

Advancing the Integration of Behavioral Health into Primary Care in New Jersey

REQUEST FOR PROPOSALS

The Nicholson Foundation seeks to fund up to four New Jersey-based primary care clinics or practices interested in integrating behavioral health (BH), which includes mental health and substance misuse, into primary care. We plan to support these clinics or practices in implementing the [Cherokee Health Systems](#)' model, which is an integrated team-based approach to patient care that has proven to improve patient health outcomes and is financially sustainable.

This Request For Proposals (RFP) is divided into five sections: Background, Description of the Grant Opportunity, Overview of the Integrated Care Model, Project Requirements, Project Proposal Template.

I. BACKGROUND

A. NEED FOR INTEGRATED CARE

Nearly 57% of the U.S. population will experience a BH disorder at some time during their lifetime¹ and more than 32% will have experienced a BH disorder during the previous twelve months.² Despite this great need, most people with BH disorders remain either untreated or under-treated. As a result, they and their families suffer detrimental consequences emotionally, physically, and financially. More than half of adults who need BH services go without them³ due to lack of access to quality specialty BH care⁴ and other systematic barriers, such as lack of transportation, finances to pay additional deductible and/or copayments, and inability to take time away from work. This is especially true among poor and disadvantaged populations.

Individuals with untreated BH problems show higher use of healthcare resources and greater medical morbidity and mortality than do those with BH problems who have been treated. As a result, they are more expensive to treat and have worse physical health outcomes. The evidence indicates that treating these problems early will result in better initial care and fewer subsequent hospitalizations.⁵

¹ Kessler, Ronald C.; Berglund, Patricia; Chiu, Wai Tat; Demler, Olga; Heeringa, Steven; Hiripi, Eva; Jin, Robert; Pennell, Beth-Ellen; Walters, Ellen E.; Zaslavsky, Alan; Zheng, Hui (June 2004). "The US National Comorbidity Survey Replication (NCS-R): Design and field procedures" *International Journal of Methods in Psychiatric Research*. 13 (2): 69–92

² <http://www.hep.med.harvard.edu>

³ CenterforBehavioralHealthStatisticsandQuality:2015tz

⁴ <http://www.mentalhealthamerica.net/issues/state-mental-health-america>

⁵ <https://www.namep.org/healthgmtinst/Benefits%20of%20Preventative%20Behavioral%20Health%20Treatment%20Part1%208%2029.pdf>

Historically, the healthcare delivery system has been fragmented. BH services have been separated from physical health care, requiring that patients with BH problems be referred out from the primary care setting to specialty BH providers. However, studies have shown that individuals are more likely to seek BH treatment with their primary care provider. It is more convenient and also reduces the stigma attached to seeking treatment within a specialty care setting. In addition, a growing body of evidence indicates that treating both physical and behavioral health conditions in an integrated way is a better approach because it improves access and results in enhanced clinical outcomes and lower health care costs.⁶ The Federal government and states around the country are showing an increased interest in the integration of BH care into primary care settings,⁷ not only because of the tremendous need and high costs associated with untreated or under-treated BH conditions, but because of the evidence that integration improves outcomes and reduces costs.

B. THE NICHOLSON FOUNDATION'S SUPPORT OF INTEGRATION

The Nicholson Foundation (TNF) is dedicated to improving the health and well-being of vulnerable populations in New Jersey. TNF's primary goal is to improve outcomes in health and early childhood. Our strategic approach is to transform service delivery systems by informing policy and developing sustainable models that better serve vulnerable populations.

As part of this overall mission, TNF has expanded its efforts to strengthen New Jersey's primary care system. A central focus for these efforts since 2012 has been helping primary care clinics enhance their capacity to treat BH conditions within the primary care setting. We have worked with Cherokee Health Systems (Cherokee) and supported the implementation of their model at eight treatment sites consisting of five Federally Qualified Health Centers (FQHCs) and three ambulatory outpatient clinics as a way to help these clinics and practices serving the safety-net population develop the necessary skills to deliver evidence-based integrated health care. We have also supported [analyses](#) of the regulatory and fiscal barriers that impede integrated care and are funding [Seton Hall University Law School](#) to work with the State of New Jersey to remove or minimize these barriers. In addition, as way to address future workforce development needs, we are currently supporting [Rutgers University](#) to develop the necessary framework to create a new training paradigm across multiple departments at the University for future students enrolled in the health professions that focuses on the integration of behavioral health into primary care.

