MHM Transparency Documents

MHM is committed to transparency in grant-making. This *Plan* includes a description of the application review and selection process. In addition, the following information for new and recompeting applications will be published on the Sí Texas website within 90 business days after grants are awarded:

- A list of awarded Sí Texas grantees
- The full applications of awarded Sí Texas grantees
- A list of all compliant applications submitted
- Executive summaries of all compliant applications as submitted by the applicants
- Summaries of external reviewer comments on successful applications
- A blank template of the external review form
- A description of the grantee selection process
- A list of all external reviewers that completed the review assignment

Publication of this *Plan* does not obligate MHM to award any specific number of grant agreements or to obligate the entire amount of funding available.

Sí Texas Cycle 2 Grantees:

The University of Texas Health Science Center at Houston

Nuestra Clinica del Valle

A description of the grantee selection process

Goal of the Competition:

To select high-performing organizations that offer effective IBH interventions, with adequate integration of care and at least preliminary evidence of effectiveness, levels of evidence, to participate in the Sí Texas Collective Impact project, Sí Texas: Social Innovation for a Healthy South Texas.

Eligibility Criteria

- Phase 1 review criteria: Application review to ensure eligibility with RFP requirements including but not limited to: serving low income populations, amount requested in proportion to organizational budget, financial controls, agreement to seek match, and all submitted requirements are in place.
- Phase 2 review or selection criteria: Review of the application's project description, need, evaluative measures, collaboration, resources and capabilities, sustainability, and support requested.
- Phase 3 review criteria: Level of Evidence, IBH integration, scaling potential, financial maturity and capacity, capacity to match, long-term sustainability, and evaluation capabilities are assessed to determine value of award.

Review Process

- Key subgrant eligibility criteria required by the Statute are assessed to ensure compliance.
- The proposed review and selection process timeline is included.
- MHM will ensure that: nonprofits with preliminary levels of evidence will receive less funding than nonprofits with higher levels of evidence in accordance with the Continuum for Scaling matrix, subgrantees have the information to develop adequate evaluation budgets, and have addressed long-term sustainability. MHM will use evaluations to inform subgrantee organizations as they improve levels of evidence, organization capacity, and evaluation capacity.
- Who will review grant applications, and avoidance of Conflict of Interest: Teams of three reviewers per team will include at least one person from each of categories: Evaluation, Other Funders, and IBH Providers.

Evaluation Considerations and the Award Process:

- Relationship between interventions and evaluation: Subgrantees will be implementing more than one intervention across multiple subgrantees, and will participate in the same evaluation.
- Clear descriptions of evaluation expectations and how this will be communicated: MHM will communicate evaluation expectations to subgrantees (a) in the RFP instructions; (b) through applicant workshops and webinars; (c) through group TA calls and webinars; (d) through one-on-one coaching; (e) through group e-mails to the subgrantee cohort. Subgrantees are expected to: have the infrastructure to track outcomes, track shared metrics for the project, continuously

improve and build the strength of their evidence, cooperate with the external evaluator and build their own capacity for evaluation.

- When and how evaluation plans, evaluation capacity, and budget will be considered as part of the overall review. Involvement of qualified evaluator(s) in the review process: Evaluation plans, capacity, and budgets will be considered during **Phase 2** of the review, which is review and scoring by external evaluators
- Who makes the final decision: The fully informed Sí Texas team recommends subgrant amounts and recipients, which are submitted to SIF for review. A committee of the MHM Board makes the final determination for subgrant awards.

Emmett has more than 40 years of experience, much of which he gained during his time in the United States Air Force. He served in a variety of leadership positions in military hospitals and clinics around the world, and retired as Chief of Mental Health at the U.S Air Force Clinic on Randolph Air Force Base.

Project description

a.The Ecumenical Center's proposal would fall in Level 6 on the Levels of Collaboration/Integration (See Table 1) for the following reasons:

The Counselors and Pastoral Counseling Staff would office within the GMC sharing office space and functioning as one integrated system with the Primary Care Physician (PCP). Physician, Counselor and Counseling Staff would communicate consistently at the system, team and individual levels, and actively collaborate, driven by the shared concept of team care. This research team would have both formal and informal meetings to support the integrated model of care. The PCP and Counselors would operate out of the same office with billing and scheduling being accomplished by the PCP's staff.

The Guajira Medical Clinic in McAllen, Texas, is under the director of Dr. Ernesto Griego and four Physician's Assistants serve in the clinical practice. The Clinic reports that an average of 150 patients per day are seen. Of these 150 patients, 75% are diabetic. The average HbA1c levels are 9.0-9.5. This would allow for the Pastoral Counseling Staff to adminster the PROMIS Anxiety and Depression screenings and The World Health Organization Quality of Life screening to those diabetic patients who agree to participate. GMC reports that they would expect approximately 50% of patients to actively participate in the study and anticipate that 37%, or 19 patients, would have a score below 50 on at least one of the screenings, Depression or

Anxiety. Quality of Life Screening will be done for counselor information only. Thus, the LPC Counselor could expect to have a potential of 15 - 19 counseling patients per day.

See Figure 5 for a further description of the Project Design.

The collaborating Primary Care Physician runs four clinics in Hidalgo County and Starr Counties. The Ecumenical Center's program would operate out of the GMC main office in McAllen. Depending upon patient volume at each clinic, decisions could be made to expand to all four of the Guajira Medical Clinics in McAllen, Edinburg, Westlaco and Rio Grande City . Depending upon the number of patients at each clinic and the Primary Care Physician's schedule and the Physician's Assistant's schedules, the Counseling Staff could allocate time according to the PCP's schedule at each of the clinics. Because the PCP has all four clinics staffed and functioning, it would be easy to expand to all clinics. The model proposed could be replicated in the Rio Grande Valley or any other area, either by opening new clinics with new doctors and new counselors, or collaborating with other doctors in other areas. The innovative part of this program involves using the Bi-lingual Counseling Staff trained in The Ecumenical Center's two year Specialty in Pastoral Counseling Training program in the Rio Grande Valley. These Pastoral Counseling Staff would administer the NIH Promis Depression and Anxiety screening and the World Health Organization's Quality of Life screening instrument. Since many of the Guajira Medical Clinic patients also live in Starr County, this project will make a considerable impact in Hidalgo and Starr Counties. With a counselor helping the patient monitor their lifestyle choices and encourage an adherence to medical procedures there would be fewer days lost from work for depression, fewer complications of diabetes requiring expensive medical procedures and hospital stays and it would mean an investment in the future of the children of The Rio Grande Valley by instilling positive lifestyle choices into their early training and

practice so that they do not have to suffer the serious consequences of losing a parent prematurely, or developing diabetes themselves.

b. Describe the Integrated Care Model

The research design is a holistic model of wellness care that pays attention to the biological, psychological, social and emotional dimensions of the human being. The mental health clinicians will be using an evidence-based psychotherapy approach called REBT. Acronyms used in Figure 5 include: REBT: Rational Emotive Behavioral Therapy, PROMIS: NIH validated screening tool for depression and anxiety, WHO: World Health Organization, QOL: Quality of Life, PCP: Primary Care Physician. **(See Figure 5 for The Integrated Care Model Design)**

c. Describe the evidence-based IBH interventions.

The level of evidence for The Ecumenical Center's Project is Preliminary. The Ecumenical Center's project is most similar to the project entitled: "Collaborative care for comorbid depression and diabetes: a systematic review and meta-analysis." It is done by a different organization, and the project is only similar to that proposed by The Center since only depression, without anxiety was treated. The Center's proposal will treat depression and anxiety, so the highest our level of evidence could be is Preliminary. This qualifies The Center to request 15% of our budget.

d. Describe how you are tracking outcomes and their results.

Outcomes of the counseling sessions will be measured by a pre and post test using the NIH Promis Screening for Depression and Anxiety. Although the WHO's Quality of Life screening is also administered, it is for counseling information only. All screenings are in English and Spanish and will be given at 12 week intervals. All of these instruments have been validated and are offered at no cost to this program. HbA1c will be monitored by lab results at 12 week

2. Project Narrative

Need

a. Describe the service area/target population.

A needs assessment of Starr and Hidalgo Counties and the Rio Grande Valley demonstrates needs in four areas:

- There is limited access to Primary Care and Specialized Medical Care,
- There is limited access to Mental Health Care,
- There is limited access to Health Education and Disease Prevention Education,
- There are the economic conditions of the area; specifically, poverty, unemployment and poor living conditions.

According to the Texas Healthcare Transformation and Quality Improvement Program Regional Partnership Plan, December 31, 2012, page 7. The "rapidly growing population of the Lower Rio Grande Valley, home to 1.26 million residents, is relatively young, predominately Hispanic and is characterized by high poverty rates and high rates of adults without a high school education Diabetes is an underlying component of over half of hospital admissions for heart attack, hypertension, sepsis and stroke, based on a 2011 analysis of admissions at six hospitals in these counties. This analysis found that diabetes contributes to more than 16,000 extra bed days per year at an additional cost of $49 million to $83 million annually."

b. Low Income status measures

The study further states that, "Median family income … ranges from $27,000 in Starr County to $34,500 in Hidalgo and Cameron Counties (Figure 3). This is between 45% and 59% of the Texas median income of $57,998, and 40% to 55% of the US median family income of $62,112. Nearly half (47%) of families … earn less than $25,000 annually. Additionally, 40% of all

families live below the federal poverty line—twice the poverty rate for Texas and 2.5 times the U.S. poverty rate. The McAllen– Edinburg–Mission metropolitan statistical area ranks last … with a per capita income of $15,184 among families with a single female head of household, over 60% live below the poverty line, half again the proportion in Texas and the U.S. (Figure 4).” pgs. 20-21. From these statistics, it is evident that the populations of Starr and Hidalgo County would qualify as low income and below the poverty level for purposes of this study.

c. Training Needs of the Current Staff to provide Integrated Care

1. The Ecumenical Center has a two year Specialty in Pastoral Counseling Program in the Rio Grande Valley that has been serving the community for 10 years. This program, led by Dr. Esteban Montilla, Assistant Professor at St. Mary’s University, trains and prepares the Specialty in Pastoral Counseling Students. These Specialty in Pastoral Counseling Graduates will administer the National Institutes of Health Promis Screening for Depression and Anxiety and The World Health Organization’s Quality of Life Screening to the diabetic patients on their initial intakes to the Guajira Medical Clinic (GMC). All graduates of the program are bi-lingual.

2. A Licensed Professional Counselor will be employed to counsel diabetic patients.

3. The Guajira Medical Clinics (Dr. Ernesto Griego), will provide office space, access to records, scheduling and record keeping facilities for this program at their clinics. All staff in the GMC office are fully trained and HIPPA compliant.

4. Project Coordinator -The Ecumenical Center has staff who are qualified in project management. Specific to this study additional training in data collection and reporting would be completed by staff at The Ecumenical Center.

5. Training Staff-

Mary Beth Fisk, MT, CQA, CTBS and CEO/Executive Director of The Ecumenical Center

Ms. Fisk is an experienced research scientist and has published manuscripts in several medical journals over the past 25 years. Her experience as a medical technologist, clinical scientist, certified quality auditor, as well as administrator spans 30 + years. Ms. Fisk will provide study oversight and guidance to include design, implementation and statistical results review.

