The Mark Etzel Patient-Centered Medical Home Demonstration Project Research Award

2010 Special Call for Applications
One-Time Special Opportunities Award

In recognition of the many policy and research contributions by former California HIV/AIDS Research Program (CHRP) Advisory Council Member Mark Etzel[i] towards ensuring access to care and treatment for all Californians with HIV/AIDS, CHRP announces a special Patient-Centered Medical Home Demonstration Project Research Award:

> In collaboration with researchers at the University of California San Francisco (UCSF), grant recipients will conduct research that evaluates the effectiveness of Patient-Centered Medical Homes (PCMH) for persons with HIV /AIDS. The research will examine cost, quality, patient satisfaction, and patient self-management related to organizations and service delivery systems.
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> To support these research activities and to strengthen the capacity of grant recipients to demonstrate a PCMH model for this research project, selected organizations will receive grants based on a two-tiered system.
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> Tier I: Selected institutions based in urban counties[ii] and with larger patient populations will receive an Urban County Tier I Grant ranging from $750,000 to $1,200,000 in direct costs for a 36 month period. Tier II: Selected institutions located in rural counties[iii] will receive a Rural Provider Tier II Grant of up to $300,000 for a 36 month period. Note: Institutions located in rural counties that meet the patient population eligibility requirements for Urban County – Tier I grants (page 4) can apply for either a Tier I or Tier II Grant.
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> In addition to the amount available for direct costs, up to 25% of eligible direct costs may be available for non-University of California Institutions for indirect costs.[iv]
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> CHRP will accept applications from a Consortium of organizations, with one organization identified as the Lead Institution and other organizations as Subcontractors.

Important Dates

- March 1, 2010: Release of the Call for Applications, Instructions for the submission of Letters of Intent posted
- March 11, 2010: Prospective Applicant Webinar (2:00 PM Pacific Time). See the CHRP Website for details.
- March 23, 2010: Letters of Intent due before noon, Pacific Time
- April 30, 2010: Applications due before noon, Pacific Time.
- Mid-July, 2010: Funding notification
- September 1, 2010: Award start date

Additional information is available in the *General Information* section later in this document.
For general information about the California HIV/AIDS Research Program at the University of California, please visit the Program Web Site.

Organization of Initiative

The organizational structure of the proposed initiative is different from other CHRP funded projects. In this Call for Applications, CHRP is specifically seeking to identify qualified organizations that could implement a PCMH model and that would be willing and able to collaborate in a multi-site evaluation. As such, the application focuses primarily on describing (1) experience and capacity in research endeavors and the delivery of HIV/AIDS services, (2) existing infrastructures that support a PCMH, and (3) proposed uses of funding to support and enhance implementation of PCMH that contribute to models that can be replicated in California. *Institutions are not asked to propose or design a research project within the application.*

The research of the initiative will be led by UCSF researchers funded through a previously awarded AIDS Policy Research Center Grant from CHRP. The UCSF researchers are responsible for developing a multi-site evaluation. Finalization of the evaluation's design and procedures will occur in collaboration with grantees that are funded as part of this Call for Applications.

Purpose

The intent of this demonstration is to evaluate the effectiveness of the Patient-Centered Medical Home (PCMH) as a model of service delivery for HIV care, support services, and prevention. The PCMH is a community-based care system which provides coordinated, high quality, client-centered service for persons with HIV/AIDS.

In this initiative, the following areas will be the focus of research:

1. Quality of care. Data already required to be collected by the HRSA HIV/AIDS Bureau will be used for many of the metrics to determine quality of care. UCSF, in consultation with grantees, will develop additional metrics, including some specific to PCMH that are evidence-based and measurable.
2. Cost-effectiveness. Examples of potential metrics include: reduction in emergency room visits, reduction of service duplication, enhanced retention of patients, and expanded utilization of alternative benefits or insurance programs.
3. Patient satisfaction. Examples of potential metrics include: access to services, experience of being a partner with the care team, knowledge and clarity about how to navigate the medical home, and rating of quality of care received.
4. Patient self-management. Examples of potential metrics include: patient participation in setting care and prevention goals and the extent of health education services offered by providers.

