



Depression in Late-Life Initiative

Care Partners: Bridging Families, Clinics, and Communities to Advance Late-Life Depression Care Phase 2, Cohort 2 Request for Proposals

Archstone Foundation

Archstone Foundation is a private nonprofit grantmaking foundation whose mission is to prepare society in meeting the needs of an aging population. Archstone Foundation's current funding priorities include, Depression in Late-Life, Family Caregiving, and Aging in Community.

In June 2014, Archstone Foundation Board of Directors, as part of the Foundation's Depression in Late-Life Initiative, awarded a four-year grant to the University of Washington (UW), and the University of California, Davis (UC Davis), to support the *Care Partners: Bridging Families, Clinics, and Communities to Advance Late-Life Depression Care* project. The four-year project, commissioned by Archstone Foundation, supported community-engaged partners who worked together to improve care for older adults with depression by strengthening the involvement of family, friends, and community-based organizations (CBOs) in depression care. To support organizations participating in the project, Archstone Foundation engaged experts Jürgen Unützer, MD, MPH, MA, at the University of Washington's AIMS Center (Advancing Integrated Mental Health Solutions), and Ladson Hinton, MD, at the University of California, Davis.

In July 2015, Archstone Foundation, awarded two-year grants to seven sites throughout California that were interested in further developing partnership between clinics and community partners (i.e., CBOs and / or family care partners) when implementing collaborative care to improve late-life depression care. In 2017, four of the original sites in the Care Partners program were awarded continuation funding for an additional three years. This group of Phase 2, Cohort 1 projects began in July 2017, and will continue through June 2020. Archstone Foundation also approved plans for the addition of a second cohort to join the learning collaborative of Care Partners sites in July 2018. The UW / UC Davis technical assistance and evaluation team is supporting this effort to identify and select a second cohort of sites interested in enhancing collaborative care through partnerships with CBOs working with older adults or through engaging the family and/or friends of older adults with depression in their care.

Background on Late-Life Depression

Depression is common among older adults, and it comes at a high cost to patients and their families. Major depression affects 2 to 5% of community dwelling older adults, up to 10% of older adults in primary care clinics, and up to 30% of older adults with chronic medical illnesses. Late-life depression impairs quality of life, the ability to function, and to enjoy late-life. It is associated with increased health care costs, family stress, and increased risk of suicide. Depression is the most important and arguably the most treatable risk factor for completed suicide.

Over the past two decades, there has been significant progress in the ability to diagnose and treat depression in older adults. Research has demonstrated that collaborative care programs in primary care (i.e., IMPACT: Improving Mood – Promoting Access to Collaborative Treatment), where primary care physicians are supported by mental health professionals to treat depression in older adults, can dramatically improve the effectiveness and cost-effectiveness of depression treatment. Collaborative care models in the community, such as PEARLS, are also effective at engaging older adults in depression care and improving depression outcomes. Despite advances, older adults suffering with depression often times do not access, or fail to engage sufficiently in, treatment. Vulnerable groups at particularly high risk for ineffective depression care include: 1) minorities; 2) older men; and 3) older adults with multiple medical problems, less formal education, and/or lower socioeconomic status. Closing gaps in care to improve access to effective depression treatment is important and timely. One of the most promising approaches to improving the reach, and effectiveness of late-life depression care, is through the systematic involvement of CBOs, family, and primary care clinics that work with older adults. These community-engaged partnerships have tremendous potential to improve: 1) access to care; 2) engagement in treatment; 3) the patient care experience; and 4) quality of care for depressed older adults.

Collaborative Care for Late-Life Depression

Collaborative care in primary care is a patient-centered approach that treats mental health conditions, such as depression and anxiety, in primary care where older adults are comfortable and already have secure established relationships. Effective collaborative care teams use established principles of chronic illness care, and draw upon shared knowledge, principles, and care plans as they work toward patient goals. The collaborative care teams provide proven treatments, such as antidepressant medications and evidence-based, brief counseling strategies such as Problem Solving Treatment (PST) in primary care.

Collaborative care takes a population-based approach ensuring that anyone who needs help does not fall through the cracks. Over 80 studies have found collaborative care to be significantly more effective than usual care for mental health conditions, such as depression and anxiety. The largest study of collaborative care to date, the IMPACT study, demonstrated that collaborative care more than doubles the effectiveness of depression care even in settings with existing co-located behavioral health providers. Additionally, collaborative care reduces disability, improves quality of life, and earns a return of investment of \$6.50 for every \$1.00 spent; thereby achieving the Triple Aim of improved patient care experiences, better clinical outcomes, and lower health care costs. The evidence base for collaborative care prompted the Centers for Medicare and Medicaid Services (CMS) to recently approve billing codes for previously unbillable time spent in collaborative care. Information on these codes and additional information on collaborative care in primary care can be found in the Resources Section.