Dr. Esteban Montilla- PhD, LPC, DMin.

Dr.Montilla has been involved in the research design of this project and will work to train, oversee and advise those involved in this project from the Rio Grande Valley location. Dr. Monilla trains those students enrolled in the Specialty in Pastoral Counseling in the Valley. Dr. Esteban Montilla is an ordained clergyman, a licensed professional counselor and a Latin-American theologian known for his ability in scriptural/psychological integration at both theoretical and practical levels. He received his master and doctoral degrees in counseling from Texas A&M University-CC. Dr. Montilla is a diplomate/CPE-supervisor, as well as a board certified pastoral counselor and clinical chaplain with the College of Pastoral Supervision and Psychotherapy (CPSP). He is a pioneer in establishing counseling and pastoral care programs in several Latin American countries, and the architect of several Spanish language pastoral trainings. Dr. Montilla is the author of several books including "Viviendo la Tercera Edad" (2004), Family Counseling with Latinos and Latinas (2005), Pastoral Counseling with Latinos and Latinas (2006) and several articles on the various aspects of counseling and pastoral care in multicultural environments. Dr. Montilla is an assistant professor for the master and doctoral programs offered in the Department of Counseling and Human Services at St. Mary's University.

Frank E. Emmett, PhD (LT COL, Ret) Clinical Director of The Ecumenical Center

Dr. Emmett has also been involved in the research design of this project and will work to train, oversee and advise those involved in this project. A licensed clinical psychologist, Dr. Frank

Emmett has more than 40 years of experience, much of which he gained during his time in the United States Air Force. He served in a variety of leadership positions in military hospitals and clinics around the world, and retired as Chief of Mental Health at the U.S Air Force Clinic on Randolph Air Force Base.

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Outcomes of the counseling sessions will be measured by a pre and post test using the NIH Promis Screening for Depression and Anxiety. Although the WHO's Quality of Life screening is also administered, it is for counseling information only. All screenings are in English and Spanish and will be given at 12 week intervals. All of these instruments have been validated and are offered at no cost to this program. HbA1c will be monitored by lab results at 12 week

intervals at GMC's laboratory and results captured in the research file record. Collaboration will occur every 12 weeks with Counselor, PCP and patient.

e. Describe how the organization will achieve the outcomes. Provide a timeline.

August 1, 2015-Oct. 1, 2015-

- Grants Awarded by MHM and Baptist Legacy Foundation
- Hiring of needed personnel commences in San Antonio and The Rio Grande Valley. Furniture, supplies and computer hardware and software are purchased for counseling offices in McAllen, Texas.
- The Ecumenical Center and Methodist Healthcare Ministry (MHM) personnel will train project personnel at The Ecumenical Center location in San Antonio.

Oct. 1, 2015-

- Following training, Counseling Staff and PCP (Dr. Griego) will begin screening patients and offer collaborative care to patients at the GMC clinic in McAllen, Texas using the Integrated Behavioral Health model of complete collaboration on all aspects of patient care.

Nov. 1, 2015-

- Project Coordinator will travel to the McAllen, Texas, location and collect data and assess any problems, supplies or materials that are needed on a monthly basis.
- Collaboration and data sharing will occur with Research Scientist, external evaluator, MHM personnel and Baptist Legacy Foundation personnel, as required.

Dec. 1, 2015 –July 31, 2017

- Integrated Behavioral Health model continues to be implemented at GMC's McAllen, Texas location.

- Analysis of patient needs and services is ongoing and is done by conferences with The Ecumenical Center's CEO/Executive Director, Project Manager, Dr. Griego or designee and the Project Counselor.
- Adjustments are made to counselor's locations to maximize outreach to the most possible patients. The Project Coordinator travels to the McAllen, Texas, location monthly to collect data and assess any problems, supplies or materials that are needed.
- Collaboration and data sharing will occur with Research Scientist, external evaluator, MHM personnel and Baptist Legacy Foundation personnel, as required.

f. Describe how the core competencies of the Integrated Behavior Model will be achieved by the end of the 3-5 year period.

As described in Figure 5 Diagram for Integrated Model of Care and Appendix A-Work Plan, all of the core competencies are built in place from the start of the collaboration. GMC is providing a waiting room, a counseling room and access to all of the daily patients at the McAllen, Texas clinic. Shared patient scheduling will be done by GMC's staff, as will shared treatment planning and shared service provision, and shared record keeping.

g. Future Scalability Possibilities.

GMC and Dr. Ernesto Griego will provide The Ecumenical Center support for this study to include providing access the clinic, a dedicated counseling office, a dedicated waiting room and collaborative support. Future study expansion includes other three clinic locations which would allow study enrollment to grow in number of clients. The services provided at GMC McAllen, Texas will continue to have the highest level of integration of services.

Evaluative Measures

a. Organization's existing evaluation capacity.

The Ecumenical Center is currently using the ACORN Data Center's assessment tool for determining the outcome of assessment, counseling, and psychotherapy done at the Ecumenical Center. This is a mandate from the Samaritan Centers International with whom the Center is affiliated and certified. The survey instrument assesses improvement (or lack thereof) for children (completed by parents), Adolescents, and Adults. Surveys are given with the initial and then each subsequent visit, thereby compiling a picture of change in thoughts, moods, attitudes and behaviors over the course of the therapeutic treatment(s).

b. Describe your experience in working with an external evaluator.

Mary Beth Fisk, CEO/Executive Director has extensive experience working with an external evaluator. She has headed numerous scientific research studies and has 30+ years experience in laboratory medicine. She is a published research author and scientist.

c. Logic Model and Theory of Change

If the Ecumenical Center partners with the Guajira Medical Clinics and Dr. Ernesto Griego to create an Integrated Behavioral Health model to treat diabetes along with depression and anxiety this will lead to a better quality of life, improvements in behavioral health and region wide improvements in chronic disease in Starr and Hidalgo counties.

d. Description of lead evaluation personnel

1. Mary Beth Fisk, MT, CQA, CTBS and CEO/Executive Director of The Ecumenical Center is an experienced research scientist and has published manuscripts in several medical journals over the past 30 years. This experience with external evaluators is vast. Effective communication of study design, implementation and data collection is critical. With this experience, as well as the history of funded medical care and education programs of The Ecumenical Center, we believe the professional interaction with the external evaluator will be very effective. Ms. Fisk would

oversee the entire project in conjunction with clinical staff leadership. Under Ms. Fisk's direction, research study data protocols are in place.

2. Dr. Frank Emmett-PhD Psychologist/Clinical Director- A licensed clinical psychologist, Dr. Frank Emmett has more than 40 years of experience, in the Air Force Biomedical Service, as well as managing private practice settings. He served in a variety of leadership positions in military hospitals and clinics around the world and was special consultant to the Air Force Surgeon General, and the Air Force Special Operations Command.

3. Dr. Esteban Montilla- PhD, LPC, D.Min-Dr. Montilla will be located in the Valley and will oversee the research protocols. Dr. Esteban Montilla is an ordained clergyman, a licensed professional counselor and a Latin-American theologian known for his ability in scriptural/psychological integration at both theoretical and practical levels. He received his master and doctoral degrees in counseling from Texas A&M University-CC. Dr. Montilla is a diplomate/CPE-supervisor, as well as a board certified pastoral counselor and clinical chaplain with the College of Pastoral Supervision.

e. Describe the process by which progress toward enhancement, replication or expansion will be tracked. The Project Coordinator, along with the CEO/Executive Director, Ms. Fisk, Dr. Montilla, the Counselor and GMC (Dr. Griego), PCP will be in communication, as previously mentioned, to evaluate if this project needs to expand to GMC's other 3 clinics. Tracking of patient participation in the study will determine expansion or replication plans.

f. Current process of data collection- The Ecumenical Center is currently using the ACORN Data Center's assessment tool for determining the outcome of assessment, counseling, and psychotherapy done at the Ecumenical Center. For further information see Evaluation, Section a above.

g. The Electronic Medical Record system currently in use at The Ecumenical Center is Care Cloud. The Counseling Staff that is working with GMC (Dr. Griego's) office will use the system that is in place in at the GMC office location in keeping with the integrated behavioral health model.

h. Dr. Griego's practice in Edinburg, Westlaco and Rio Grande City have populations that are similar to the McAllen clinic. These clinics could provide a very similar comparison group.

Collaboration

a. Collaboration is occurring with Dr. Ernesto Griego and the 4 Guajira Medical Clinics in McAllen, Edinburg, Westlaco and Rio Grande City, Texas. This collaboration with The Ecumenical Center will bring mental health services to a population who would have a low probability of resource to seek mental health counseling.

b. The Ecumenical Center participates in a wealth of collaborative activities with groups in the San Antonio Metropolitan area and the State of Texas. The Center has a partnership with Methodist Healthcare Ministries for Children's Play Therapy, Conversations about Ethics (medical ethics), Specialty in Pastoral Counseling Training Program and Neurofeedback services. In addition, The Center will be collaborating with the San Antonio Medical Foundation and other funders to create Meditation Gardens and bring a unique new modality of therapeutic benefit to the community of Nature Play on the grounds of The Ecumenical Center.

Resources/Capabilities

a. The Ecumenical Center has and will continue to be the vanguard of investigating, implementing and sharing knowledge about new techniques and technologies available to the medical profession and the counseling community. The Center was the pioneer in

neurofeedback in the San Antonio and South Texas area and the disciplines of play and art therapy.

b. The Ecumenical Center is fortunate to have an organizational structure including a CEO/Executive Director, a Board of Directors and a Foundation Board of Directors who have a wealth of experience in business, counseling and corporate management. As a whole, the CEO and these Boards of Directors are visionaries, supporters and implementers who are well equipped and committed to carry out this Integrated Behavioral Health Model.

c. The governing Board of Directors is made up of 14 members, an equal number of men and women, the Foundation Board is made up of 94 people, men and women, from all races and ethnicities who are willing and able to support new programs. Meetings are held bi-monthly for the Board of Directors and three times per year for the Foundation Board of Directors.

d. i. All schedules and medical records are on the electronic medical record system called the Care Cloud. ii. With programs in collaboration with Methodist Healthcare Ministries, The Center engages in the local and regional health information exchanges. iii. The Center tracks patients referred to complex or specialty behavioral health care. iv. The Center has telehealth capabilities and with a new partnership with the Rio Grande Methodist Ministers, will be using telehealth for wellness visits.

Sustainability

Payment for salaries is built into the current budget for all staff needed. The Guajira Medical Clinics will provide support for this project and future project growth. Additional counselors maybe hired that have the ability to accept Medicare payments. In future expansion plans, The

Guajira Medical Clinics would bill insurances and Medicare for services provided by The Ecumenical Center's mental health counselors.

