Request for Applications RFP – 2017

From Planning to Action: Pilot Demonstrations Supporting Integrated, Collaborative Care for People with Intellectual and Developmental Disabilities

FUNDING AGENCY: The Arc of NC with funds awarded by the North Carolina Council on Developmental Disabilities (NCCDD), NC Department of Health and Human Services (DHHS)

Release DATE: the week of January 30, 2017

Teleconference Call overview: February 7, 2017, 3pm. 877-594-8353. Code 33687575#

SUBMISSION DATE: March 10, 2017 by 6pm EST

Letters of notification: April 4, 2017

In its Five Year Plan, the NCCDD set the goal to increase community living for individuals with intellectual and other developmental disabilities throughout their lifespan, with a specific objective to increase Health and Wellness Opportunities.

From Planning to Action is a partnership among The Arc of NC, Easter Seals UCP, and the Autism Society of NC that transitions the systems-change planning groundwork of the Medical Health Home Initiative (MHHI) into actionable demonstrations that advance innovation in healthcare and services for people with I/DD. It is essential to pilot and evaluate innovative approaches before full-scale implementation. "If we knew what worked, we wouldn't need a pilot".

Who May Apply

Eligible applicants include any North Carolina not-for profit agency/organization that demonstrates organizational expertise and capacity to conduct described activities[1]. Pilot sites will be selected with considerations for geographic variability, feasibility of proposal, required match, and engagement of community partners.

In addition to pilot goals, additional issues of concern identified by our Advisory Consortium include the needs of rural communities, aging caregivers, individuals with IDD and co-occurring behavioral health needs, life transitions, and bilingual populations. It is not expected that one applicant will address all of these considerations, but identify priority needs and gaps, populations of concern, and community assets based on their organizational mission, resources, and partnerships.

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[1] From Planning to Action: Supporting Integrated, Collaborative Care for People with Intellectual and Developmental Disabilities partnering agencies, The Arc of NC, Easter Seals UCP, and the Autism Society of NC, are not eligible to apply but may be included as an identified community partner.

An organization / agency may submit ONLY one application, selecting one of the two focus areas. However, an organization/agency can be a partner on another proposal/application.

Budget

The funding for this RFP is $25,000 per year with **required minimum of $25,000 match (funds or dedicated staff) per year**. The application requires a budget outline and justification for year one (maximum of 2 pages). The required match must be included in the budget outline. This three-year project, funded by the NC Council on Developmental Disabilities, runs January 2017 through December 2020, and it is anticipated that the pilot demonstration sites will be funded at $25,000 each year through 2020. Continuation of funding is contingent upon the applicant's performance AND continued funding from the United States Administration on Intellectual and Developmental Disabilities (AIDD) and the NC Council on Developmental Disabilities.

Additional Requirements

- Minimum participation of (2) community partners confirmed by a documented MOA (memorandum of agreement)
- Formation of a community advisory group linked specifically to the pilot demonstration. Members must include individuals with IDD, family members, health care providers and disability providers among others
- Active engagement with the Planning to Action project team and an external evaluator; and sharing data linked to evaluation plan
- Participation in the established Community-Academic-Provider Advisory Consortium that meets 3 times per year. One in person meeting per year, other meetings can be in person or via conference technology

Application Process:

Submit application and attachments electronically to Karen Luken, Project Director, karenluken@gmail.com

Background

From Planning to Action: Pilot Demonstrations Supporting Integrated, Collaborative Care for People with Intellectual and Developmental Disabilities is a partnership among The Arc of NC, Easter Seals UCP, and the Autism Society of NC that transitions the systems-change planning grant, Medical Health Homes (MHHI) for People with IDD, into actionable demonstrations that advance innovation in integrated, collaborative care and services for people with I/DD. The project will support two (2) pilot demonstrations with each pilot focusing on either health care consultation OR health informed navigation:

Pilot Foci:

1. **IDD Health Care Consultation** is designed to improve the capacity of primary and community health care providers to provide quality care to individuals with IDD through consultative access to medical and clinical professionals with I/DD expertise. This focus links directly to the Key Recommendation Access to & Continuity of Care: to *establish*

statewide consultation network of medical, mental health, and dental health professionals knowledgeable about IDD; *and address poly-pharmacy and medication issues by improving evidence-based prescribing and monitoring*. The consultation pilot is aligned with Session Law 2015-245: progress toward integrated care, person-centered health communities and systems, and improved quality and consistency of care.

The goal of a Consultation team/network is to develop a multidisciplinary resource that improves knowledge, skills and ability of primary care and community providers to care for patients with IDD in their practices, so that individuals with IDD can access care in their community of choice.