Funding will support the institution's collaboration in a multi-site evaluation of PCMH led by the University of California San Francisco (UCSF) by supporting data-gathering and augmenting the institution's implementation of a PCMH model in order to address the key research questions of this initiative. The results of this research will advance the body of knowledge as applied to HIV/AIDS and PCMH, and will inform policy decisions in California and nationally in regards to improving systems and organizational approaches to HIV/AIDS services.

Research Rationale and Framing

The Patient-Centered Medical Home (PCMH) model is a nationally known system which has been identified as a promising approach to providing better quality care and prevention, improved management of resources, and enhanced patient satisfaction and outcomes for those with chronic disease. This Call for Applications was recommended through the Visioning Change Initiative, a three-year, collaborative, multi-disciplinary statewide planning and decision-making process sponsored by CHRP involving key HIV planners, policymakers, and providers across California.

Interest in models such as PCMH is driven in part by the changing nature of the HIV epidemic and in part by potential changes to the United States healthcare system. HIV increasingly affects populations in the United States that have faced inequities in access to the health care system, and that require additional support in order to access and maintain care. HIV among low-income populations is also increasingly affecting individuals who have multiple health needs and who face complex challenges to remaining in care, such as ethnic minority individuals, persons recently released from prisons or jails, individuals with substance addiction and/or mental health issues, homeless persons, transgender persons, women, and persons infected with Hepatitis C, to name but a few. In addition, successful care in underserved communities often necessitates enhanced support and prevention services or more integrated models of care that help the patient navigate the medical system.

As a result of successful antiretroviral therapies, people with HIV/AIDS are also living longer lives. But as they grow older, they face the chronic conditions typically associated with advanced age—and may do so at higher levels than the uninfected population. As such, care for people with HIV/AIDS increasingly involves expertise not only in infectious disease, but also collaborations with other clinicians who have expertise in oncology, cardiology, rheumatology, and endocrinology. New approaches to collaboration and service integration are needed to more effectively monitor and ensure the health of older persons with HIV/AIDS.

Concurrent with these changes is the fact that both the government and private sectors are considering substantial reform regarding care for those with chronic diseases, driven in part by a desire to control spiraling costs. There is interest in technologies and models of service delivery that help integrate and coordinate care and prevention across a range of providers while meeting the needs of populations with complex health care problems. PCMH models offer a promising avenue for achieving desired cost controls while also responding to the increasingly multidisciplinary nature of HIV care and prevention.

The Patient-Centered Medical Homes (PCMH) model includes the following components and activities:

- Developing community-level partnerships that incorporate a range of disciplines and organizations working together to prevent and treat all diseases and promote health and wellness in response to the needs of each individual.
- Integrating secure electronic registry and medical record systems that support coordination of services regardless of location, improve health outcomes, increase access to services, and enhance patient safety.
- Mobilizing teams of multidisciplinary providers that work together to organize, plan, implement, and evaluate ongoing care, prevention, and support services. This includes specialists who identify client care, prevention, and support goals and who link clients with health and other community organizations to cost-effectively attain these goals.
- Developing and utilizing service plans containing client-centered goals that are consistently addressed in both medical and community based settings.

- Working with clients as partners in developing their service plans, including supporting clients in expanding their health literacy and increasing their ability to plan and manage their own health, including HIV.
- Generating greater system focus on retaining clients in care and prevention.
- Increasing client access through insurance providers and payor sources that support client utilization of all components of the PCMH.
- Establishing care standards that are integrated into each client service plan.
- Developing and implementing quality assurance guidelines that are evidenced-based, measurable, regularly updated, and clearly delineate expectations for all providers.

These grant funds are specifically intended to support and evaluate targeted, cost-effective modifications and enhancements to existing systems of care for HIV/AIDS populations that create effective PCMH models while ensuring simplified access to a comprehensive range of health, psychosocial, and ancillary support services, including access to ongoing HIV prevention support programs. These modifications will be specific to individual gaps or needs of each service organization or Consortium of organizations. For example, one institution might seek funding to implement enhanced computerized records management and data systems, along with modifications that incorporate better tracking of client outcomes and adherence to care standards. Another institution might propose a new collaboration with geriatric medical providers and/or specialists to better coordinate care for older persons with HIV/AIDS. These, however, are only examples, and institutions are encouraged to propose the specific set of systemic modifications and enhancements that is most appropriate to their region, partnerships, and service population characteristics.