Budget Narrative

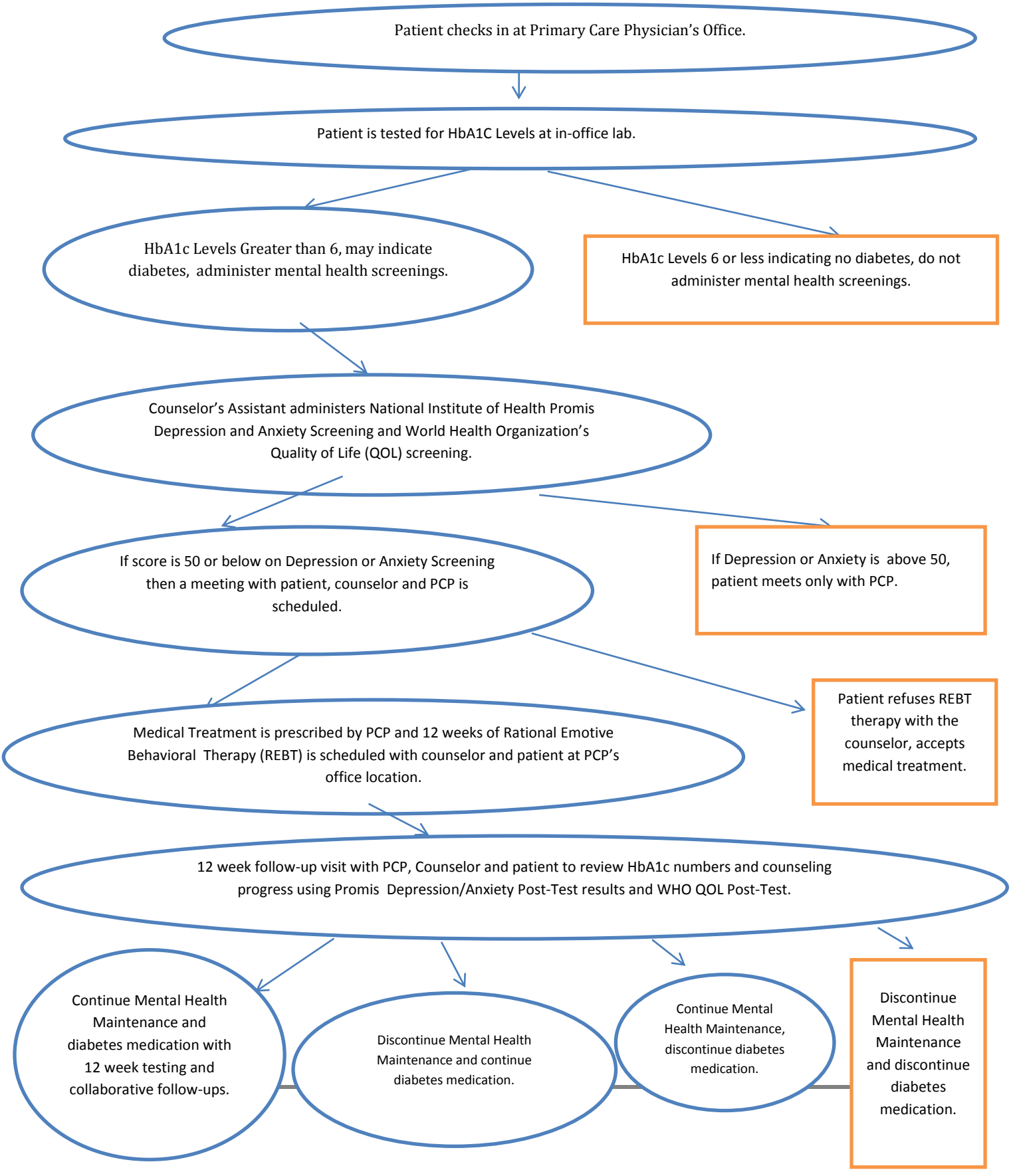
A matching grant is being requested from The Valley Baptist Legacy Foundation. Data Management will be the responsibility of the Project Coordinator with time built into the budget for travel to the external evaluator, as necessary. The Ecumenical Center has experience with MHM grant reporting requirements. Key Personnel for this project include: The Project Coordinator who will be located in San Antonio and will be responsible for the data collection and financial reporting duties included in the grant. This person will travel to the Valley and be available for calls and interaction with the External Evaluator. This person will be hired upon award of the grant. The Financial Director will also be responsible for control of funds, accounting for the funds and disbursement of the grant funds. The Financial Director is already a staff member. Both these key personnel will be at The Ecumenical Center's San Antonio office and will report to The CEO/Executive Director of The Ecumenical Center. A Professional Counselor, licensed by the State of Texas would be hired. The duties of the Counselor will be to evaluate test results of the Promis screenings and The Quality of Life Screenings, make appropriate treatment plans and keep notes on the Electronic Medical Record System that the Guajira Clinics use. Further duties would be to be available to meet with the patient and the PCP, as necessary, for follow-up collaborative meetings. This counselor will be hired upon award of the grant. The additional counseling staff will be hired from the graduates of The Center's Specialty in Pastoral Counseling in the Valley. They will be responsible to administer and score the Promis Depression and Anxiety screenings and the WHO Quality of Life screenings. They will be hired upon award of the grant.

Basic financial controls are in place for all of the following: cash management; to assure Federal eligibility and use of Federal funds only during the intended periods; to ensure that costs are allowable grant charges; to assure that all contracts that are charged to grants are properly authorized and competitively bidded; to ensure that all staff involved with grants are knowledgeable about compliance requirements; to ensure that complex operations, programs or projects within grant funding are identified and monitored; to ensure that procedures are in place to implement changes in laws, regulations and funding agreements; to ensure that procedures are in place to account for all equipment and real property acquired with Federal awards and procedures are in place to ensure that program income is correctly earned, recorded, and used in accordance with program requirements.

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
›› Have separate systems ›› Communicate about cases only rarely and under compelling circumstances ›› Communicate, driven by provider need ›› May never meet in person ›› Have limited understanding of each other's roles	›› Have separate systems ›› Communicate periodically about shared patients ›› Communicate, driven by specific patient issues ›› May meet as part of larger community ›› Appreciate each other's roles as resources	›› Have separate systems ›› Communicate regularly about shared patients, by phone or e-mail ›› Collaborate, driven by need for each other's services and more reliable referral ›› Meet occasionally to discuss cases due to close proximity ›› Feel part of a larger yet ill-defined team	›› Share some systems, like scheduling or medical records ›› Communicate in person as needed ›› Collaborate, driven by need for consultation and coordinated plans for difficult patients ›› Have regular face-to-face interactions about some patients ›› Have a basic understanding of roles and culture	›› Actively seek system solutions together or develop work-a-rounds ›› Communicate frequently in person ›› Collaborate, driven by desire to be a member of the care team ›› Have regular team meetings to discuss overall patient care and specific patient issues ›› Have an in-depth understanding of roles and culture	›› Have resolved most or all system issues, functioning as one integrated system ›› Communicate consistently at the system, team and individual levels ›› Collaborate, driven by shared concept of team care ›› Have formal and informal meetings to support integrated model of care ›› Have roles and cultures that blur or blend

Diagram of Integrated Model of Care-Figure 5



Executive Summary

- **Project Title:** Service On Site (SOS)
- **Organization Name:** Pregnancy Testing Centers, Inc.
- **Address:** 216 E. Tom Landry Blvd. Mission, Texas 78572
- **Project Directors Name:** Danny Anderson
- **Phone Numbers (voice, fax):** 956-519-9997
- **E-Mail Address:** ptcdirector@hotmail.com
- **Amount Requested:** $300,000

Overview

The Pregnancy Testing Centers (PTC) are located in the Rio Grande Valley of SE Texas. Started in a private home by a couple who saw the existing need, services have expanded over the years to include three counties along the Texas/Mexico border. Statistics in Texas show these areas to be among the poorest in both socioeconomic status, and in affordable, accessible obstetrical and preventative care for women. The primary target population will be women living in impoverished areas of the border counties of Cameron, Hidalgo, Starr, and Willacy.

Key components of our plan for on-site prenatal and women's health services will include assessing mental, physical and social health concerns as well as providing education and behavioral modification strategies relating to pregnancy and wellness. Behavioral risk assessment is integral in the provision of preventative and prenatal health care.

The proposed project will both expand services at existing sites and extend to new sites. This project will expand current pregnancy testing services to include prenatal care as well as preventive services for women. Care, screening, treatment, counseling, education, and support will be brought to women who have no other way to access services.

Low-income women in these communities will derive substantial, measurable benefit. Many of the women living in these communities have no transportation, no money, no ID, and are not eligible for federal or state services. Care will be brought to them, free of charge. Community partnerships will be expanded. State and county relationships will be strengthened.

External Reviewers:

Kandyce Fernandez

Celeste Harrison

Judy Quisenberry

Toni Terling Watt

Becky Adeigbe

Lisa Wolff

Sí Texas Project Budget

Budget Period: August 1, 2015 to July 31, 2017

	A	B	C	D	E
3	**Organization Name:**	Nuestra Clinica del Valle, Inc.			
4	**Project Title:**	NuCare			
5	**EXPENSES**	**Justification**	**Sí Texas Grant Request**	**Amount from Matching Sources**	**Project Total**
6	Project Personnel Expenses				**$ -**
7	Project Director & Evaluator	1 person @ $100,000 x 40% usage	$ 20,000	$ 20,000	**$ 40,000**
8	Data Collector/Manager	1 person @ $30,800 x 100% usage	$ 15,400	$ 15,400	**$ 30,800**
9	RN Case Manager	1 person @ $60,000 x 100% usage	$ 30,000	$ 30,000	**$ 60,000**
10	Nurse	3 FTE @ $37,000 x 100% usage	$ 55,500	$ 55,500	**$ 111,000**
11	Licensed Professional Counselor	3 FTE @ $57,000 x 100% usage	$ 85,500	$ 85,500	**$ 171,000**
12	Psychologist Intern	2 FTE @ $26,150 x 100% usage	$ 26,150	$ 26,150	**$ 52,300**
13	Community Outreach Assistant	8 FTE @ $17,285 x 100% usage	$ 69,140	$ 69,140	**$ 138,280**
14	Nutritionist	2 FTE @ $38,000 x 100% usage	$ 38,000	$ 38,000	**$ 76,000**
15	**Poder Project Personnel**				
16	Nurse	1 person @ $37,000 x 12.50% usage	$ 2,313	$ 2,313	**$ 4,626**
17	Certified Medical Assistant	1 person @ $25,300 x 50% usage	$ 6,325	$ 6,325	**$ 12,650**
18	Outreach Assistant/MPH Student	7 FTE @ $28,840 x 50% usage	$ 50,470	$ 50,470	**$ 100,940**
19					
20	Personnel Fringe Benefits				**$ -**
21	FICA	$745,295 x 7.65%	$ 28,508	$ 28,507	**$ 57,015**
22	Health Insurance	Health Insurance for 18 staff	$ 43,474	$ 43,474	**$ 86,948**
23	Retirement	Retirement for 18 staff	$ 13,296	$ 13,295	**$ 26,591**
24	Life Insurance	Life Insurance for 18 staff	$ 432	$ 432	**$ 864**
25					
26	Travel		$ 12,563	$ 12,563	**$ 25,126**
27		Nat'l meeting to upgrade skills (4 persons/yr@$1,800) **$7200**;			**$ -**
28		Promotora & Supervisor travel to community sites (50 miles/week x 5 persons x 52 wks x .55/mi) **$7,150**			**$ -**
29		Attend quarterly evaluation collaborative meeting (hotel @ $150 x 2 nights), (mileage 288 mi/roundtrip @ .55/mi), (per diem 2 days @$50) $540 x 4 qtrly meetings = **$2,160**			**$ -**
30		Poder Project: Students & Staff to present at meetings (6 x $1,436) **$8,616**			**$ -**
31					
32	Equipment		$ -	$ -	**$ -**
33					