TNF now seeks to support additional clinics or practices to implement Cherokee's evidence-based model of integrated care. To ensure that we build on the lessons learned from the eight treatment sites referenced above, we are proposing a structured project, which we describe below in the Project Requirements section in this RFP. We provide detailed instruction and expect that successful applicants will adhere closely to these specifications. In keeping with TNF's approach to grant-making, we tie a portion of the grant award to specific attainable performance objectives to ensure that grantees are accountable for outcomes. These objectives were developed based on the performance of the earlier Nicholson-funded sites in their first year of implementation. They are designed to help grantees that are new to integrated care to implement the Cherokee model. Our aim is that the model will provide an operational and clinical framework that over time will lead to financial sustainability without additional grant funds. Once grants are awarded, Cherokee will work closely with each selected grantee to maximize project success.

⁶ Butler, M. et al, Evidence Report/Technology Assessment. *Integration of mental health/substance abuse and primary care*. Nov 2008 (173):1-362

⁷ Matthew J. Press, M.D., Ryan Howe, Ph.D., Michael Schoenbaum, Ph.D., Sean Cavanaugh, M.P.H., Ann Marshall, M.S.P.H., Lindsey Baldwin, M.S., and Patrick H. Conway, M.D (February 2017)

II. DESCRIPTION OF THE GRANT OPPORTUNITY

The total value of this opportunity is \$200,000 for each clinic or practice to offset the costs of implementing this project (e.g., hiring new staff and/or allocating existing staff time to work on this project as well as travel and lodging to participate in Cherokee's Training Academies in Knoxville, Tennessee). The training and technical assistance provided by Cherokee and other consultants will be separately funded by TNF at no cost to the clinics or practices. Twenty-five percent of the grant will be contingent upon achieving specific performance objectives, which are identified below in Table 2, page 10.

This funding opportunity will be for 15 months, beginning in July 2019. The first three months will be considered a start-up period. A maximum of four organizations will be selected to participate in this funding opportunity. Organizations with multiple sites must submit a proposal for one site only.

Successful applicants must be a primary care clinic or practice, such as an FQHC or an ambulatory outpatient clinic, serving a high percentage of Medicaid patients. Applicants must also:

- Demonstrate the commitment of their executive team to implement this project (e.g., through the amount of time allocated to working with Cherokee, other designated consultants, and TNF, as well as in-kind contributions to the project);
- Hire or select a qualified behaviorist (e.g., licensed psychologist or licensed clinical social worker) in consultation with Cherokee to serve as a Behavioral Health Consultant (BHC);
- Collect and share data and participate in an evaluation of this project; and
- Participate in all Cherokee-facilitated training, technical assistance, and support services, which are described below.

All primary care clinics or practices agreeing to these criteria are invited to apply.

Any questions pertaining to this RFP can be directed to Barbara Kang, Senior Healthcare Program Officer, The Nicholson Foundation at bkang@thenicholsonfoundation.org. Proposals should be submitted to her at the same email address.

IMPORTANT DATES:

- Proposal submissions due: March 15, 2019
- Notification of awards: May 1, 2019
- Start date of funding: July 1, 2019
- End date of funding: September 31, 2020
- Cherokee Health Systems Training Academy: August 22 & 23, 2019
- Cherokee Health Systems BHC Academy: October 24 & 25, 2019

III. OVERVIEW OF THE INTEGRATED CARE MODEL

A. DESCRIPTION OF CHEROKEE HEALTH SYSTEMS

Cherokee Health Systems (Cherokee) has a long history of providing integrated primary care and BH services to underserved communities in Tennessee. Since 1960, Cherokee has delivered quality treatment to all members of its community, with a particular focus on those who are uninsured, underinsured, and have limited resources (less than 200% of federal poverty level). Cherokee has grown from a small community mental health center (CMHC) to a statewide FQHC. In 2017, Cherokee served nearly 79,000 patients with approximately 410,000 services, and currently employs 711 staff in Knoxville, Chattanooga, Memphis, and rural East Tennessee, including 81 primary care providers and 15 BHCs. In addition, Cherokee is a teaching health center with 21 primary care residents.

Since 2010, Cherokee has offered Integrated Care Training Academies in Knoxville, and has trained more than 4,500 individuals from more than 700 organizations (primarily FQHCs, CMHCs, and health systems) in all 50 states and Puerto Rico, the United Kingdom, and Singapore. In addition, Cherokee has worked with 18 State Primary Care Associations, and has provided integrated care trainings and technical assistance to numerous organizations across the United States.