It is critical to stress that the proposed program will **not** support any direct care or support services for clients, but instead will help fund targeted systemic enhancements designed to improve the overall quality, accessibility, and cost-effectiveness of HIV care within the context of the PCMH model

Eligibility Requirements

***Institutional Eligibility*:** Institutions must be nonprofit 501(c) (3) community-based or academic institutions or local health jurisdictions based in California. Also, demonstration projects funded through this initiative must exclusively serve persons with HIV/AIDS in California. In order to achieve the research goals of the project, institutions must meet all eligibility requirements listed below: A1 or A2 and B-F.

Please note that institutions may apply for this program as a single Institution or as a Lead Institution of a Consortium[v] of agencies. If applying as part of a Consortium, a Lead Institution must be identified to submit the application and receive grant funds and all participating agencies must be identified in the application. In the case of a Lead Institution and Consortium, the Consortium as a whole can meet the requirements.

Other Eligibility Requirements: Single Institutions or a Lead Institution and Consortium applying for Urban County – Tier I Grants must meet requirement A.1, while those applying for Rural County – Tier II Grants must meet requirement A.2. Single Institutions or a Lead Institution and Consortium located in a rural county that meet the 'Populations Served' requirements for *Urban County – Tier I Grants* can apply for either a Tier I or Tier II grant.

A. Populations Served:

1. **Urban County – Tier I Grants.** Currently serve at least 300 persons with HIV/AIDS to participate in the demonstration project who represent populations most highly-impacted by HIV, particularly those with a history of health disparities and inequities in accessing HIV services, and/or who are over the age of 50***.***
2. **Rural County – Tier II Grants.** Currently serve at least 50 persons with HIV/AIDS to participate in the demonstration project who represent populations most highly-impacted by HIV, particularly those with a history of health disparities and inequities in accessing HIV services, and/or who are over the age of 50***.***

B. Currently provide the following services:

1) Primary care, offering the patient with a broad spectrum of care, both preventive and curative.
2) HIV/AIDS primary care[1]by clinicians who actively manage at least 20 HIV-infected patients[2].
3) Broadly based medical case management or care coordination.
4) Pharmacy and/or enrollment center for the AIDS Drug Assistance Program (ADAP).
5) HIV treatment adherence.
6) Need-based, targeted HIV prevention, including prevention services for those who are HIV positive (prevention with positives).
7) Heath Education/Risk Reduction (HIV and for other conditions and diseases, e.g. diabetes.)

C. Currently provide the following services or have established referral protocols with one or more providers for each of the following:

1) Specialty medical care[3] (e.g. oncology, cardiology).
2) Mental health services, including psychiatric services.
3) Nutritional counseling.
4) Substance abuse treatment services.
5) Hospital care.

D. Have already established referral protocols with community organizations that provide HIV prevention, support, and/or care services to the population(s) identified in A.

E. Have already established an electronic health record (EHR) system that is in active use. For Lead Institutions and Consortium, the electronic health record system must be in active use in at least one of the Consortium member agencies that provides HIV/AIDS primary care. The Institution or Consortium member EHR will be secure, support coordination of services provided by the Institution or Consortium member, and be designed to improve health outcomes, increase access to services, and enhance patient safety.

F. Have already begun to establish one or more of the key elements of a PCMH model, such as:

1) The transmission of electronic medical information across providers in the medical home. Examples of this might involve establishing interoperability among electronic medical records at different clinics or establishing a secure web-based platform where providers at all parts of the medical home can enter and share data.
2) Partnerships working to prevent and treat all diseases and promote health and wellness in response to the needs of each individual.

[1] The HIV/AIDS specialist may also serve as the primary care provider.

[2] HIV/AIDS Bureau (2008). "HIV/AIDS Core Clinical Performance Measures for Adults/Adolescents: Group 1" recommends HIV primary care be provided by a clinician actively managing at least 20 HIV-infected patients. The Health Resources and Services Administration.