	A	B	C	D	E
1		**Sí Texas Project Budget**			
2		Budget Period: August 1, 2015 to July 31, 2017			
3	**Organization Name:**	Nuestra Clinica del Valle, Inc.			
4	**Project Title:**	NuCare			
5	**EXPENSES**	**Justification**	**Sí Texas Grant Request**	**Amount from Matching Sources**	**Project Total**
34	Supplies		$ 71,932	$ 71,932	**$ 143,864**
35		Educational supplies ($2,500/clinic x 4) **$10,000**			
36		Printing ($2,500/clinic x 4) **$10,000**			
37		Computer & printers **$14,800**			
38		Food items for demonstrations ($40/meeting x 4 days/wk x 50 wks/yr x 4 promotoras) **$32,000**			
39		Poder Project: Lab supplies (HbA1c plus microalbumin, urine cups) **$41,526,** Printing **$10,300,** Incentives **$5,000,** Miscellaneous: fans, heaters, maintenance supplies **$7,463,** graphci design for education materials **$2,122,** Office supplies, computers, tables, chairs **$10,653**			
40					
41	Contractual/Consultant Services	Statistician (50 hrs x $110/hr)	$ 2,750	$ 2,750	**$ 5,500**
42	Training				**$ -**
43	Poder Project Contractual	Evaluator & oversight of students @ 15% effort,	$ 7,611	$ 7,610	**$ 15,221**
44		Fringes at standard rate, TAMU	$ 1,952	$ 1,953	**$ 3,905**
45	Other Costs				
46	Poder Project Rent	4 rooms @ $115/mo x 12 months (Standard rotation Mercadome)	$ 2,760	$ 2,760	**$ 5,520**
47					**$ -**
48	Criminal History Checks	30 persons @ $50	$ 750	$ 750	**$ 1,500**
49					**$ -**
50	Office Visit Costs	4 visits/year including labs for 500 patients @ $200	$ 200,000	$ 200,000	**$ 400,000**
51					
52	Federally approved indirect cost rate (not to exceed 10% of subtotal)				**$ -**
53	**Subtotal - budget year 1**		**$ 784,826**	**$ 784,824**	**$ 1,569,650**
54	**Year 2 Total Budget**		$ 784,826	$ 784,824	**$ 1,569,650**
55	**TOTAL EXPENSES - Year 1**		$ 784,826	$ 784,824	**$ 1,569,650**
56	**Funding percentages**		50%	50%	**100%**

	A	B	C	D	E
1		**Sí Texas Project Budget**			
2		Budget Period: August 1, 2015 to July 31, 2017			
3	**Organization Name:**	Nuestra Clinica del Valle, Inc.			
4	**Project Title:**	NuCare			
5	**EXPENSES**	**Justification**	**Sí Texas Grant Request**	**Amount from Matching Sources**	**Project Total**
57					
58	**SUMMARY OF FINANCIAL REQUEST**				
59	Total organizational operating budget				$ 19,461,666
60	Grant Request to Organizational Budget Ratio				4%
61	Level of Evidence		Moderate		**Up to 25%**
66	*Reminder: Grant request may not exceed 25% of the organization's total operating budget.*				
67					
68	**LIST MATCH SOURCES**	**Status**	**Type**		**Amount**
69		Select	Select		
75		Select	Select		
76		Select	Select		
77		Select	Select		
78		Select	Select		
79		Select	Select		
80		Select	Select		
81	**Total Matching Funds**				**$ -**
82	*Total Matching Funds must equal Total Expenses in "Amount from Matching Sources" column above*				
83					
84	**OTHER FEDERAL SOURCES OF FUNDING (does not count toward match)**				**Amount**
85	Name of Federal agency				
86					
87					
88					
89	**Total Federal Source Funds**				**$ -**

Nuestra Clinica del Valle Care (NuCare):
Integrated Behavioral Health Reducing Diabetes, Obesity, & Depression

Narrative

Need. NuCare will address a critical need and save lives of chronically ill patients of Nuestra Clinica del Valle (NCDV) in Hidalgo County and the neighboring county to the west, Starr County. The health center will improve the health of the patient population through integrated primary care, particularly involving diabetic, obese, and depressed patients.

a. Service area and target population. In Region 11 of the Department of State Health Services, which includes the two counties, 39% of respondents reported symptoms of chronic depression and 11.2% reported a clinical diagnosis of major **depression** (Professional Research Consultants, 2011; see also Mier et al., 2008). Hidalgo County has an **obesity** rate among adults of 42.9% (CDC 2014; Zhang et al. 2014); Starr County, 31% (University of Wisconsin Population Health Institute 2014, 2015; Texas Dept. of State Health Services 2015). The prevalence of **diabetes** in the region is 30.7% (Fisher-Hoch et al., 2012). The region is a mental health services shortage area (HRSA 2015; PRC 11 2014). Nuestra Clinica serves about 30,000 patients at 11 clinics in the two counties.

b. Unique characteristics that impact access to and use of behavioral health care. Hidalgo County has a poverty rate of 34.0%; Starr County, 36.3% (U.S. Census Bureau 2013) and a high rate of uninsured (36.4%) (U.S. Census Bureau 2013). The influence of rural Mexican culture leads to self-reliance and a tendency not to seek medical care until absolutely necessary, especially not for mental health problems, which are highly stigmatized out of fear and misunderstanding (Barrera et al. 2013).

c. Training needs. All clinic employees will be carefully and diplomatically oriented to the value of integrated primary care and the new program. Every effort will be made to establish ownership of the new protocols by the entire clinical hierarchy. The LPCs/LSWs will be trained online in Integrated Behavioral Health and, along with the culturally competent Community Health Workers (promtor/as), will be trained

online in Motivational Interviewing. The psychology interns will be trained in all of these areas.

Project Description

a. Stage of behavioral health integration. NCDV currently provides integrated primary care at the main clinic in San Juan at Level 5 and at the rest of the clinics at Levels 3 and 4. For years throughout the region, it has been the common pattern that patients often break behavioral health appointments because of stigma and lack of understanding of mental illness and behavioral health, a pattern that accentuates the importance of a warm handoff. San Juan Clinic has integrated primary care with Dr. Bonura, a psychologist on site involved in a warm handoff. She also works with LPCs and LCSWs at the S. Juan Clinic, and they follow up with appointments for counseling at the clinic for all NCDV patients. They use a common electronic health record. NCDV offers nearly all services at the San Juan Clinic and only partially covers 3 other clinics at least once monthly, leading to an IBH level 3-4 categorization. In the expansion, each of the four clinics will hire a behavioral health specialist and a promotor/a (male or female community outreach worker) as peer support. The integration of psychology interns with LPCs and LCSWs was developed in consideration of the scarcity of psychologists in the region.

b. The integrated care model

i. Integration of primary medical and behavioral health care. Behavioral healthcare services will be integrated into clinic procedures in several ways with training and other processes of ramping up to put the different protocols into practice. The four clinics will add an IBH team and include the warm handoff, in which the primary care provider directly introduces the patient to the behavioral health provider (BH provider) during a medical visit. The BH provider then immediately provides a brief behavioral health intervention. This process breaks through the strong local barrier of stigma against behavioral health services and allows the counselor to develop rapport, encouraging patient confidence in the services offered. NCDV has found that warm handoffs benefit patients, more of whom receive IBH services, and providers, who save time and reduce their own stress levels through a warm handoff.

Nuestra Clinica del Valle Care (NuCare):
Integrated Behavioral Health Reducing Diabetes, Obesity, & Depression

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Promotor/as will be trained to assist with the behavioral health component of the project in addition to other activities. The focus in hiring will be on promotor/as who are controlled diabetics, Hispanic, suited to positions of leadership and program facilitation, and eager to accept training. They will apply the depression screening tool (PHQ-9) with which the clinic population is likely to need assistance because of challenges in reading and fear of behavioral healthcare. This information will be used by the physician and care team in further behavioral health assessments.

ii. Use of a team-based, integrated model of care that incorporates behavioral health services and primary care. NuCare will integrate behavioral health care services in a primary healthcare setting with a multidisciplinary team approach including physicians, nurses, counselors, and promotor/as.

iii. Innovative components. A major innovative, evidence-based component is to train and give behavioral health responsibilities to promotor/as as peer support. Usually promotor/as are limited to outreach at health fairs and directing patients to various clinic waiting rooms. In this project, the community health workers will meet patients in the reception area and accompany them through the visit, assist with the PHQ-9, and meet the patient after the physical examination for an invitation to a wellness program.

In another innovation, NuCare promotor/as will replicate an evidence-based wellness program, the Healthy Living Partnerships to Prevent Diabetes (HELP PD), sited in the community (Katula et al. 2010, 2011, 2013). NuCare will translate it into Spanish and include culturally appropriate details on nutrition while maintaining fidelity.

Another innovation is the addition of an NCDV access point, a flea market diabetes screening and education component. This effort began in 2014, has a steady flow of participants, nearly half of them men, and will identify about 500 yearly who have indications of diabetes (24% of participants to date). They will be referred to NCDV to start medical care earlier than would occur otherwise.

c. Describe the evidence-based IBH interventions. The experience of NCDV with IBH interventions at the main clinic in San Juan has been positive and contributes to a moderate evidence base for this

proposal. In 2006, the San Juan Clinic began providing integrated primary care with PHQ-9 depression screening of patients (≥ 12 years). The PHQ-9 has a high degree of internal consistency (ICC= 0.88) and test-retest reliability (correlation=0.94) (Zuithoff et al. 2010). By 2012, the clinic had fully integrated primary care. Flores (2015), in a pre-post study of 1261 patients receiving behavioral health services at NCDV (2006-2012) found large, clinically significant declines in depressive symptoms on average from an initial PHQ-9 of 17.00 to 9.66 (see also SAMHSA 2005). (A PHQ-9 ≥ 10 is frequently used to initiate behavioral health assessment and intervention.) Flores analyzed records of all patients who were in treatment for at least 3 months; thus statistical tests of significance are not required because the study included the entire statistical universe of patients accessing the services. It is highly likely that these results would apply to other NCDV clinics, although they would not be generalizable. The IBH expansion will replicate the work at San Juan clinic.

According to a study of NCDV patients with end-stage renal disease (N=136) during 18 months in 2012-2014, 52.94% were uninsured and 61.03% were using emergent dialysis, which exacerbates health problems and costs about three times as much as regularly scheduled dialysis (Boggess 2015).