Cherokee has become a leader in the development and delivery of integrated behavioral and primary health care. It was highlighted as an exemplary model of integrated care in a 2012 review⁸ sponsored by the Milbank Memorial Fund and also in a 2015 report⁹ prepared by the Agency for Healthcare Research and Quality. In 2015, The National Committee on Quality Assurance honored Cherokee's "whole health approach" and recognized the organization's work as a Patient-Centered Medical Home. Cherokee was also selected by the National Association of Community Health Centers as one of nine "best practice" exemplars of educational health centers across the nation.

In 2013, Blue Cross and Blue Shield of Tennessee conducted a study that compared Cherokee Health Systems (using an integrated care model) to its "peers" (which did *not* use an integrated care model) and found a 117% increase in primary care visits, a 68% decrease in emergency room visits, a 32% decrease in hospitalizations, a 32% decrease in referrals to specialists, and an overall decrease of 22% in total cost of care for their members. It is important to note that the dramatic increase in primary care visits is a desired result, as it demonstrates greater engagement in a primary care "home," and less dependence on emergency departments for routine care.

B. CHEROKEE'S INTEGRATED PRIMARY AND BEHAVIORAL CARE MODEL

Cherokee's integrated health care model is an interdisciplinary team-based approach designed to provide patients with access to collaborative, continuous, and cost-efficient care for a comprehensive array of physical and behavioral health problems. In this approach, a primary care team of medical, behavioral, and other healthcare professionals works together to provide patients with preventive, primary, and behavioral health care. Licensed behaviorists serve as BHCs in primary care

⁸ <https://www.milbank.org/wp-content/uploads/2016/04/EvolvingCare.pdf>

⁹ www.ahrq.gov/professionals/prevention-chronic-care/improve/mental/index.html

settings, working as a part of a primary care team that also include up to four primary care providers (PCP), a nurse, and a care manager. The clinic or practice can bill for the BHC's patient services.

During a typical primary care visit, a nurse from the primary care team will take a patient's medical vitals (e.g., height, weight, blood pressure) and BH vitals, which consists of four questions (two prescreen questions for depression and two prescreen questions for substance misuse). If responses to any of the BH questions are positive, the nurse will ask additional BH screening questions. Once completed, the results of all vitals (medical and behavioral) are entered into the electronic health record (EHR) for the PCP. A patient who screens positive and/or discloses a BH issue directly to the PCP will be referred to the BHC, who conducts a brief assessment and intervention in real-time during the primary care visit.

In this model, the BHC works as an integral member of the primary care team to help address BH and medical issues that affect patient overall health and well-being. The BHC provides a range of health-related services to patients, including psycho-education, management of behavioral factors in illness and health, and implementation of evidence-based treatment protocols for mental health and substance misuse disorders. Providers and other members of the primary care team can also consult with the BHC regarding patients' BH issues, as needed. These functions are performed with the goal of keeping services in the primary care setting whenever clinically appropriate, rather than referring out to specialty care, as BH treatment is limited and difficult to access, especially for underserved populations.

The interdisciplinary primary care team gathers for brief daily team huddles and weekly meetings to review, discuss, and coordinate clinical issues of their patients. This level of communication and collaboration between physical health and BH providers improves access to much of the care that is needed and facilitates quality integrated care. In addition to in-person consultations and team meetings, interdisciplinary communication is facilitated by Cherokee's integrated EHR in which all providers (e.g., medical provider, psychologist, care manager) document their patient contacts, services, and treatment goals. This integrated care approach enables providers to coordinate and co-manage care in a cost-effective and clinically effective manner by reducing service duplication, increasing inter-professional communication, and capturing broader diagnostic impressions for treatment planning.

Typically, 70% to 80% of Cherokee's patients presenting with BH issues continue to meet with the BHC during subsequent follow-up primary care visits. They remain in the primary care setting and are not referred out to specialty care. The remaining 20% to 30% of patients require more traditional treatment and are referred to specialty BH care in the community by the BHC. The treatment progress of these patients is monitored by the care manager, noted in Cherokee's EHR, and communicated to the BHC and other members of the primary care team. At subsequent primary care visits, the BHC and/or the PCP follows up and checks in on these patients' BH condition.

C. DESCRIPTION OF CHEROKEE AND OTHER CONSULTING SERVICES TO BE PROVIDED TO ORGANIZATIONS SELECTED TO RECEIVE A NICHOLSON GRANT

Cherokee and other consultants will provide training, technical assistance, and support services to participating clinics or practices to guide them in integrating BH into their primary care services, as described below. These services will be provided at **no** additional cost to grantees.

Kick-off Meeting – An all staff kick-off meeting will be held at each clinic or practice where the organization’s leadership team and Cherokee will explain the project in more detail, provide an overview of Cherokee’s support and coaching services, review project timelines and requirements, and provide an opportunity for questions and answers. We anticipate that this kick-off meeting will occur once at each organization at the start of this project and last approximately 2 to 2 ½ hours.