[3] When appropriate, consultations can be conducted via telemedicine.

3) Teams of multidisciplinary providers that work together to organize, plan, implement and evaluate ongoing care, prevention, and support services, including specialists to develop and link client care, prevention, and support goals with health and community organization.
4) Utilization of service plans containing client-centered goals that are consistently addressed in both medical and community based settings.
5) Working with clients as partners in developing their service plans while supporting clients to expand their health literacy to proactively plan and manage their health and prevention needs, including HIV.
6) Retaining clients in care and prevention.
7) Ensuring access to a broad range of insurance providers and payor sources.
8) Implementing care and prevention standards that are integrated in the client service plan.
9) Incorporating quality assurance guidelines that are evidenced-based, measurable, regularly updated, and clearly delineate expectations for all providers.

Proposed Use of Funds

Awards made through this Initiative will support: (1) collaboration in a multi-site evaluation led by UCSF; (2) the development of Electronic Health Record Systems; (3) additional PCMH model development; (4) dissemination activities; and (5) collaborative meetings.

1. ***Research Collaboration.*** All grantees will be expected to collaborate with the UCSF team and with fellow grantees in a multi-site evaluation of the funded PCMH. During the first six months of funding, grantees will work with UCSF investigators to finalize HIV/AIDS and PCMH measures. UCSF will have ultimate responsibility for finalizing the design and measures across the funded sites and will coordinate data collection, provide technical assistance to grantees, and conduct the multi-site data analysis. UCSF is funded to conduct this research through a previously awarded AIDS Policy Research Center Grant from CHRP.

   Each grantee site will collaborate with UCSF on twice annual collection of patient and provider surveys and key informant interviews. All grantees are required to reserve 30% of their total direct costs to support grantee expenses resulting from implementing these activities. These funds may also be used by the grantee to support costs related to analyzing their own data to improve services and produce findings for dissemination.

2. ***Electronic Health Record (EHR) System for Single Institutions:*** By the end of the first grant period (August 2011), the institution will implement strategies that establish and/or improve the electronic exchange of health information with other providers in an effort to increase access to services, improve health outcomes, enhance patient safety, and support service coordination for the populations served through this grant.

   Electronic Health Record System for Lead Institutions and Consortium: By the end of the first grant period (August 2011), the Consortium will implement strategies that establish and/or improve the electronic exchange of health information within the Consortium and with other providers in an effort to increase access to services, improve health outcomes, enhance patient safety, and support service coordination, improve the quality of care, and enhance service coordination for the populations served through this grant.

   Additional Guidance: Proposals should include a description of how a single Institution or Lead Institution and Consortium plan to implement the electronic exchange of health information. Funds

may be used to enhance existing EHRs and implement the electronic exchange of information. Sources of funding separate from this grant that support these activities should be identified in the proposal.

Until an operational EHR is developed, the grantee will establish and implement protocols for patient information sharing and referrals among providers utilizing existing structures, such as paper records and fax machines.

3. ***Additional PCMH Model Development.*** Funds may be used to develop and implement other key components of a PCMH in addition to the electronic exchange of information described above. Recognizing the unique stage of PCMH development for each organization, a single Institution or Lead Institution and Consortium is expected to prioritize which system elements are needed for the population(s) served through this grant. Examples include:
    1) Implement procedures to help track and ensure successful referrals.
    2) Increase coordination among a broader range of providers and services, to better meet the needs of specific populations.
    3) Establish or expand teams of multidisciplinary providers that work together to organize, plan, implement and evaluate ongoing care, prevention, and support services, including specialists to develop and link client care, prevention, and support goals with health and community organization.
    4) Develop expanded client literacy programs and/or programs that support and empower clients to better manage their own health care and set and maintain life goals.
    5) Increase service sustainability by accessing additional payor sources.
    6) Enhance quality of care through staff training and team building, including activities to ensure the cultural competency of services.
    7) Develop Quality Assurance standards that are shared by other providers within a given system.
    8) Increase linkages to fill service gaps and expand the range of services available within the PCMH network.

    Proposals should include a description of how the single Institution or Lead Institution and Consortium plan to implement key components of the PCMH. Sources of funding separate from this grant that support these activities should be identified in the proposal.