PEARLS is also a collaborative care program that treats individuals out in the community through a team including both home visiting providers who offer brief psychotherapy in the home setting plus support / supervision from specialty mental health providers through regular scheduled consultation meetings. PEARLS providers can follow-up with primary care providers as needed for individuals who are connected to different primary care clinics. Further information on the PEARLS program can also be found in the Resources Section.

Care Partners: Bridging Families, Clinics, and Communities to Advance Late-Life Depression Care, Phase 2, Cohort 2

Archstone Foundation now seeks to support a second cohort of projects that are implementing innovative approaches to treating depression in older adults through the following three types of partnerships:

1. Primary care clinic that has implemented collaborative care and now seeks to partner with a CBO;
2. CBO-based PEARLS site strengthening their program by forming stronger connections with primary care clinic(s); and
3. Primary care clinic that has implemented collaborative care and now seeks to enhance their model by including family members.

Applicants will propose effective partnerships that build on, and learn from, the strengths each organization brings to the team, to better understand, reach, and treat late-life depression. Together, partners will develop programs based on evidence-based collaborative care in primary care or PEARLS in the community to improve late-life depression care. These programs will enhance collaborative care through the inclusion of community partners. Innovations in care, funded through this Initiative, will explore collaborative care programs that can be applied in other settings to improve late-life depression reach, engagement, and treatment across California and, ultimately, in similar settings across the country.

Successful applicants will propose innovative programs that: 1) build on strong partnerships between primary care and CBOs or families to leverage existing services; and 2) deliver evidence-based, effective collaborative care to older adults with depression.

Collaborative care services must include:

- Screening for depression;
- Depression diagnosis;
- Patient education and engagement;
- Treatment, and treatment support, as appropriate to each patient (for examples, refer to the Collaborative Care Task Matrix and PEARLS Task Matrix appendices);
- Systematic tracking of depression outcomes using the PHQ-9 depression measure (Patient Health Questionnaire – 9 item version) using a registry; and
- Regular psychiatric case review with recommendations for treatment adjustment if patients are not improving.

Collaborative care services can be broken down into a list of tasks that partners share when collaborating to offer late-life depression treatment in their communities. The sharing of tasks aligns with the concept of “task shifting”, or “task sharing”, to improve access to late-life depression treatment for older adults. Task sharing is described as the rational redistribution of tasks among a health care team to make more efficient use of each team member’s qualifications and skills. More information on task sharing can be found in the Resources Section. A list of key tasks in collaborative care in primary care can be found in the Collaborative Care and PEARLS Task Matrices in the Appendix. Each matrix is a guide for applicants to consider how they will share tasks in addressing the treatment needs of older adults with depression in their communities.

Archstone Foundation seeks community-engaged partnerships that can effectively collaborate and share the list of tasks to improve depression care for older adults—partnerships that can extend traditional collaborative care to enhance access to care and effectiveness of care. Such programs can either: 1) focus on extending collaborative care in primary care to include CBOs or family; or 2) extend a PEARLS program to more actively partner with primary care clinics and their providers. Such programs should consider the benefits and potential challenges to such collaborations alongside plans for long term sustainability if the program is to be successful.

Community-engaged partnerships will share collaborative care tasks. For example, a CBO might partner with a primary care clinic to assist with depression screenings, referrals, and monitoring of symptoms for patients receiving treatment. Alternatively, a primary care clinic might develop, and test, a “team approach” that includes family members to deliver one or more of the collaborative care tasks. These are only two approaches, of many, that community-engaged partners may consider.

Funding Opportunities

Archstone Foundation’s Depression in Late-Life Initiative will fund approximately three (3) sites total from the following types of partnerships below in this second cohort of sites. The grant decisions will be based on the quality of the proposals received, thus more than one site may be selected from any given category and, conversely, in another category a site may not be selected.

Primary Care Clinic – CBO Partnership:

Primary care clinic partnering with a CBO partnerships may be funded up to \$150,000 per year for two (2) years and \$75,000 in year three (3) for a total of \$375,000 divided between the partners.

PEARLS – Primary Care Clinic Partnership:

CBO delivering a PEARLS program partnering with primary care clinic(s) grants may be funded up to \$150,000 per year for two (2) years and \$75,000 in year three (3) for a total of \$375,000 divided between the partners.

Primary Care Clinic – Family Partnership:

Primary care with family care partner grants may be funded up to \$150,000 in year one (1), \$100,000 in year two (2), and \$75,000 in year three (3) for a total of \$325,000.

The funding amount for the *Primary Care Clinic – CBO Partnership* and *PEARLS – Primary Care Clinic Partnership* awards is higher due to the additional costs of collaboration across organizations in these programs. In addition to the amount funded to the organization(s), sites will be offered additional training as needed or requested in collaborative care, including Problem Solving Treatment (PST).