Onsite Visits and Ongoing Calls to Improve Billing Protocols – Establishing appropriate billing protocols is critical to financially sustaining this model. Therefore, an independent consultant with expertise in billing and coding practices in New Jersey will provide each clinic or practice with assistance to efficiently bill for integrated services. These services will include an initial assessment, recommendations for modifications, and regularly scheduled visits and calls to improve the billing and coding protocols at each clinic or practice to increase approval rates and reimbursement of integrated services.

Integrated Care Training Academy – In this 2-day training program held in Knoxville, Tennessee (August 22 and 23, 2019), Cherokee’s executive leadership will give an overview of their model of integrated care and provide information about billing and reimbursement, staffing and hiring best practices, operational workflow, and sharing of patient documentation. Each organization should send a minimum of three staff to attend the Academy Training. At least one of the attendees should be a member of the grantee’s executive leadership (e.g., Chief Executive Officer, Chief Medical Officer, Chief Financial Officer). Attendees can also include members of the primary care team, such as providers or the BHC.

Assistance in Hiring and/or Selecting a BHC to Participate in this Project – Because the selection of the BHC is critical to the success of this project, Cherokee’s clinical leadership will provide technical assistance in the BHC selection. They will work with grantee leadership to develop a job description and help identify the best candidate for this position. Before the grantee makes the final hiring decision, Cherokee, along with the appropriate grantee staff, will meet by teleconference with the BHCs being considered for this project and provide feedback to grantees to help inform their BHC selection. The expectation is that a BHC is selected and onboard by October 1, 2019. Therefore, upon notification of awards on May 1, 2019, organizations are encouraged to begin recruitment activities immediately, which will allow up to five months to complete the hiring process.

BHC Academy Training – In this 2-day training in Knoxville, Tennessee (October 24 and 25, 2019), Cherokee’s clinical leadership will instruct BHCs on clinical approaches to brief assessment and intervention, motivational interviewing, effective communication styles, and working as a member of a primary care team. The behaviorist hired to be the BHC in this project must attend this training.

Onsite Training, Clinical Supervision, and Coaching Calls – Recognizing the need for ongoing support, coaching calls and onsite training and supervision will be provided to the BHCs, members of the primary care team, and clinic or practice administrators. This assistance will help clinics or practices to operationalize and implement Cherokee’s model (e.g., develop workflow, draft protocols, improve clinical interventions, structure team meetings and huddles, assist with billing/reimbursement).

The onsite training and supervision provided by Cherokee staff will be half or all-day sessions, allowing sufficient time for Cherokee to work with all staff, including providers at each clinic or practice who will be involved in this project. These onsite visits will occur every other week, during the first quarter of project implementation, and then decrease in frequency in subsequent quarters. Cherokee will provide guidance to the BHC on improving clinical skills and intervention techniques. They will observe the BHC during patient interventions and provide immediate feedback. Cherokee will also work with the primary care teams to develop an efficient workflow and help structure team huddles and meetings. In addition, they will conduct an educational series targeted specifically at providers to enhance their engagement and collaboration with the BHC.

The coaching calls will be 1 to 1½ hours and are intended to provide clinical and operational support to the BHCs and other staff involved in this project. The coaching calls will occur every other week during the first quarter of project implementation, and then decrease in frequency in subsequent quarters. The frequency of these visits and calls may change slightly based on the needs of the BHC and the primary care team at each clinic or practice.

Group Collaborative Calls – Because each clinic or practice will only have one BHC on staff, it is important to provide opportunities for group supervision to allow the BHCs from all of the participating organizations to provide peer support, learn from each other’s experiences, and share successes and challenges. These calls will occur quarterly, in the last three quarters of this grant, and will last approximately 1 to 1½ hours.

Leadership Meeting and Ongoing Calls – As a way of engaging the leadership at each clinic or practice, Cherokee will meet regularly with each grantee’s leadership to review project expectations and progress, including measuring outcomes and evaluating quality of services, discussing financial sustainability, getting insight about contracting with managed care companies, providing strategy and execution tips, and helping to resolve issues to ensure that project objectives are met. At the beginning of the project, Cherokee’s leadership will meet in person with the leadership from each of the participating clinics or practices. This initial leadership meeting will last approximately 1 to 1½ hours and will be followed by conference calls, which will occur monthly and then decrease to quarterly.

Table 1 below illustrates the timeframe and frequency of each Cherokee and billing and coding consulting service to be provided. The frequency of some of these services may change based on the needs of the clinic or practice.