The wellness program will replicate Healthy Living Partnerships to Prevent Diabetes (HELP-PD), shown to be effective in randomized controlled trial studies (Katula et al. 2011, 2013). This diabetes education program was delivered by community health workers with participation by health experts in some group education sessions, and one-on-one meetings with dietitians. HELP-PD resulted in a decline in blood glucose of -4.3 vs. -0.4 mg/dl ($p<0.001$) in patients under standard medical care; a decline in insulin of -6.5 vs. -2.7 μU/mL ($p<0.001$), and a decrease in BMI of -2.1 vs. -0.3 kg/m^2 ($p<0.001$). The Guide to Community Preventive Services (2014a, 2014b; Community 2015) found that the program used scientific standards of the highest quality including low risk of sampling bias, low dropout rate and outcome measures that were reliable and valid. Other studies of HELP-PD include Katula et al. (2010) and Lawlor et al. (2013), showing impressive cost-effectiveness. These outcome evaluations were done by external evaluators, i.e.,

researchers, who were not involved in implementing the program. The program was carried out in 14 sites. Other studies have also found statistically significant effectiveness of peer education and support for community groups (Brown 2002; Millard et al. 2011; Qi et al. 2015; Spencer et al. 2011; Wilson and Pratt 1987; see also Blackwell et al. 2011).

d. Tracking outcomes and their results. It will be possible to track outcomes through the EMR and if necessary, chart reviews, for data on changes in depressive symptoms (measured with PHQ-9 scores), obesity (BMI), and severity of diabetes (HbA_{1c} levels). Short questionnaires on nutrition and physical activity and community-based activity records of attendance will also be used.

e. How NCDV will achieve the outcomes and timeline. The Work Plan shows that the project will advance integrated behavioral healthcare (IBH) and collaboration in an increasingly integrated system.

TIMELINE: including ramping up to achieve outcomes

Year 1	A	S	O	N	D	J	F	M	A	M	J	J
Secure matching funds	x	x	x	x	x	x	x	x	x	x	x	x
Weekly project meetings	x	x	x	x	x	x	x	x	x	x	x	x
Project plus clinic staff meetings	x	x	x			x			x			x
MHMcalls, meetings & learning collaborative	x	x	x	x	x	x	x	x	x	x	x	x
Hiring & training personnel in IBH, PHQ-9 & other IBH issues	x	x	x	x	x	x						
Roll out IBH increasingly				x	x	x	x	x	x	x	x	x
Flea market access point	x	x	x	x	x	x	x	x	x	x	x	x
Refine bilingual educational materials	x	x	x	x	x	x	x	x	x	x	x	x
Health education activities at market	x	x	x	x	x	x	x	x	x	x	x	x
Train existing staff in IBH collaboration			x	x	x	x	x	x	x	x	x	
Increase IBH collaboration				x	x	x	x	x	x	x	x	x
Wellness activities in community					x	x	x	x	x	x	x	x
Ongoing process & outcome evaluation	x	x	x	x	x	x	x	x	x	x	x	x
Evaluation data entry	x	x	x	x	x	x	x	x	x	x	x	x
Years 2-5												
Weekly project meetings	x	x	x	x	x	x	x	x	x	x	x	x
Project plus clinic staff meetings			x			x			x			x
MHMcalls, meetings & learning collaborative	x	x	x	x	x	x	x	x	x	x	x	x
Flea market access point	x	x	x	x	x	x	x	x	x	x	x	x
Refine bilingual educational materials	x	x	x	x	x	x	x	x	x	x	x	x

Health education activities at market	x	x	x	x	x	x	x	x	x	x	x	x
Continue IBH rollout as needed (year 2)	x	x	x	x	x	x	x	x	x	x	x	x
Increase IBH availability to pts	x	x	x	x	x	x	x	x	x	x	x	x
Increase IBH collaboration	x	x	x	x	x	x	x	x	x	x	x	x
Wellness activities in community	x	x	x	x	x	x	x	x	x	x	x	x
Ongoing training in evidence-based practices	x		x		x		x		x		x	
Ongoing process & outcome evaluation	x	x	x	x	x	x	x	x	x	x	x	x

f. How core competencies will be achieved by the end of the 3- to 5-year period. The integration is strongest at the main clinic in San Juan, which has shared patient scheduling, shared treatment planning, shared service provision, and shared record keeping. This project will support fully integrated primary care at four other clinics, replicating the San Juan Clinic practices.

g. Describe any current or future scalability possibilities. NCDV has other clinics to which IBH services can extend in the future. As a federally qualified health center, it can also provide examples of IBH to other FQHCs and similar clinics in the region and across the nation. The integration of LPCs and peer support of promotor/as may provide an advantage to patients through delivering IBH in a de-stigmatizing, reassuring framework. If successful, this model should be disseminated widely as an effective and economical way to implement integrated primary care.

The integration of psychology interns into NCDV will lead to increased numbers of psychologists in the region helping to remedy the extreme scarcity of BH providers. Community health workers are receiving increasing attention nationally as ancillary staff who make primary care more effective. Texas and some other states have certification programs for them and reimbursement for their services is increasing; Medicaid reimbursement is available with a provider recommendation for services preventing disease or improving physical or mental health (American Academy 2013). Health coaching is also being taught and certified in a number of universities, increasing availability of wellness services.

Evaluative Measures

The patient population of NCDV provides an excellent base for project goals of improved behavioral health and reduced diabetes and its complications. Clinically diagnosed major depression syndrome affects 11.2% of adults in the region (Professional Research Consultants, 2011). Type 2 diabetes affects 30.7% of adults (Fisher-Hoch et al., 2012). On this basis, in the NCDV patient census of 30,000 people, there will be sufficient numbers of patients to recruit into the project's intervention and comparison groups. Evaluation showing effective program results will then allow the comparison group members to enter the intervention.

a. NCDV's evaluative capacity and the team's experience in evaluation. NCDV has a long history of providing detailed reports to the Board of Directors, the federal government, the state, and foundations. NCDV has occasionally implemented chart reviews to answer questions about patients, services provided, and so on. The professional staff is well educated and some participate at times in research projects. On staff, the center lacks people trained in outcome evaluation and statistics; the center lacks statistical analysis software, and NCDV has interest in developing and collaborating to increase evaluation skills.

The flea market project has an ongoing research component, POD^{2}ER coordinated by Dr. Brian Wickwire, M.D., and Dr. Ann Millard, a public health faculty member who specializes in program evaluation at Texas A&M-McAllen Campus. The POD^{2}ER process evaluation monitors participation rates by flea market patrons and MPH students, inventory of supplies, calibration of lab equipment, and regularly scheduled meetings of the project team to discuss how the project is going, to trouble shoot, and to incorporate improved practices. Research data are collected by trained students and staff in questionnaires and through screening tests of HbA_{1c} and microalbumin; data are entered and checked. The research project focuses on outcome measures such as changes in body mass index, HbA_{1c} levels, eating patterns, and levels of physical activity.

b. External evaluators examine NCDV regularly in regard to clinic conditions, practices, records, and finances. Occasionally a researcher collaborates with staff on outcome research.

c. Logic model, theory of change, and SMART goals. Our theory of change is that combined

programs with integrated behavioral health and promotion of healthy eating and physical activity can decrease depression, obesity, and type 2 diabetes. Improvement in physical and mental health will be achieved over 5 years in measureable outcomes in depressive symptoms, obesity rates, and HbA_{1c} levels among program participants. The logic model shows the resources at NCDV, including staff to be provided by the proposed program, including an RN for developing plans of care, and promotor/as. Activities of the project are integrated primary care including the warm handoff and other behavioral health services for patients, a plan of care for each program participant, and the HELP PD lifestyle modification program provided in the community and to be pursued by each participant for two years. NCDV will integrate behavioral health and a wellness program into patient care at four clinics and the community to deliver a higher quality of care to patients who are depressed, obese, or diabetic. The access point at the flea market will provide approximately 500 new patients annually whose primary care visits and lab tests will be provided by project funds for one year to reduce barriers to establishing a medical home and regular primary care visits. The project will provide opportunities for educating families, aiming to spread a culture of health in preventing and controlling diabetes. In the two counties of nearly a million people, however, we do not expect that this one program will make a large change, even if it does so for at least one-third of the participants in the program.

The SMART goals are as follows:

At least 33% of obese, depressed, or diabetic patients in the NuCare program will have a decline of 4 points in depressive symptoms on the PHQ-9 in one year if they participate in project activities (behavioral health care, HELP PD, or both).

At least 33% of obese or overweight patients in the NuCare program will meet their weight loss goals in six months if they participate in HELP PD, as measured by weekly weigh-ins.

At least 33% of diabetic patients in the NuCare program will lower their HbA_{1c} level by a statistically significant amount within two years of beginning participation in the program.

d. Lead evaluation personnel. A staff member, to be hired, will be a Data Manager/Evaluation Contact for the external evaluation team, to facilitate access to data.

e. **Process for tracking progress toward enhancement of IBH and related programs**

Process evaluation will be ongoing throughout the project to deal with any problems as they arise and to ensure a high quality of data collection. Quantitative aspects of process evaluation will involve counts of patient encounters by promotor/as, counts of warm handoffs, counts of patients enrolled in wellness programs, and attendance at group and individualized sessions. Progress in enhancement of IBH will be tracked through these counts and through interviews with clinic staff about their perceptions of the push toward integration.

Another evaluation avenue in tracking progress will be outcome measures on patients' health status. We expect improved health for one third of participants or more in the wellness program as measured by the SMART goals. Additional measures in Katon et al. (2004) and Peña-Purcell et al. (2011) may also be useful.

f. Current process of data collection and use. NCDV has an EMR and collects and uses data for reporting to funding sources and to answer questions of the Board and staff about patients, healthcare quality, and other aspects of the work of the center. For example, trends in HbA_{1c} are tracked for individual patients to assess their individual progress and across all diabetic patients to assess practices of NCDV in general.

g. Data capture systems. NCDV's EMR is Henry Schein MicroMD. The center is in the process of developing access to a Rio Grande Valley HIE (RGV HIE).

h. Comparison group. A comparison group can be recruited from one or more clinics that continues to lack integrated primary care or from the participating clinics.

Collaboration

a. **Collaboration with community organizations** includes joining with other nongovernmental

organizations to seek grant funding, including Hope Clinic, and Texas A&M School of Public Health-McAllen, and other organizations serving low-income people. NCDV also seeks care for patients in need from local providers who normally charge for their services.

b. **Common goals, shared measurements**. Drs. Bonura and Wickwire at NCDV are eager to participate in a learning collaborative related to the proposed project. NCDV belongs to the Collective Impact project funded by MHM, and the project shares the common goal of slowing and reversing the diabetes epidemic in the region through upstream preventive efforts. Also, Nuestra Clinica del Valle, El Milagro Clinic, Hope Clinic, and Texas A&M-McAllen Campus collaborated in a four-year study of community health workers funded by Robert Wood Johnson Foundation (2001-2005). These organizations have a history of working smoothly and productively together. Nuestra Clinica is currently an internship site of the Lone Star Psychology Internship Consortium, serving a number of Texas-Mexico border locations, and NCDV also hosts physician assistant and nursing students from the local university.

Resources/Capabilities

a. Experience and expertise to carry out the proposed five-year plan. NCDV is capable of implementing integrated primary care as is evident at the San Juan Clinic, which achieved fully integrated primary care in 2012 and in 2014, added the warm handoff to a Ph.D. psychologist. The IBH protocols include support from LPCs/LCSWs, use of a common EMR, and a team approach. As a federally qualified health center serving 30,000 patients with 11 clinics in two counties, NCDV is well prepared to implement the proposed project.

b. Organizational structure and operational and oversight needs. The existing organizational structure of NCDV has staff members assigned to each clinic and who are sometimes tasked to work at multiple clinic locations and referrals across clinics to make more services available to patients. The center has experience in working with LPCs, LCSWs, promotor/as, and psychology interns as well as researchers and various data collection projects. NuCare will fit well into the existing organizational structure and culture.