The consultation proposal should address the following questions:

- Who is the target "patient" population of need?
- Who are the target care providers/recipients of consultation services?
- What is the proposed composition of the consultation team to be developed over time?
- How will you outreach to the intended recipients of consultation services?
- What are the potential outcomes that the consultation services are intended to address?
- How can they be measured?
- What consultation model/approach do you consider a best fit for your organization, target population and community?
- How will consultation enhance the ability of healthcare professionals to provide accessible and quality care to people with IDD?

There are a number of established and emerging consultation models, including the Massachusetts Child Psychiatry Access Program, Project ECHO, University of New Mexico Transdisciplinary Evaluation and Support Clinic, and Cleveland Clinic Virtual Team.

The applicant can select one of these models, elements of a specific model, a combination of models, or propose a different model. The proposal should describe the consultation service goals, structure, evidence, and relevance to people with IDD.

An abbreviated description of cited models is below:

MCPAP: Regional behavioral health consultation teams based at an academic center; team includes child psychiatrists, licensed therapists, care coordinators and administrative support; target is primary and pediatric care practices and their patients with behavioral health needs; access point is primarily telephonic and technology based.

http://www.mcpap.com/

Project ECHO: Collaborative model of medical education and consultation to clinicians; links specialist/subject matter experts to primary care to enable them to effectively manage patients with complex conditions; team composition based on targeted patient population and health condition; access point is primarily technology-based.

http://echo.unm.edu/about-echo/

Transdisciplinary Evaluation and Support Clinic: Inter-professional clinical consultation; focus on community-based physicians and other providers to enhance their ability to care for patients with IDD with behavioral or complex health issues; evaluation offered at university clinic with limited community follow-up at primary care practices.

http://fcm.unm.edu/programs/teasc/

Cleveland Clinic Virtual team based service; improve health services delivery for adults with Down syndrome through the use of a virtual consultation team comprised of a physician with expertise in developmental medicine, clinical pharmacist, and community disability advocate. Prior to scheduled primary care appointment, consultation team reviews electronic health record and generates a consultation report, outlining recommendations that are individualized for each patient. There is no person-to-person contact with primary care practice or patient.

2. **Disability-Informed Health Care Navigation** is designed to address a critical gap identified by multiple stakeholders: guiding people with intellectual and developmental disabilities (IDD) and their families through the complexities of health care and disability service systems. People with IDD often have complex health care needs that require more intensive medical services coordinated across different providers in multiple settings, as well as a wide range of disability and social supports. The intent is not to duplicate existing services, but to address an unmet need and persistent gap in people's lives.

Disability-Informed Health Care Navigation links to the Key Recommendation Person-Centered Services: *establish explicit system of 'care navigation" from prevention to complex care that offers direct assistance to individuals and families*; *develop best practices for integrated plan of care, provide education to individuals and families; and streamline policies and practices.* The navigation pilot aligns with North Carolina's Session Law 2015-245 call for creating person-centered health communities and systems, supporting systems outcome accountability, and improved integrated care.

The navigation proposal should address the following questions:

- Who is the target population of need to receive navigation services?
- What are the proposed knowledge and skills of the navigator (s)?

- How will you outreach to individuals in need of navigation services?
- How will you connect to the health care community?
- What are the potential outcomes? How can they be measured?
- What navigation model or elements do you consider a best fit for your organization, target population, and community?
- How will navigation enhance the individual's ability to access and successfully interact with health care professionals and make informed decisions?

Navigation roles can include facilitator, problem-solver, educator, and resource finder. Services can emanate from multiple settings, such as primary care practices, disability service agency, advocacy organization, or hospital. Established and emerging navigation models include family centered health navigators; oncology nurse navigators; pediatric intensive care navigator; and Pediatric Practice Enhancement Project.

The applicant can select one of these models, elements of a specific model, combination of models, or propose a different model. The proposal should describe the consultation service goals, structure, evidence, and relevance to people with IDD.