Table 1: Cherokee Services

QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4	QUARTER 5
Kick-off Meeting (1x)	BHC Academy Training (1x)	Onsite Training & Clinical Supervision (1x/month)	Onsite Training & Clinical Supervision (1x/quarter)	Onsite Training & Clinical Supervision (1x/quarter)
Integrated Care Academy Training (1x)	Onsite Training & Clinical Supervision 2x/month)	Clinical Coaching & Supervision Calls (1x/month)	Clinical Coaching & Supervision Calls (2x/month)	Clinical Coaching & Supervision Calls (1x/month)
BHC Selection & Hire (1x); START DATE OF OCTOBER 1	Clinical Coaching & Supervision Calls (2x/month)	Leadership Council Calls (1x/quarter)	Leadership Council Calls (1x/quarter)	Leadership Council Calls (1x/quarter)
Leadership Council Meeting (1x)	Leadership Council Calls (1x/month)	Group Collaborative Calls (1x/quarter)	Group Collaborative Calls (1x/quarter)	Group Collaborative Calls (1x/quarter)
Billing & Coding Assessment Visit & Follow Up Call (1x)	Billing & Coding Consulting Calls (3x)	Billing & Coding Consulting Calls (1x)	Billing & Coding Consulting Calls (1x)	Billing & Coding Consulting Calls (1x)

IV. PROJECT REQUIREMENTS

As noted earlier, Cherokee’s model is a primary care interdisciplinary team approach to integrated care. This team typically comprises one BHC, up to four PCPs, a nurse, and a care manager. Because TNF is recommending the implementation of Cherokee’s team approach in this project, the funding from this grant should be used to hire new staff and/or allocate existing staff for the BHC position. Funds can also be used toward patient engagement support (e.g., care manager, community health worker) or other staff time that serve functions integral to this project (see below for suggestions). In addition, TNF funds should be used to support staff to travel to Knoxville and participate in the required Cherokee training. **Organizations are strongly encouraged to provide additional in-kind resources to assist in the successful implementation of this project** (e.g., project lead’s time, PCPs’ time to participate in team huddles, staff time, including leadership to participate in Cherokee trainings and calls).

Although we anticipate that each clinic or practice will make slight modifications to Cherokee’s model based on current staffing, patient population, facility design, and clinic or practice resources, we ask that the general tenets of the model be followed. Clinics or practices should select one adult medicine primary care team to participate in this project. In their proposal submission to TNF, clinics or practices should describe how they will implement this project using the suggested staffing, described in section IV.A. below, and how they will achieve the required project objectives, described in section IV.C. below. Detailed instructions for completing the project proposal can be found on pages 11-13.

A. STAFFING

1. Required Staffing: *These staff can be an in-kind contribution or Nicholson-funded*

Project Lead (.20 FTE) – A project lead must be identified in the proposal to serve as the primary contact with TNF and Cherokee. This individual oversees the management of the project and ensures that the clinic or practice meets project objectives. Priority will be given to organizations that select a Chief Medical Officer or the Director of Integrated Care to lead this project and designate his or her time as an in-kind contribution.

Behavioral Health Consultant (1.0 FTE) – A BHC must be hired or assigned to work full-time on this project. The BHC works as a member of a primary care team, provides brief assessments and interventions to patients in real-time during the primary care visit. This position should be funded by the Nicholson grant.

2. Other Staff or Functions to Consider: *These staff or functions can be in-kind contribution(s) or Nicholson-funded*

Nurse or Medical Assistant – Works with BHC or other members of the primary care team to screen patients for BH issues and coordinate patient care.

Patient Engagement Support Staff – Works with the BHC or other members of the primary care team to connect patients to community services based on the needs identified by the primary care team. This person can be a care manager, community health worker, or medical assistant.

Billing and Fiscal Staff – Works with the Project Lead and/or the BHC to accurately bill for services, track revenue from BHC patient encounters, and provide feedback to Cherokee and TNF regarding reimbursements. This information will be used to gauge progress toward the program’s financial sustainability.

Data Analyst– Collect data and provide reports to the project lead and/or the BHC to manage and monitor progress of the project. Work closely with the BHC to identify and generate reports of patients who are seen by the BHC, provided an intervention, and followed over time. These data will be used to measure impact on health outcomes (see Performance Measures description in C. below).

B. Required Participation in Training and Technical Assistance

Cherokee and other consultants will provide approximately 150 hours of training and technical assistance to support the integration efforts at each clinic or practice (see page 8, Table 1), and clinics or practices are expected to take advantage of this opportunity to participate fully in this assistance.