The governing board supports this proposal as long as matching funds are secured before project activities begin.

c. **Governing board: number of members, number of meetings, diversity, and willingness to support program expansion.** The NCDV Board of Directors meets monthly and includes 14 members who are committed to supporting the integrated behavioral health initiative with program expansion. The Board includes professional members (2 bankers, a pharmacist, a counselor, an attorney, a dental hygienist, 7 clinic representatives and a migrant clinic representative). Board members differ by ethnicity and gender, representing the local population. The board is responsible for recommendations and decisions on clinic policy.

d. Current and planned systems as applicable:

i. Electronic medical records (EMR). NCDV has an EMR system, Henry Schein MicroMD, providing a single integrated medical and behavioral health record for use with clinic patients and evaluation of this project.

ii. Engage in a local or regional health information exchange (HIE). The center is in the process of becoming a participant in a regional HIE, RGV HIE, which received some DSRIP funds.

iii. Track patients referred for complex/specialty BH care. The center tracks all patients referred to specialists.

iv. If applicable, make behavioral health services available through telebehavioral-health. Many clinic patients have transportation problems, and NCDV has 11 clinics spread through two counties to reduce that barrier. There may be a way in the future to connect with some patients through telebehavioral health technology although internet-based communication is spotty in many low-income and rural areas of the region. Internet availability may be enhanced by wireless “hotspots” potentially available through promotor/as.

Sustainability after the grant period. Grant support will be sought as a normal process of the clinic to

secure funding. In addition, as noted below, Medicaid reimbursement can be obtained for at least some promotor/a-led wellness activities. Facing much the same environment and potential philanthropic sources of funding as NCDV, other clinics serving low-income communities such as Hope Family Health Clinic may be able to partner on some grant applications.

a. Describe the recruitment and retention plan for staff

Recruitment. The budget covers new professional staff and community health workers to be hired to support the project. Recruitment of staff will be through public advertisement, widely distributed. Recruitment of promotor/as will also be through the South Texas Promotoras Association, located in Hidalgo County, with over 200 members. Additional behavioral health assistance may be obtained through the University of Texas Pan American (soon to become the University of Texas Rio Grande Valley) School of Social Work, which already places students at NCDV as part of their training.

Retention. The retention plan for the staff during the project is to make sure they understand the project, are well trained, and sense that they are valued. The retention plan at the end of the project is the same as the sustainability plan for the project: grant applications and extension of clinic services to insured patients to generate income. In addition, Medicaid reimbursement for the services of promotor/as, when recommended by a provider, can help in sustaining HELP PD, whether in current or modified form to conform with reimbursement policies (American Academy 2013).

b. Describe the behavioral health care reimbursement environment. Medicaid reimbursement is available for provider-recommended community health workers services to improve physical and mental health (American Academy 2013). Medicaid covers a psychological diagnostic visit and a certain quantity of LPC visits thereafter based on the diagnosis. Other sources of payment are unknown.

c. How the applicant proposes to maximize collections and reimbursement. NCDV can take advantage of Medicaid reimbursement noted immediately above. As the proposed grant comes to an end. NCDV will try to diversify the patient population to generate more program income. As the community

realizes the value of the services offered, patients with medical coverage can be expected to seek services there. Adolescents and adults in the region seek ways to prevent diabetes and to reduce obesity, including resort to bariatric surgery, which is quite costly. The potential paying patient population is likely to seek services at NCDV as soon as the clinic is recognized for its services in reducing obesity and diabetes.

Budget Narrative

a) **Budget narrative, first year**.

Personnel: The Project Director, Data Manager/Evaluation Contact, and RN will be hired to provide the main leadership of the project at the 4 clinics. Additional personnel to be hired include behavioral health staff: nurses (LVNs), LPCs/LCSWs, psychology interns, and Community Outreach Assistants. Other staff will include nutritionists and Community Outreach Assistants to lead community-based wellness activities, and at the POD^{2}ER flea market site providing access to NCDV: a Nurse, a Certified Medical Assistant, 7 Outreach Assistants/MPH students, and a faculty member for oversight of project activities.

Personnel fringe benefits: Provided at standard rates of NCDV.

Travel: Includes travel for BH staff to national meetings; local mileage for project staff; and POD^{2}ER students and staff to present at meetings.

Supplies: Includes educational supplies, printing, computers, printers, graphic design for posters and banners, and food items for demonstrations for Community Outreach Assistant-led wellness activities in the community. The POD^{2}ER project will purchase supplies for testing HbA_{1c} and microalbumin plus items for the flea market site including educational materials, office furniture, and repair materials and labor.

Consultant Services: Includes a statistician to analyze data and faculty oversight to coordinate the POD^{2}ER project.

Other Costs: Includes rent for the POD^{2}ER site at the flea market, criminal history checks, and the cost of office visits and labs for a year for those with indications of diabetes referred to NCDV for care.

b) Capability to obtain a match. The project team includes a grant writer and has capability to write competitive grants. We have begun to review potential funding sources, will seek meetings with foundation staff at the annual conference of the American Diabetes Association in Boston in early June, and will apply for funding during the summer.

c) Personnel responsible for data management. A staff member will be hired into this position, will facilitate access to data for the external evaluation team, and will attend scheduled required meetings.

d) Internal Control and financial systems. NCDV has appropriate financial systems necessary to administer federal, state, and local funds, and extensive experience managing such grants. Reporting is completed on time. NCDV has regularly received grants from MHM and administered them successfully. NCDV's Chief Financial Officer oversees the finance department. NCDV has in place internal controls to include separation of duties which are conducted daily. Internal controls reflect cash reconciliations and verification of deposits are conducted on a daily basis. NCDV conducts periodic inventory of center assets which then reported to the Compliance Performance Improvement Committee. NCDV's well-designed internal controls protect assets from accidental loss or loss from fraud. Audits are performed including proof of income calculation requirements, encounter and progress notes posting, accounting history, encounter charges, HIPAA policies and diagnosis documentation. A financial audit is performed by an independent auditor on an annual basis. Currently, NCDV has received a dental supplement grant and several years ago a Methodist Healthcare Ministries grant to initiate the behavioral health service.

e) Brief description of key personnel, position title; responsibilities; position qualifications; supervisory role

Program Director: Ph.D., MPH, or similar training, bilingual, responsible for major ramping up in year 1, participating in securing matching funds, familiar with healthcare settings, understanding of IBH, obesity, diabetes, passionate advocate of integrated primary care and community-based wellness programs; to

report to CEO; to direct project team, ensure training, & support RN and Data Manager; to coordinate with existing staff; to write quarterly report. To be hired.

Data Manager/Evaluation Contact: 2- or 4-year college degree, MPH, or degree in accounting, bilingual, ideally with experience in clinical setting and with medical records; to report to Program Director; responsible for ensuring that data entry is accurate and timely and that staff value accuracy and evaluation, and for facilitating data access for external evaluation team. To be hired.

RN: credentialed in Texas, bilingual; to report to Project Director; responsible for coordinating new IBH hires (LPCs, LCSWs, psychology interns, promotor/as) and nutritionists. Participate in ensuring training, data entry, record keeping. Facilitate integration of IBH into clinic protocols. Facilitate community-based component with promotor/as. To be hired.

f. State degree to which the organization has basic financial controls in place. NCDV has appropriate financial systems necessary to administer federal, state, and local funds. All clinics are linked to one another through a centralized administration and data system. NCDV uses MicroMD, a practice management system for patient scheduling, billing, collections and reporting. For maintaining financial records and generating financial reports, NCDV utilizes MIP accounting software. With this system, administration can generate custom reports to determine site-specific, grant specific, departmental expenditure details and other reports required. The following are overseen rigorously:

a. Cash management.

b. Eligibility.

c. Period of Availability of Federal Funds

d. Allowable Costs/Costs Principles

e. Procurement; Suspension and Debarment

f. General Control, staff grants knowledge

g. General Control, monitoring operations

h. Activities Allowed or Unallowed

i. Equipment and Real Property Management

j. Program Income

Nuestra Clinica del Valle Care (NuCare):
Integrated Behavioral Health Reducing Diabetes, Obesity, & Depression

Focus Area 1: Expand integrated primary care to 4 clinics			
Goal 1: At least 75% of primary care providers at the clinics will incorporate behavioral health assessments into each routine primary care visit by the end of the five year funding period.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Secure matching funds	Program Director	Months 1-12	Secure match as quickly as possible so that program activities can begin
Advertise positions, hire & train staff	Program Director	Months 1-4	Initiate only after securing match
Weekly project meetings	Program Director	Throughout the 5 year project	Keep attendance records for evaluation
Project plus clinic staff meetings: support IBH integration	Program Director & NCDV Administration	Months 1, 2, 3, and quarterly thereafter throughout the 5 year project	Keep attendance records for evaluation
Train LPCs/LCSWs and promotor/as, online Motivational Interviewing	Program Director	Months 2-6	Pay tuition and certificate fees
Train LPCs, LCSWs, psychology interns, online Integrated Primary Care class	Program Director	Months 2-6	Pay tuition and certificate fees
Train all healthcare staff & promotoras at the 4 clinics in depression scale administration (PHQ-9)	Program Director, healthcare providers, LPCs (LCSWs), psychology interns, promotor/as	Initial training with return demonstration and initial efforts with patients: Months 2-4	Training & implementation evaluation through questionnaires, informal interviews & observation
Train all healthcare staff & promotoras in de-stigmatizing mental illness	Program Director and IBH staff	Initial training with role playing: Months 2-4	Training will be ongoing throughout this part of the project to refresh knowledge, update procedures, and take care of any promotor/a turnover

Key Action Steps	Person/Area Responsible	Time Frame	Comments
Train promotor/as in record keeping on data for behavioral health assessment	Program Director, Data Manager/Evaluator	Months 1-4; train with return demonstration	Team building exercises, train on implementation and evaluation, keeping attendance records for evaluation
Develop referral and tracking system for NCDV clinic access through flea market	Program Director, Data Manager/Evaluator, RN, Medical Director	Months 1-6	
Roll out IBH increasingly and begin HELP PD activities	Medical Director, Program Director, RN	Month 3 and through the end of the 5 year project.	Track progress in IBH and Lifestyle Interventions & HELP PD program
Collect evaluation data on % of providers who incorporate behavioral health assessments	Data Manager/Evaluator, Project Director	Ongoing for the remainder of project, every 3 months	Data collection on medical records & in interviews with providers & observations in the clinic
Collect evaluation data on % of providers who engage in warm handoff referrals	Data Manager/Evaluator	Ongoing for the remainder of project, every 3 months	Data collection on medical records & in interviews with providers & observations in the clinic
Retrain on all trainings to date as necessary	Program Director and Evaluator	Ongoing for the remainder of the project, at least every 6 months	Train 100% of new hires within 1 week Keep attendance records for evaluation