An abbreviated description of cited models is below:

Project LAUNCH family centered health navigator is a parent from the community that actively partners with and coaches families as they maneuver through the complex system of services and supports they may need. Services provided can include: caregiver support, help in identifying family strengths and needs, developing a Family Health Plan and locating community resources, such as transportation, food, social support, etc.

http://www.cfha.net/blogpost/753286/207948/NC-Project-LAUNCH-A-Family-Centered-Care-Approach

Rhode Island's Pediatric Practice Enhancement Project places specially trained parent consultants in pediatric primary and specialty care practices that serve large numbers of children with special health care needs and their families. Parent consultants help the physicians provide comprehensive medical homes, to support both families and practitioners.

http://health.ri.gov/programs/detail.php?pgm_id=93/index.php

Oncology nurse navigators coordinate care between the various practices and disciplines involved in the patient's care as well as arranging needed consultations with social services, financial counselors and nutrition services. The nurse navigator also serves as a source of information for the patient and his/her family.

https://www.aonnonline.org/

Health Systems Navigator helps create effective links between appropriate health and social resources, assisting clients to engage pro-actively with community, family and friend through care mapping and coaching**,** referral to appropriate health and social services, advocacy and public education.

http://www.pqchc.com/health-services/health-system-navigator/

Evaluation

An external evaluator, a core member of the project team, will guide the development of a formative and summative evaluation. The evaluation will be informed by the context and realities of the pilot demonstrations, taking into consideration the limited resources available. With the guidance of the evaluator each pilot site will be asked to develop a logic model during year one (1) that illustrates their current situation, the changes they hope to bring about through the pilot demonstration, activities that will contribute to desired outcomes, resources needed, key partnerships, assumptions, and external factors that could influence results.

The evaluator will assist the pilot site in documenting the process of development and implementation to inform future replication. The evaluator will also assist the pilot sites with developing a sustainability plan to maintain the program post grant funding. A draft sustainability plan outline will be submitted in the fourth quarter of Year 2 with a final plan submitted the final quarter of Year 3. The pilot site will be supported in determining which processes and services is most impactful and efficient, resulting in a final streamlined system at the end of the grant period. Pilot sites will be asked to provide quarterly reports to the Arc of North Carolina with support from the evaluator.

Pilot and site specific outputs and outcomes will be developed with the applicants and their partners in collaboration with the evaluator. The key targeted outcomes include:

- Number of healthcare professionals who receive consultation services, satisfaction with service, recommendations, changes in recipients knowledge of the health care needs of people with IDD, ability to collaborate meaningfully with other healthcare and disability providers;
- Number of people who receive navigation services, satisfaction with the service, recommendations, changes in recipients knowledge of the health care system, ability to collaborate meaningfully with health care providers

Applicant Responsibilities

Develop and Facilitate a Pilot Specific Advisory Group that reflects multiple sectors, including individuals with IDD, family members, health care providers, disability providers.

Applicant should have identified no less than two organizational partners at the time of the application. As part of the application, the applicant will submit MOA from a minimum of 2 organizational partners and individuals who have committed to participating in the advisory group.

Applicant should also include a letter of commitment from the organization's leadership/executive team endorsing the pilot activities and agency support.

Applicant should identify how they will get input from their community stakeholders, including self-advocates and families.

Participate in the Evaluation of the Pilot Demonstration and Share Lessons Learned

The applicant agrees to collaborate with the project team and external evaluator in the development of the evaluation, gather evaluation data and share lessons learned, effective processes, challenges, and successes. The applicant will also assist with the dissemination of evaluation findings in partnership with the core project team. Potential venues include NCCDD, partner agencies, conferences, workshops, web postings, policymakers, and briefs.

Required Attachments: applicant profile page, project narrative, budget outline and narrative, partner MOAs. The applicant can provide additional attachments they deem relevant, limited to 6 documents, with a combined total of no more than 25 pages.

Application outline:

Project description (six pages maximum for items 1, 2, and 3) using 1 inch margins, 1.5 spacing and a 12 point font, with 10 point font for figures/tables.

1. Organizational background: mission, population served, geography covered, organizational structure, organizational capacity to undertake pilot demonstration, and staff expertise
2. Pilot focus: specific aims, identify the target population, specific geographical areas that the pilot will target, data sources that can be linked to the pilot, proposed partners, challenges this pilot will address, intended outcomes
3. Outline for year one: two required activities are the establishment of project advisory group within the second quarter of the calendar year (April – June 2017); development of an evaluation plan in partnership with the external evaluator and advisory group (April – June 2017).

Budget (two page maximum): the applicant is asked to provide a budget outline and justification for year one. The required match must be included in the budget outline.

Participation and Reporting Requirements:

Participate in CAP advisory meetings 3 x per year; submit quarterly reports and annual summary; annual renewal application.

Application Review and Selection

The project team will conduct an initial review of each application to determine if it meets the basic requirements. An external evaluation team will then review the applications and score them according to the RFP criteria. Two applications will be awarded funding: ONE for IDD Health Care Consultation and ONE for Disability Informed Health Care Navigation.

Scoring criteria (80 points)

- Organizational Background: 10 points
- Pilot focus: 40 points
- Outline for Year One: 10 points
- Partner organizations: 10 points
- Budget: 10 points