activities you will do to accomplish the objectives)</p>	<p align="center">Timeframe</p> <p>(Show when you intend to do each activity)</p>	<p align="center">Responsible Party</p> <p>(Describe who will accomplish each activity. You may list individuals from partner organizations with whom you will have a formal relationship)</p>	<p align="center">Monitoring</p> <p>Describe how you will know you accomplished the activities and what data sources you will use)</p>
<p align="center">•</p>	<p align="center">•</p>	<p align="center">•</p>	<p align="center">•</p>	<p align="center">•</p>

Appendix E Logic Model



APPENDIX F

MeHAF's COMPREHENSIVE CARE POLICY

The Maine Health Access Foundation seeks to expand the provision of comprehensive care in Maine.

Comprehensive care, as defined by the American Academy of Family Physicians, is the “concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events, and environment.” The Maine Health Access Foundation further defines comprehensive care as patient and family-centered rather than disease-centered or institution-centered. Because it is patient and family-centered, comprehensive care includes the timely and proactive dissemination of a full range of information about health and health services, in addition to the actual provision of preventive, diagnostic, therapeutic, rehabilitative, and counseling services. Comprehensive care is integrated and strengthens the linkages between population-based public health services, primary care, follow-up and specialty care.

Guidelines:

- All proposals will be scored on the level to which the proposed project meets the standards set forth by the definition of comprehensive care and the extent to which they will enhance their approach to comprehensive care with MeHAF funding.
- The definition will apply to programs, not institutions. Thus, institutions that do not conform to this standard in some operational areas are not prohibited from applying for grants.

APPENDIX G

MeHAF's Indirect Cost Policy

The Maine Health Access Foundation (MeHAF) has established the following policy guideline for grant applicants related to indirect cost.

MeHAF offers funding for both “direct” and “indirect costs” associated with all funded projects except for Discretionary Grants, and in very unusual circumstances, other grants as may be specified by the Foundation.

“Direct costs” are those costs directly related to the design, planning and implementation of a particular project. MeHAF allows the following costs directly related to the project:

- Salaries and benefits of project and administrative personnel who assist or manage;
- Subcontractors, consultants, or professional services;
- Equipment: Purchase or Maintenance
- Equipment or Facilities: Rental
- Office Supplies
- Program Materials
- Postage & Courier
- Printing & Copying
- Rent
- Stipends and Honoraria
- Telephone & Internet
- Travel: Local
- Travel: Other
- Utilities
- Other costs directly related to the project (with Foundation approval; include on budget form)

In some cases, the calculation of direct costs is straightforward: for example, the portion of staff FTE, expressed as a percentage of salaries and benefits, devoted to a funded project, or materials, such as pamphlets, used exclusively for a funded project. In other cases, such as telephone costs, a reasonable formula may need to be developed. For example, if an agency has five projects with roughly equal telephone usage, it would be reasonable to allocate 1/5 of telephone expenses to each project. Direct costs should be presented on the MeHAF budget form, and their rationale and method of calculation should be explained in the proposal in the budget justification.

“Indirect costs” are costs which are incurred by an organization in the execution of its activities but which cannot be readily identified with a particular activity. Indirect costs include general overhead costs, such as bank, payroll processing and audit fees; liability insurance; office equipment purchase or maintenance not directly related to the project; and salaries and benefits of executive or administrative personnel who are not directly engaged in the project. Organizations may request an indirect cost rate of up to 15%. This should be calculated on the MeHAF budget form as all direct expenses multiplied by the requested rate.

Please note that both direct and indirect costs must be contained within the total amount requested, and taken together, may not exceed any specific maximum request amount.

End Notes

- ¹ Institute of Medicine of the National Academies. 2006. Crossing the Quality Chasm Series: Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC: The National Academies Press.
- ² Institute of Medicine of the National Academies. 2006. Crossing the Quality Chasm Series: Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC: The National Academies Press.
- ³ Butler M, Kane RL, McAlpine D, Kathol RG, Fu SS, Hagedorn H, Wilt TJ. October 2008. Integration of Mental Health/Substance abuse and Primary Care, 2008. (AHRQ Publication No. 09-E003). Rockville, MD: Agency for Healthcare Research and Quality.
- ⁴ National Priorities Partnership. 2008. National Priorities and Goals: Aligning Our Efforts to Transform American's Healthcare. Washington, DC: National Quality Forum.
- ⁵ Economic and Social Research Institute. 2006. Patient-Centered Care for Underserved Populations: Definition and Best Practices. Prepared for the W.K. Kellogg Foundation.
Available at: http://www.esresearch.org/documents_06/Overview.pdf
- ⁶ IOM (Institute of Medicine of the National Academies). 2006. Crossing the Quality Chasm Series: Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC: The National Academies Press.
- ⁷ Economic and Social Research Institute. 2006. Patient-Centered Care for Underserved Populations: Definition and Best Practices. Prepared for the W.K. Kellogg Foundation.
Available at: http://www.esresearch.org/documents_06/Overview.pdf
- ⁸ Kodner DL, Spreeuwenberg C. 2002. Integrated Care: Meaning, logic, applications and implications—a discussion paper. *International Journal of Integrated Care* 14(2). 1-6.
- ⁹ Doherty WJ, McDaniel SH, Baire MA. October 1996. Five levels of primary care/behavioral health care collaboration. *Behavioral Healthcare Tomorrow*. 25-28.
- ¹⁰ Berwick DM, Nolan TW, Whittington, J. 2008. The Triple Aim: Care, Health and Cost. *Health Affairs* 27(3). 759-769.