The training and technical assistance provided through this grant is designed to help clinics or practices successfully integrate behavioral health interventions into their primary care services, using a team-based approach. The services, which are detailed earlier in this RFP (pages 6-8), will focus on four main topics: (1) providing training to primary care teams, as well as clinic administrators, on Cherokee’s integration model, (2) providing clinical supervision to the BHC and primary care teams, (3) assisting clinics or practices to operationalize the model (e.g., staffing, workflow), and (4) assisting clinics or practices to develop a financial sustainable integration model.

In addition to Cherokee’s training, clinics or practices are also expected to take advantage of the billing and coding consulting services that will be provided through this grant (see pages 6-8). Assistance will be tailored to meet the specific needs of each participating clinic or practice to adjust billing protocols to enhance reimbursement of integrated care services.

C. Required Project Objectives

The project objectives in Table 2 (below) are intended to serve as a roadmap to help structure and operationalize this project. We have identified a number of key objectives that are important to successfully implement Cherokee's model. Achieving these objectives will advance integrated care and financial sustainability. These objectives are based on the experience of the clinics and practices previously funded by TNF to implement Cherokee's model of integrated care.

Start-up activities – We have identified necessary start-up activities and included them as objectives to achieve in Quarter 1 of this grant.

BHC Patient Encounters – We have identified a target number of patients that a BHC should see each day and an approximate quarterly target and included these as objectives. Based on our previous experience, we think it is important to set these targets immediately at the outset. The target number is very low at the start of this project to allow for learning opportunities for the BHC and it steadily and slowly increases each quarter.

Billing and Revenue Projections – Cherokee's approach is one that not only improves patient care and health outcomes, but also becomes financially sustainable because the clinics or practices bill for BHC patient encounters. Therefore, we are requiring clinics or practices to provide revenue projections based on the number of BHC patient encounters and each clinic's or practice's average reimbursement rate. We have identified a target number of Medicaid and other claims (which are tied to the number of target safety-net patient BHC encounters) that we expect each clinic or practice to submit for payment. Although the revenue generated from this project will vary depending on each clinic's or practice's reimbursement rate, we expect that over the 15 months of this grant, each clinic or practice will submit claims for approximately 420 BHC patient encounters (see Table 2 below). We recognize that all claims submitted may not be reimbursed. Cherokee and our designated billing consultant will work with each grantee to ensure maximum reimbursement. It is uncertain how much revenue each clinic or practice will generate from this project. However, the expectation is that grantees will work closely with Cherokee and the billing consultant to improve billing practices and that all revenue generated from the BHC patient encounters will go toward supporting the overall goals of this project.

Performance Measures – As a part of this project, grantees will be asked to develop a protocol to measure the impact of delivering integrated care on patient health outcomes. Each clinic or practice should identify metrics and develop a mechanism to report on patient progress after receiving BHC interventions. The metrics should include the number of patients and physical and/or BH conditions (suggested conditions include depression, diabetes, and hypertension) that clinics or practices plan to monitor. We require that clinics or practices choose at least one physical health condition and one behavioral health condition to monitor.

As previously referenced, 25% (\$50,000) of the overall grant award will be contingent upon achieving specific performance benchmarks. As shown below, the amount associated with each objective varies and was developed based on lessons learned from our earlier Nicholson-funded clinic or practice. **Please review and complete Table 2 below and insert it in the Measurable Objectives section of your project proposal submission to The Nicholson Foundation, which is further described on pages 12-13. Potential grantees may include additional objectives and**

also suggest alternative payments for achieving these objectives in their project proposal submission.