Focus Area 2: Collaboration in a fully integrated system			
Goal 1: 75% of patients in need of behavioral health services at the 4 clinics will be receiving integrated health care by the end of the 5 year funding period			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Weekly project meetings	All project staff	Throughout the 5 year project	Keep attendance records for evaluation
Project plus clinic staff meetings	All staff at the 4 clinics	Months 1, 2, 3, and quarterly thereafter throughout the 5 year project	Keep attendance records for evaluation
Train staff in shared IBH patient scheduling	Program Director, RN Online course for LPCs, LCSWs	Months 4-6: training 90% By month 8, 80% of appointments will be shared	Keep attendance records for evaluation
Train staff in shared IBH treatment planning	Program Director, RN, Psychologist Online IBH class for LPCs, LCSWs	Months 7-9: training 90% By month 11, 80% of appointments will have shared treatment available	Keep attendance records for evaluation
Train staff in shared IBH service provision	Program Director, RN, Psychologist Online IBH class for LPCs, LCSWs Online Motivational Interviewing class for LPCs, LCSWs, CHWs	Months 10-12: training 90% By month 2, Year 2, 80% of patients will have shared service provision available	Keep attendance records for evaluation
Train staff in shared IBH record keeping	Program Director, RN, Psychologist Online IBH class for LPCs, LCSWs	Months 1-3, Year 2: training 90% By month 5, Year 2, 80% of records will be available for sharing	Keep attendance records for evaluation
Increase IBH collaboration	Medical director, providers, clinic staff, project team	Month 6 – end of 5-year project	
Ongoing training in Evidence-Based Practices	Program Director and project team and clinic staff	May and November, years 2 – 5.	Keep attendance records for evaluation

Key Action Steps	Person/Area Responsible	Time Frame	Comments
Measure level of health care integration and respond as necessary	Program Director and Evaluator	Month 19 and every six months thereafter	

Sí Texas Cycle 2 Application Scoring Rubric

1. Introduction

Please provide your Reviewer ID and the applicant's organization name.

*** 1. Please select your name from the dropdown below.**

*** 2. Please select the applicant's organization name:**

Sí Texas Cycle 2 Application Scoring Rubric

2. NEED: 5 points

Review criteria for "Need":

- Applicant's description of service area/target population demonstrates a clear need for integrated primary health care/behavioral health services. (At a minimum, prevalence data on depression, obesity and diabetes in their target area/population is provided).
- Applicant describes the unique characteristics of the service area/target population that impact access to or utilization of behavioral health care.
- Applicant will provide services in the eligible target counties in Texas (Webb, Zapata, Duval, Jim Hogg, Starr, Brooks, Jim Wells, Kleberg, Kenedy, Hidalgo, Willacy, Cameron) to a low-income population, as defined in the RFP.
- Applicant's training needs (organizational capacity) are described.

*** 3. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Need" review criteria, out of a possible 5 points.**

Please comment on the score you selected.

*** 4. Please comment on this proposal's strengths and weaknesses in relation to the "Need" review criteria.**

Strengths

Weaknesses

Sí Texas Cycle 2 Application Scoring Rubric

3. PROJECT DESCRIPTION: 40 Points

*** 5. Please rate the applicant's current stage of integrated behavioral health according to the SAMSHA-HRSA IBH continuum (provided in your reviewer packet).**

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
○	○	○	○	○	○

*** 6. Please rate the applicant's proposed intervention's stage of integrated behavioral health according to the SAMSHA-HRSA IBH continuum (provided in your reviewer packet).**

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
○	○	○	○	○	○

7. Please comment on your selections in questions 5 and 6.

*** 8. The Work Plan describes plans to (*check all that applicant has included*):**

- ☐ Expand services to more clients
- ☐ Replicate the program to additional sites
- ☐ Increase the level of integration of services
- ☐ None of the above

Please comment on quality of applicant's plan to accomplish these tasks:

*** 9. Based on the applicant's description of their proposed intervention and the evidence described, please rate the level of evidence of effectiveness of the proposed intervention, according to the definitions below.**

- ◯ **STRONG**: Strong evidence means evidence from previous studies on the program, the designs of which can support causal conclusions (i.e., studies with high internal validity), and that, in total, include enough of the range of participants and settings to support scaling up to the state, regional, or national level (i.e., studies with high external validity). The following are examples of strong evidence: (1) more than one well-designed and well-implemented experimental study or well-designed and well-implemented quasi-experimental study that supports the effectiveness of the practice, strategy, or program; or (2) one large, well-designed and well-implemented randomized controlled, multisite trial that supports the effectiveness of the practice, strategy, or program.
- ◯ **MODERATE:** Moderate evidence means evidence from previous studies on the program, the designs of which can support causal conclusions (i.e., studies with high internal validity) but have limited generalizability (i.e., moderate external validity) or viceversa - studies that only support moderate causal conclusions but have broad general applicability. Examples of studies that would constitute moderate evidence include: (1) at least one well-designed and well-implemented experimental or quasiexperimental study supporting the effectiveness of the practice strategy, or program, with small sample sizes or other conditions of implementation or analysis that limit generalizability; or (2) correlational research with strong statistical controls for selection bias and for discerning the influence of internal factors.
- ◯ **PRELIMINARY:** Preliminary evidence means the model has evidence based on a reasonable hypothesis and supported by credible research findings. Examples of research that meet the standards include: 1) outcome studies that track participants through a program and measure participants' responses at the end of the program; and 2) third-party pre- and post-test research that determines whether participants have improved on an intended outcome.
- ◯ **NOT YET PRELIMINARY:** Insufficient evidence exists of the effectiveness of the proposed intervention.

Please comment on your selection:

Additional review criteria for "Project Description":

- Applicant has proposed an integrated care model, including components such as: integration of primary medical and behavioral health care and use of evidence-based practices to support the interventions.
- Applicant describes a realistic process for ensuring that shared systems (such as*patient/client scheduling, treatment planning, service provision, record keeping*) will be achieved through the five-year project.
- Applicant describes evidence of potential for scalability (such as:*support from key program stakeholders, expansion of services to more clients/patients, replication of their program in additional sites and/or increasing the level of integration of their services*).
- Applicant's proposed intervention is realistic, attainable, innovative, likely to make an impact within a 5-year time frame, and a cost-effective approach to meeting the behavioral health needs of the target population.
- Applicant describes innovative components of their proposed intervention.
- Applicant provides a 3- to 5-year Work Plan that is detailed, realistic, logical and responsive to the needs of the target population.

*** 10. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Project Description" review criteria, out of a possible 40 points.**

Please comment on the score you selected.

*** 11. Please comment on this proposal's strengths and weaknesses/challenges in relation to the "Project Description" review criteria.**

Strengths

Weaknesses

4. EVALUATIVE MEASURES: 15 points

12. Based on your review of the *Monitoring & Evaluation Capacity Assessment, Logic Model, Past Evaluation Samples (if provided) and Narrative*, please indicate how much you agree/disagree with the following statement:

The applicant has the capacity to participate in evaluation and assessment (including capable staff identified to participate in the evaluation).

◯ Strongly Agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree ◯ Strongly disagree

Please comment on your selection:

Additional review criteria for "Evaluative Measures":

- Data collection, data use and analysis inform the applicant's objective and outcomes and are used to improve the organization's programming.
- Applicant is capable of tracking progress (and has listed process measures that will be used, separate from the required outcome measures).
- Applicant presents a strong theory of change and logic model (including inputs, activities and outcomes) that is aligned with MHM's Theory of Change and likely to produce results.
- Applicant's proposed outcome measures are sound and conform to SMART goal criteria.
- Applicant proposes an adequate budget and has identified staff to create a robust evaluation in cooperation with the MHM-funded external evaluator.
- Description of preliminary ideas for constructing a comparison group suggest feasibility of experimental or quasi-experimental evaluation design.

*** 13. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Evaluative Measures" review criteria, out of a possible 15 points.**

Please comment on the score you selected.

*** 14. Please comment on this proposal's strengths and weaknesses/challenges in relation to the "Evaluative Measures" review criteria.**

Strengths

Weaknesses

5. COLLABORATION: 10 points

Review criteria for "Collaboration":

- The proposed formal and informal collaborations will support the proposed project and will increase the overall behavioral health of the target population.
- If needed, the applicant has adequately described how collaborations will be strengthened in support of the proposed project.
- Applicant describes past, current or future work with other organizations on a shared goal where shared measurements, continuous communication and reinforcing activities were evident.
- Applicant demonstrates experience and/or readiness to work collectively with other organizations/stakeholders.

*** 15. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Collaboration" review criteria, out of a possible 10 points.**

Please comment on the score you selected.

*** 16. Please comment on this proposal's strengths and weaknesses/challenges in relation to the "Collaboration" review criteria.**

Strengths

Weaknesses

6. RESOURCES/CAPABILITIES: 10 points

17. Please indicate how much you agree/disagree with the following statement:

The applicant demonstrates that current or proposed systems will support program expansion, replication or enhancement (such as: *ensuring a single integrated medical and behavioral health care record through use of electronic medical records - EMR, engaging in a local or regional health information exchange - HIE, tracking patients referred for complex/specialty behavioral health care, and/or making behavioral health services available through telebehavioral health*).

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree ◯ Strongly disagree

Please explain your selection:

Additional review criteria for "Resources/Capabilities":

- The experience and expertise described in the proposal qualify the applicant to carry out the proposed three- to five-year plan, including readiness to replicate, support or enhance integrated care.
- The applicant's organizational infrastructure as described in the Narrative (*including IT and financial systems, fundraising processes, commitment of administration, management and the governing board*) is appropriate for the operations and oversight necessary to implement the project.
- The applicant has provided adequate evidence of effective board governance and of a diverse, qualified board that will help to support program expansion.

*** 18. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Resources/Capabilities" review criteria, out of a possible 10 points.**

Please comment on the score you selected.

*** 19. Please comment on this proposal's strengths and weaknesses/challenges in relation to the "Resources/Capabilities" review criteria.**

Strengths

Weaknesses

7. SUSTAINABILITY: 5 points

20. Please indicate how much you agree/disagree with the following statement:

The applicant demonstrates ability to sustain the project after the grant period.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree ◯ Strongly disagree

Please comment on your selection

Additional review criteria for "Sustainability":

- *If applicable*, the applicant has described a sound recruitment and retention plan for behavioral health staff.
- *If applicable,* the applicant has demonstrated a sound plan for a health care reimbursement environment that will sustain the program.

*** 21. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Sustainability" review criteria, out of a possible 5 points.**

Please comment on the score you selected.

*** 22. Please comment on this proposal's strengths and weaknesses/challenges in relation to the "Sustainability" review criteria.**

Strengths

Weaknesses

Sí Texas Cycle 2 Application Scoring Rubric

8. COST EFFECTIVENESS & BUDGET ADEQUACY: 15 points

23. Please indicate how much you agree/disagree with the following statement:

The applicant demonstrates the ability to seek a match or has secured a match.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree ◯ Strongly disagree

Please comment on your selection

Additional review criteria for "Cost Effectiveness & Budget Adequacy":

- The applicant demonstrates, with consistent and complete information, a detailed and appropriate Budget with justification that is supportive of the Budget Narrative and is consistent with the Project Description section of the Narrative.
- The applicant has a strong financial team in place, enabling potential growth.