4. ***Dissemination***: Proposals should describe plans for dissemination of findings through print or online publications, creation and dissemination of training materials, and through presentation of findings to local planning bodies and at meetings and conferences.

5. ***Collaborative Meetings:*** Projects approved for funding must adhere to the aims of the initiative and work collaboratively with other grantees, UCSF, and CHRP on study implementation to ensure that the goals of the research initiative and the scientific validity of the project are maintained, and that challenges encountered during implementation that could compromise achievement of intended outcomes are adequately addressed. To meet this requirement, grantees will attend at least six collaborative meetings with UCSF and CHRP over the three-year grant period and participate in at least one annual site visit.

Mechanisms of Support

1. Urban County – Tier I Grants: the total combined amount for this award may not exceed $1,200,000 in direct costs over the entire 36-month grant period. Single Institutions or Lead Institutions will be required to submit recent audited financial statements for fiscal review, and final determination of the contracting arrangements will be determined by CHRP after administrative review. If appropriate, other institution(s) may participate through subcontract(s) from the grantee.
2. Rural County – Tier II Grants: the total combined amount for this award may not exceed $300,000 in direct costs over the entire 36-month grant period. Single Institutions or Lead Institutions will be required to submit recent audited financial statements for fiscal review, and final determination of the contracting arrangements will be determined by CHRP after administrative review. If appropriate, other institution(s) may participate through subcontract(s) from the grantee.
3. Non-University of California institutions are eligible for additional indirect costs up to 25% of total eligible direct project costs, or at the rate established for the institution through a U.S. Department of Health and Human Services (DHHS) negotiated indirect cost rate agreement (or other similarly established rate), whichever is lower.
4. If multiple organizations apply as a Consortium, the Lead Institution should submit the application with the other Consortium members included as subcontractors.
5. It is the intent of CHRP to fund at least one meritorious[4] Institution or Lead Institution and Consortium each from Northern and Southern California.
6. For purposes of ensuring a sufficient sample size with demographic diversity, it is the intent of CHRP to fund meritorious[5] Institutions and/or Lead Institutions and Consortia that in the aggregate sufficiently represent diverse populations most highly-impacted by HIV/AIDS, particularly those with a history of health disparities and inequities in accessing HIV services and/or those with HIV/AIDS over the age of 50.
7. The project start date is September 1, 2010, and the project period will span 36 months (3 years), ending August 31, 2013.
8. Grants are one-time, non-renewable grants.
9. CHRP reserves the right to not award funds for this initiative if there are no institutions that meet qualifying standards.

Merit Review Criteria

Reviewers will evaluate applications for:

1. Experience and capacity to collect relevant data and collaborate with researchers.
2. Documentation of meeting the eligibility requirements outlined in this Call for Applications.
3. Capacity and readiness to implement proposed activities.
4. Qualifications and experience in providing various components of a Patient-Centered Medical Home for persons with HIV/AIDS or other chronic diseases.
5. Feasibility of the proposed plan to establish and/or improve the electronic exchange of health information with other providers in an effort to increase access to services, improve health outcomes, and enhance service coordination for the HIV/AIDS population identified to be served.
6. Feasibility of the proposed capacity building plan and likely effectiveness in strengthening a Patient-Centered Medical Home for the HIV/AIDS population identified to be served.
7. Inclusion of populations most highly-impacted by HIV, particularly those with a history of health disparities and inequities in accessing HIV services and/or those with HIV/AIDS over the age of 50.

[4] 'Meritorious' is defined by a merit score in the very good, excellent, or outstanding range.
[5] Ibid

8. Extent to which the results will contribute to advancing Patient-Centered Medical Home models that can be replicated in California and how results will be disseminated.