Table 2: Measurable Objectives

Performance Objectives	Due Date	Staff Responsible	Supporting Documentation	Payments for Achieving Objectives
Assign required staff to participate in this project	Quarter 1	TBD	List of staff names & titles	N/A
Work with Cherokee to Hire or Assign BHC	Quarter 1	TBD	BHC résumé & start date	\$2,000
Develop new operational workflow for this project	Quarter 1	TBD	Description of workflow	N/A
Develop policies and procedures for this project	Quarter 1	TBD	Written policies & procedures document	N/A
Ensure that three clinic or practice staff (one clinical and one from the executive leadership) attend Cherokee’s Academy Training in Knoxville	Quarter 1	TBD	Signed attendance	\$2,000
Ensure that at least two members of the grantee’s leadership attend Cherokee’s leadership council meeting	Quarter 1	TBD	Signed attendance	\$2,000
Ensure that leadership and designated staff engage in billing consulting services	Quarter 1	TBD	Assessment & recommendations	\$2,000
Identify metrics to monitor physical and/or behavioral health outcomes during this project. Develop protocol for ongoing data collection and monitoring (e.g. number of patients, health conditions that will be tracked).	Quarter 1	TBD	Summary report identifying metrics & describing protocol	\$2,000
Complete 2 BHC encounters/day (approximately 120 BHC encounters/quarter)	Quarter 2	TBD	EHR-generated report	\$2,000
Complete & submit claims for at least 50% (60) of all BHC patient encounters	Quarter 2	TBD	Claims report	\$2,000
Ensure that BHC participates in all Cherokee onsite clinical visits and coaching calls	Quarter 2	TBD	Attendance list from Cherokee	\$2,000
Ensure that leadership and designated staff engage in billing consulting services	Quarter 2	TBD	Summary of follow up actions	\$2,000
Complete 3 BHC encounters/day (approximately 180 BHC patient encounters/quarter)	Quarter 3	TBD	EHR-generated report	\$2,000
Complete & submit claims for at least 50% (90) of all BHC patient encounters	Quarter 3	TBD	Claims report	\$2,000
Ensure that BHC participates in all Cherokee onsite clinical visits and coaching calls	Quarter 3	TBD	Attendance list from Cherokee	\$2,000
Submit interim report describing 6 months of project operations, including challenges & successes, number of BHC patient encounters, amount of revenue generated, and any planned changes	Quarter 3	TBD	Interim report	\$3,000
Complete 4 BHC encounters/day (approximately 240 BHC patient encounters/quarter)	Quarter 4	TBD	EHR-generated report	\$2,000
Complete & submit claims for at least 50% (120) of all BHC patient encounters	Quarter 4	TBD	Claims report	\$2,000
Ensure that BHC participates in all Cherokee onsite clinical visits and coaching calls	Quarter 4	TBD	Attendance from Cherokee	\$2,000
Report baseline data for 50 patients whose physical and behavioral health conditions are being monitored, based on the metrics and protocol developed.	Quarter 4	TBD	EHR-generated report	\$3,000
Complete 5 BHC encounters/day (approximately 300 BHC patient encounters/quarter)	Quarter 5	TBD	EHR-generated report	\$2,000
Complete & submit claims for at least 50% (150) of all BHC patient encounters	Quarter 5	TBD	Claims report	\$2,000
Ensure that BHC participates in all Cherokee onsite clinical visits and coaching calls	Quarter 5	TBD	Attendance from Cherokee	\$2,000
Report baseline data for 50 patients whose physical and behavioral health conditions are being monitored, based on the metrics and protocols developed and compare outcome data to baseline data.	Quarter 5	TBD	EHR generated report	\$3,000
Submit Year 1 final report describing activities, lessons learned, and next steps. This should also include a summary of BHC encounters, revenue generation, and findings of physical/behavioral health outcomes	Quarter 5	TBD	Summary report	\$5,000
TOTAL				\$50,000

V. PROJECT PROPOSAL TEMPLATE

Please submit a proposal, using the format below. Include the bolded section headers, underlined sub-headers, remove the instructions under each category, and add your information in its place. In the Project Description section, include the bolded section headers and sub-headers, the questions or issues, and your responses. Do not exceed 15 pages. The budget and budget narrative are not included in this 15-page limit. Please note that organizations providing in-kind contributions toward the implementation of this project will receive stronger consideration.

1. **DATE OF THIS PROPOSAL**

Specify the date of this proposal's submission to The Nicholson Foundation.

2. **PROJECT NAME**

Create a unique name for this specific project.

3. **INDIVIDUAL RESPONSIBLE FOR THE PROJECT**

Provide the name, title, address, e-mail, and telephone number of the individual responsible for the project.

4. **ORGANIZATION AND INDIVIDUAL RECEIVING AND DISBURSING THE GRANT FUNDS**

Provide the name and address of the organization receiving the grant funds and the name, title, address, telephone number, and e-mail of the individual receiving and disbursing the grant funds.

5. **NAME AND DESCRIPTION OF THE ORGANIZATION REQUESTING FUNDING**

- A. Legal name of the organization requesting funding and, as appropriate, the acronym of the name in parenthesis.
- B. Name of the contact person, his or her title, address, telephone number, and e-mail address.
- C. Organization's web site address.
- D. Description of the mission and current principal activities of the organization.

6. **PROJECT DESCRIPTION**

Include a response or explanation to the issues raised below. Include the underlined sub-headings and issue in your submission.