Eligibility Criteria

The following are the eligibility criteria for applicants for this funding opportunity:

- California non-profit 501(c)(3) primary care clinics and non-profit 501(c)(3) CBOs are eligible to apply if they have an established (i.e., existing) collaborative care program in primary care or PEARLS program in the community as defined by the description on page 3.
- CBOs may include organizations offering Meals on Wheels programs, faith-based organizations, refugee service agencies, or adult day health services, like Community-Based Adult Services (CBAS), or other programs serving older adults.
- Organizations that partner with family members, or close friends, of depressed older adults in their collaborative care programs must demonstrate their ability to successfully engage, train, and involve family members/friends of patients in collaborative care for depression.
- Partnering for-profit organizations must cover their costs involved in the project—grant funds may not be used.
- Partnering organizations must:
 - Reside in California;
 - Currently offer services to older adults (65 years of age or older) in the community;
 - Have the capacity to engage and provide partnered care to treat at least 100 older adults with depression, over the 3 year period of the grant;
 - Have the technology infrastructure among at least one partnering organization to use a web-based online care management registry (CMTS) provided by the AIMS Center as part of this Initiative. Technology includes: 1) computers with supported web browsers (i.e., Internet Explorer 7 or higher, Firefox 4 or higher, Safari 3 or higher, and Chrome), and 2) a high speed internet connection; and
 - The applying organization must have the infrastructure to manage all grant activities (i.e., managing grant funds, subawards to the partnering organization, and reporting requirements to Archstone Foundation).

All organizations applying must be able to join specific activities as a part of the application and grant implementation process:

- Submit Letter of Inquiry (LOI) by Thursday, December 14, 2017;
- Submit full proposal by March 8, 2018, if invited to submit a Full Proposal;
- Host a site visit as part of the application process in April/May 2018;
- Attend a two-day in-person meeting/training in July 2018, and two (2) one-day annual meetings in the subsequent years. Meeting locations will alternate between Northern and Southern California.
 - Funding for travel should be included in the applying organizations budgets. At least two individuals from each partnering organization should attend.
- Care managers and the project lead will participate in regular bi-weekly or monthly coaching calls with trainers and join quarterly webinars / web-based discussions;
- Host periodic one-day on-site practice coaching visits to support continued training and workflow development at the site;

- Work with the AIMS Center at UW to explore revenue sources to support sustainability and/or continued development of the models of care developed within the partnership;
- Work with the UW and the UC Davis to evaluate the developing programs and overarching late-life depression initiative. As part of these efforts, the participating organization(s) will participate in key informant interviews yearly and focus groups. The key informant interviews will be conducted with 3 to 4 key staff at each site, last approximately one hour, and will be conducted by phone. Focus groups will be held as part of the annual meeting.
- When applicable, work with the UW and the UC Davis when preparing to submit information to their Institutional Review Boards (IRB) on the late-life depression interventions.

Technical Assistance for the RFP

The Archstone Foundation and UW / UC Davis technical assistance team will host an office hour call on Wednesday October 11, 2017 from 11:00 – 12:00pm to answer questions about the RFP.

Applicants are also encouraged to participate in a technical assistance webinar on October 23, 2017 from 12:00 – 1:00pm. The purpose of the webinar is to clarify the Initiative’s goals, and answer any questions about the RFP, or the application process.

Details about the call and webinar can be found on page 8.

Proposals will be evaluated based on:

1. Innovation with regard to the partnership and task sharing between the primary care clinic and community partners;
2. Feasibility of the proposed plan to develop upon, and enhance, an existing evidence-based collaborative care program to improve care for late-life depression through a community-engaged partnership;
3. Organizational capacity and readiness to implement the proposal, specifically, the capacity to find, engage, and maintain older adults in depression care through the proposed partnership;
4. Leadership support at the organization(s);
5. Memorandum of Understanding (MOU) between the partnering organizations;
6. Strength of the partnership to support the proposed work together; and
7. Completeness and adequacy of the budget proposed. Partnerships must offer documentation that suggests an effective and adequate sharing of funds among partners to accomplish the tasks needed.

Application Process

Letters of Inquiry (LOI) for *Care Partners: Bridging Families, Clinics and Communities to Advance Late-Life Depression Care* projects are due no later than **December 14, 2017 at 5:00 p.m.**

If invited to submit, Full Proposals will be due no later than **March 8, 2018 at 5:00 p.m.**

As part of the Full Proposal evaluation process, Archstone Foundation staff will conduct site visits with content experts from the University of Washington and University of California, Davis. Site visits serve as an opportunity to discuss the proposed project, as well as assess the capacity of the organization to meet the proposed scope of work. Full Proposals will be reviewed for consideration at the Archstone Foundation June 2018 Board of Director's meeting.