General Information

Application Cycle Timeline: *All deadlines are at 12:00 noon Pacific Time (3:00 p.m. Eastern Time). All materials will be submitted online.*

- March 1, 2010: Call for Applications Release Date.
- March 11, 2010: Prospective Applicant Webinar (2:00 PM Pacific Time). See the CHRP Website for details.
- March 23, 2010: Letters of Intent (LOI) submission deadline. It is important to follow the instructions.
- April 30, 2010: Application submission deadline. Application materials are made available upon approval of the LOI by CHRP.
- Mid-July, 2010: Funding notification
- September 1, 2010: Award start date

Prospective Applicant Webinar: Information for participation in the Prospective Applicant Webinar will be posted on the CHRP website by March 3, 2010. The webinar is scheduled for March 11, 2010 from 2:00 PM to 3:00 PM (Pacific Time). Understanding of the intent of the award and the application review process is central to the success of Applicants. Participation by potential Applicants is strongly encouraged. During this meeting, program representatives will answer questions about the application and review process.

How to Apply and Required Letter of Intent

A Letter of Intent (LOI) is required for all Research Award applications. Specific instructions for submitting a Letter of Intent for the Patient-Centered Medical Home Demonstration Project Research Award are available from the CHRP web site. *It is important that LOI submissions follow these instructions*. Each submission must use the template that is supplied to help applicants meet the requirements. LOIs, limited to 3 single-spaced pages, must be prepared using the supplied template according to the instructions and must be submitted electronically before 12 noon Pacific Time (3 p.m. Eastern Time), March 23, 2010. Applicants with approved LOIs will be notified by e-mail, and will then have access to materials to prepare a full application. LOIs will be approved as they are received; therefore, earlier submission will potentially provide earlier access to the full application materials for approved LOIs.

NOTE: It is recommended that applicants review the instructions and the LOI submission web pages as soon as possible in order to allocate sufficient time for the completion of the process before the deadline.

Contact Information:

To obtain guidance or direction on the suitability of a proposed project for this funding opportunity, contact:

John Mortimer, Ph.D.
Program Officer
510/587-6131
John.Mortimer@ucop.edu

For questions regarding CHRP application procedures, instructions, and budget requirements, contact:

Peter Agron, Ph.D.
Program Manager
510/987-9858
Peter.Agron@ucop.edu

California HIV/AIDS Research Program

The California HIV/AIDS Research Program (CHRP; formerly UARP) at the University of California provides funding for the support of merit-reviewed HIV/AIDS-related research to be conducted at universities, non-profit research institutions and community organizations throughout California. The program's mission is to support excellent, timely, and innovative research that is attentive to the needs of California and will accelerate progress towards prevention and a cure for HIV/AIDS.

How to Contact CHRP

California HIV/AIDS Research Program
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300 Lakeside Drive, 6th Floor
Oakland, CA 94612
510/987-9855 • 510/835-4220 (fax)
chrp@ucop.edu
http://www.californiaaidsresearch.org/

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[i] Mark Etzel, MPP, was a committed, innovative, and compassionate leader for all Californians affected by HIV/AIDS. For over ten years he served as the Executive Director of the Center of HIV Identification, Prevention, and Treatment Services at UCLA, "… a collaboration of researchers from UCLA, Charles Drew University of Medicine and Science, Friends Research Institute, and RAND working with the broader Los Angeles community toward a common goal: to enhance our collective understanding of HIV research and to promote early detection, effective prevention, and treatment programs for HIV." In addition to his service on the Advisory Council of CHRP, he was the Associate Director of Policy at AIDS Project Los Angeles. Mark Etzel passed away in July of 2009.

[ii] Using the California State Office of Rural Health definition of Urban Counties as counties with a Medical Service Study Area land mass of 79% or less, the following counties are considered Urban Counties: Alameda, Contra Costa, Los Angeles, Marin, Orange, Riverside, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Ventura.

[iii] Using the California State Office of Rural Health definition of Rural counties as counties with a Medical Service Study Area land mass of 80% or greater, the following counties are considered Rural Counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, San Benito, San Bernardino, San Joaquin, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba.

[iv] University of California institutions are not eligible for indirect costs. Non-UC institutions are eligible for indirect costs up to 25% of total eligible direct costs, or at the rate established for the institution through a U.S. Department of Health and Human Services (DHHS) negotiated indirect cost rate agreement (or other similarly established rate), whichever is lower.

[v] For the purposes of this Call for Applications a 'consortium' may be a network or a collaboration of providers of services for persons with HIV/AIDS. A key function of a consortium is to engage in ongoing joint planning resulting in coordinated service delivery.