Organizational Background *Provide a description of your organization and site selected.*

- a. Describe organizational background including patient population, patient volume, staffing, current payer case mix (e.g., Medicaid, Medicare, commercial), license of the clinic or practice, and service area.
- b. Describe current or previous behavioral health services provided at your clinic or practice and provide outcomes from these efforts, if available. Identify funding source(s), if any.

- c. Describe current or previous behavioral health integration efforts and provide a summary of the outcomes from these efforts, if available. Identify funding source(s), if any.
- d. Explain why you are interested in participating in this project.
- e. If your organization has multiple sites, describe the site selected and explain why it was chosen. Provide the patient volume, the number of primary care teams, and a description of the staffing.

Proposed Approach *Provide a description of how you plan to implement this project.*

- a. Explain the process you will use to work with Cherokee to hire or select a BHC. Describe how you will coordinate the required Cherokee trainings and meetings and identify which staff will participate. Identify the executive leadership of your clinic or practice who will participate in the Cherokee leadership council meeting and calls. Describe how and when you will introduce this project to your entire clinic or practice and keep them informed of progress. Describe your agenda for the kick-off meeting and how you will involve Cherokee.
- b. Identify the department, the project lead, and all other staff, including the primary care team (provide titles and credentials) who will work on this project, their roles and responsibilities, and how they will work together to ensure project success. Describe how you will configure office/exam rooms to best accommodate this project.
- c. Describe the operational workflow needed to meet project requirements.
- d. Describe how many patients you plan to screen each quarter, who will administer the screens, and how and when the patients will be screened. Identify the number of BHC patient encounters that you propose to have each quarter and describe the operational process (Note: The minimum required number of BHC patient encounters is identified in Table 2 in IV.C above).
- e. Describe how often you plan to have integrated team meetings and huddles and what they will consist of. Identify which staff will be involved. Describe how your primary care team will communicate with each other to address patient issues (e.g., through your EHR, team huddles, or another approach).
- f. Describe collaborative relationships that you will develop with any specialty behavioral health providers to which you will refer patients during the project and how each partner will work together, share information, and communicate about mutual patients.
- g. Describe the procedures for monitoring the project and obtaining feedback for quality improvement. Explain how you will determine when operational changes need to be made and how will they be implemented.

Measurable Objectives *Insert Table 2 (see p.11, above) in this section of your proposal submission to TNF and identify staff responsible for each of the objectives. You may include additional objectives and also suggest alternative performance payments, as needed.*

- a. Describe the information that you anticipate including in your interim and final reports. (Note: Suggested content for both reports is described in Table 2)

Data Collection and Measuring Outcomes

- a. Identify physical and/or behavioral health metrics that you plan to monitor for this project and why. Choose at least one physical and one behavioral health metric. Suggested metrics are HbA1c levels for uncontrolled diabetes, blood pressure for uncontrolled hypertension, and PHQ-9 scores for depression.
- b. Identify the number of patients you plan to monitor for each metric, the period of time you will monitor them, and how and when you plan to collect outcomes data. Describe the process you will use to accomplish these tasks. (Note: As identified in Table 2, the minimum number of patients to track is 50).

Revenue Projections

- a. Include your revenue projections for this project and describe how they were derived (Note: The minimum required daily BHC patient encounter projections and approximate quarterly BHC patient encounter targets are identified in Table 2).
- b. Explain how you will use the revenue generated from this project to help achieve behavioral health integration and financial sustainability.
- c. Describe your current billing practices and state whether you handle services in-house or through an outside contractor. Describe your willingness to work with a billing consultant and identify any challenges that you may have to encounter to overcome these obstacles.
- d. Describe the procedures you will use to ensure that your billing department efficiently and accurately submits claims for this project.

7. BUDGET

Complete the attached Excel document. Also include a narrative description of your budget using the underlined sub-headings below. Remove the instructions and add your information in its place. You should also include staff and other resources that will be provided in-kind in your budget.

Budget Narrative:

- a. **Personnel Costs** – Include for each staff person (if person is known):
 - i. Name
 - ii. Job Title
 - iii. FTE of each staff budgeted to this project
 - iv. Amount of budget allocated
- b. **Other Than Personnel Services** – Describe all non-salary categories (these should correspond with the categories listed in the attached Excel document).
- c. **Administrative Overhead** – State percentage added to total budget. **It is The Nicholson Foundation Policy to limit Administrative Overhead to 10% of your entire Nicholson Foundation Budget.**

- d. **Other Cash Funding** – Describe where these funds are from and how the funds will be released and made available to the project.
- e. **In-kind Funding** – Describe the services or materials that are being contributed, who is providing the support, and the dollar value of the support.