Letter of Inquiry Format

Letters of inquiry (LOI) should be no more than four (4) single-spaced pages (page limit includes items 1-8). LOIs should be written in third-person, typed using 12-point Times New Roman font, with 1-inch margins, and must include:

1. A one paragraph executive summary that includes the amount being requested, and the number of older adults (age 65-plus) being served;
2. A brief description of the project and its rationale;
3. A statement of the project's goal and objectives;
4. A brief description of the population to be served;
5. A brief description of the organization(s) capacity;
6. A description of the existing collaborative care in primary care or PEARLS program as it matches the description of services on page 3;
7. A brief description of the communication plans between partners (if applicable) throughout the planning, implementation and sustaining phases of program development;
8. A plan for sustaining, or continuing, the project upon the completion of the proposed grant;
9. A preliminary budget (please use the Foundation's budget template downloadable from the Foundation's website);
10. Budget narrative;
11. Memorandum Of Understanding (MOU) from the partnering, non-applying, organization, stating they agree to the submitted Scope of Work and preliminary grant budget;
12. A completed Collaborative Care Task Matrix (CBO and Primary Care Clinic) or PEARLS Task Matrix (CBO and Primary Care Clinic). The matrices can be found in the appendix and help illustrate how partners will share tasks. Those applying for the family-focused intervention, please complete the Collaborative Care Task Matrix - Family Intervention; and
13. A completed Depression in Late-Life Initiative Letter of Inquiry Grant Application Coversheet (downloadable from the Foundation's website);

Letter of Inquiry Format, *continued*

In addition, the following three items must be included with the LOI (not included as part of the page limitation):

- A copy of the organization’s tax exempt status letter;
- A copy of the organization’s most recent IRS Form 990; and
- A copy of the organization’s most recent audited financial statement.

Letters of Inquiry that conform to the application process, and meet the eligibility and selection criteria, may be invited to submit a Full Proposal. Archstone Foundation will provide specific instructions on the Full Proposal guidelines to selected applicants.

Timeline

The following is the timeline for this funding opportunity:

October 11, 2017	Technical Assistance Phone Call on the RFP
October 23, 2017	Technical Assistance Webinar on the RFP
December 14, 2017	Letter of Inquiry Due
March 8, 2018	Full Proposals Due
March – June, 2018	Review Process/Site Visits
June 2018	Approval and Notification of Awards
July 1, 2018	Grant Period Begins

Technical Assistance Details

Office Hour

October 11, 2017 Phone Call at 11:00 – 12:00pm Pacific

- To call in for the office hour, dial 1-800-332-0320 and enter code 313011#

Webinar

October 23, 2017 Webinar at 12:00 – 1:00pm Pacific

- To receive an email with call-in details for the webinar, please register here: <https://uw-phi.zoom.us/meeting/register/0e40264d10bc77177510d14dfea9e911>

Contact Information

The completed LOI, inquiries, and correspondence should be emailed directly to:

Laura Rath, MSG
Senior Program Officer
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Phone: (562) 590-8655
Email: lrath@archstone.org

Resources

- Archstone Foundation: www.archstone.org

Collaborative Care in Primary Care

- IMPACT: <http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/>
- UW, Advancing Integrated Mental Health Solutions (AIMS): <http://aims.uw.edu>.
- Care Partners Website: <http://uwaims.org/archstone/>
- 2017 CMS Medicare Payment Codes Cheat Sheet on billing for collaborative care: <https://aims.uw.edu/collaborative-care/financing-strategies-collaborative-care>
- Billing codes for FQHCs may be developed and released in 2018. The AIMS Center website will be updated with information on these codes when / if they are approved.

PEARLS

- <http://www.pearlsprogram.org/>

Innovations in Late-life Depression Care – Partnering with CBOs

- Future directions for late-life depression care: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4706767/>
- Task shifting in mental health: <https://www.ncbi.nlm.nih.gov/pubmed/28084667>
- Community services for high-need patients: <https://nam.edu/effective-care-for-high-need-patients/>
- Community services for socially at-risk populations: <http://www.nationalacademies.org/hmd/Reports/2016/Systems-Practices-for-the-Care-of-Socially-At-Risk-Populations.aspx>

Innovations in Late-life Depression Care – Partnering with Family

- Hinton L, Apesoa-Varano EC, Unützer J, Dwight-Johnson M, Park M, Barker JC. (2015) A descriptive qualitative study of the roles of family members in older men's depression treatment from the perspectives of older men and primary care providers. *Int J Geriatr Psychiatry*, May;30(5):514-22. doi: 10.1002/gps.4175 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4324406/>
- Hinton L, Sciolla A, Unützer J, Elizarraras E, Kravitz R, Apesoa-Varano EC. Family-centered depression treatment for older men in primary care: a qualitative study of stakeholder perspectives. *BMC Family Practice* (in press).