*** 24. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Cost Effectiveness and Budget Adequacy" review criteria out of a possible 15 points.**

Please comment on the score you selected.

*** 25. Please comment on this proposal's strengths and weaknesses/challenges in relation to the "Cost Effectiveness and Budget Adequacy" review criteria.**

Strengths

Weaknesses

9. Overall SWOT Analysis

*** 26. Please comment on the strengths, weaknesses, opportunities and threats of the proposed project in its entirety.**

Strengths	
Weaknesses	
Opportunities	
Threats	

Sí Texas Cycle 2 Complaint Applicants:

The University of Texas Health Science Center at Houston

Nuestra Clinica del Valle

The Ecumenical Center

Texas A&M University Colonias Program

Pregnancy Resource Centers

Summary of External Reviewer Comments on Successful Applications

The University of Texas Health Science Center at Houston:

- Overall score: 85.5/100
- Need: “The applicant does a good job at describing the target population and addresses the disparities in diabetes prevalence and management. The applicant also does a good job at discussing the associations with behavioral health and diabetes. “
- Project description: “The applicant has a solid plan for increasing integration. They propose a number of additional services/interventions which address a documented need (e.g. medication adherence). The initiave is innovative and comprehensive. “
- Evaluative Measures: “The program model being tested and the evaluation approach are clear and seem to minimize threats to internal validity.”
- Collaboration: “This organization has a strong history of collaboration - it is part of the culture of this organization.”
- Resources/Capabilities:” The applicant is a well-established institution with qualified, supporting staff to carry out the interventions described.”
- Sustainability: “They have the potential to see additional funding but offer little in the way of a detailed plan”
- Cost Effectiveness and Budget Adequacy: “The budget appears generally sound and well thought out.”

Nuestra Clinica del Valle:

- Overall score: 85.51/100
- Need: “Clearly communicates demographic need and unique culture issues relative to this project - their history of work in this culture is evident.”
- Project description: “They have a solid plan for integration, experience with IHC in the San Juan clinic, their own evaluation data, and the ability to expand services and sites.”
- Evaluative Measures: “This organization collects data, but does not currently have staff dedicated to evaluation. They do state a desire to learn and use the information that is gathered.”
- Collaboration: “They appear dedicated and equipped to develop a collaborative model and identified potential collaborative community partners. And they have experience working with these partners.”
- Resources/Capabilities:” The applicant appears to have a strong organizational infrastructure and governing board.”
- Sustainability: “The applicant has a long-standing history for recruiting new staff and resources towards grant writing, although a specific sustainability plan is not detailed. There is some health care reimbursement for CHW services.”
- Cost Effectiveness and Budget Adequacy: “The budget is sound and reasonable.”

MI BIENESTAR: LINKING COMMUNITY AND INTEGRATED BEHAVIORAL HEALTH IN COLONIAS AND EDAs IN SOUTH TEXAS

Texas A&M University Colonias Program

9350 S. Presa, Ste. 110

San Antonio, TX 78223

Project Director: Oscar J. Muñoz

Phone: 979-862-3173

Fax: 888-999-7002

E-Mail: omunoz@arch.tamu.edu

Requested Funding: $232119.00 Y1

Mission

The Texas A&M Colonias Program will develop and deliver solutions to enhance the quality of life for residents living in colonias and economically distressed areas in Texas. These are residents living without one or more of the major infrastructure such as potable water, paved roads, sewage system, storm drainage, and/or electricity. Additionally, behavioral health care awareness in the colonias addresses a need in the communities.

Behavioral Health Care Services in

The lack of behavioral health care services adds to the difficulty in colonial residents meeting their basic needs to live healthy lives. The proposed project will address the increase in behavioral health in the colonias by providing awareness in the Central Rio Grande Region and the Lower Rio Grande Region in Texas as this is critically needed in the colonias. The project will utilize Promotor/a/CHW using existing health curriculums in combination with behavioral health care awareness to address the need of the communities. The dual use of health curriculums and behavioral health care awareness will uniquely addresses chronic health disease and behavioral health. The Promotor/a/CHW will break down barriers as to the stigma related to behavioral health in the colonias. The project will help the residents of the colonias to gain knowledge about behavioral health care awareness and health to live healthy productive lives.

Partnerships

TAMU CP has longstanding partnerships with county, municipal, state agencies as well as local community based and private organizations. Additionally, established partners include TAMU system partners as well as other academic institutions such as members of University of Texas system partners, private universities, local school districts, private foundations. Since the above mentioned are existing partners there are opportunities for engagement in support of this project.

Methodist Healthcare Ministries' Sí Texas Project Budget

Budget Period: August 1, 2015 to July 31, 2017

Organization Name:	The University of Texas Health Science Center at Houston
Project Title:	Salud y Vida 2.0: Enhancing Integrated Behavioral Health for Individuals with Diabetes in Rio Grande Valley

EXPENSES	Justification	Sí Texas Grant Request	Amount from Matching Sources	Project Total
Project Personnel Expenses				$ -
Principal Investigator	1 person @$128,977 x 10% effort	$ 12,898		**$ 12,898**
Pharmacist	2 persons yr 1; 3 persons yr 2 @$100,944 x 50% effort each	$ 100,944		**$ 100,944**
Pharmacy Tech	YR 1-2 techs; Yr 2- 3 techs @ $29,640 x 100% effort	$ 59,280		**$ 59,280**
Physicians Asst	1 person @ $91,000 x 75% effort	$ 68,250		**$ 68,250**
Medical Asst	1 person @ $30,000 x 100% effort	$ 30,000		**$ 30,000**
Program Coordinator (2)	2 persons each yr @$38,000 x 50% each effort	$ 38,000	$ 38,000	**$ 76,000**
Program Manager	1 person @$51,384 x 50% effort	$ 25,692	$ 25,692	**$ 51,384**
Outreach Workers (3)	3 persons @ $28,000 x 50% each effort	$ 28,000	$ 56,000	**$ 84,000**
Communication Coord	1 person @ $38,000 x 50% effort		$ 19,000	**$ 19,000**
Data Manager			$ 32,500	**$ 32,500**
Evaluator/Liasion		$ 12,500	$ 37,500	
Personnel Fringe Benefits	% calculated at tiers according to salary level	$ 121,676	$ 75,821	**$ 197,497**
FICA				$ -
Health Insurance				$ -
Retirement				$ -
Life Insurance				$ -
Dental Insurance				$ -
Vision Insurance				$ -
Travel	Asheville, NC/ MTM mtg yr 1/ 5 people / 2 nights; mileage reimbursement for pharmacist; liaison mileage	$ 15,200	$ 7,006	**$ 22,206**
Equipment				$ -
Supplies	mobile clinic maint./gas	$ 10,000	$ -	**$ 10,000**
Contractual/Consultant Services				$ -
Training		$ 225,050	$ 254,102	**$ 479,152**
Evaluation		$ 6,000	$ 4,000	**$ 10,000**
Other Costs				$ -
Criminal History Checks	17 persons/$50 ea	$ 850		**$ 850**
mental health training	for outreach workers/ $150 ea	$ -	$ 15,000	**$ 15,000**
computers	for 10 project staff	$ -	$ 14,400	**$ 14,400**
statistical software licensing			$ 727	**$ 727**
appreciation retreats		$ -	$ 1,000	**$ 1,000**
peer leader training/materials		$ -	$ 3,000	**$ 3,000**
participant incentives	200 participants	$ 1,000	$ -	**$ 1,000**

Methodist Healthcare Ministries' Sí Texas Project Budget

Budget Period: August 1, 2015 to July 31, 2017

Organization Name:	The University of Texas Health Science Center at Houston			
Project Title:	Salud y Vida 2.0: Enhancing Integrated Behavioral Health for Individuals with Diabetes in Rio Grande Valley			
guest speaker fees	38 sessions/ $75 ea session	$ 1,050	$ -	**$ 1,050**
meeting room fees	372 sessions/ $50 each	$ 4,200	$ -	**$ 4,200**
physician oversight	mobile clinic PA	$ 7,000	$ 7,000	**$ 14,000**
MTM programs/ certification	for 10 pharmacist	$ 3,800	$ 800	**$ 4,600**
pharmacist insurance		$ 3,000	$ -	**$ 3,000**
Federally approved indirect cost rate (not to exceed 10% of subtotal)		$ 77,439	$ 260,281	**$ 337,720**
Subtotal - budget year 1		**$ 851,829**	**$ 851,829**	**$ 1,703,658**
Year 2 Total Budget		$ 1,007,272	$ 1,007,271	**$ 2,014,543**
TOTAL EXPENSES - Year 1		$ 851,829	$ 851,829	**$ 1,703,658**
Funding percentages		50%	50%	**100%**

Methodist Healthcare Ministries' Sí Texas Project Budget

Budget Period: August 1, 2015 to July 31, 2017

Organization Name:	The University of Texas Health Science Center at Houston
Project Title:	Salud y Vida 2.0: Enhancing Integrated Behavioral Health for Individuals with Diabetes in Rio Grande Valley

SUMMARY OF FINANCIAL REQUEST	
Total organizational operating budget	$ 1,213,708,345.00
Grant Request to Organizational Budget Ratio	0%

Reminder: Grant request may not exceed 25% of the organization's total operating budget.

LIST MATCH SOURCES	**Status**	**Type**	**Amount**
UTHSC-Houston /44% indirect	Not Available	Other	$ 260,281.00
Valley Baptist Legacy Foundation	Select	Private	$ 591,548.00
	Select	Select	
	Select	Select	
	Select	Select	
	Select	Select	
	Select	Select	
Total Matching Funds			**$ 851,829.00**

Total Matching Funds must equal Total Expenses in "Amount from Matching Sources" column above

OTHER FEDERAL SOURCES OF FUNDING (does not count toward match)		**Amount**
Name of Federal agency		
Total Federal Source Funds		**$ -**

Sample

Methodist Healthcare Ministries' Sí Texas Project Budget

Budget Period: May 1, 2015 to April 30, 2017

Organization Name:	ABC Organization
Project Title:	Building a Better Community

EXPENSES	**Justification**	**Sí Texas Grant Request**	**Amount from Matching Sources**	**Project Total**
Project Personnel Expenses				**$ -**
Project Manager	1 person @ $45,000 x 100% usage	$ 45,000		**$ 45,000**
Physician	1 person @ $125,000 x 100% usage	$ 125,000		**$ 125,000**
Psychiatrist	1 person @ $125,000 x 100% usage		$ 125,000	**$ 125,000**
Nurse	1 person @ $50,000 x 90% usage	$ 45,000		**$ 45,000**
Admin Assistant	1 person @ $30,000 x 25% usage		$ 7,500	**$ 7,500**
Accountant	1 person @ $50,000 x 50% usage		$ 25,000	**$ 25,000**
Nurse Practitioner	1 person @ $75,000 x 100% usage		$ 70,000	**$ 70,000**
Personnel Fringe Benefits				**$ -**
FICA	$452,500 * 7.65%		$ 34,616	**$ 34,616**
Health Insurance	Health Insurance for 7 staff	$ 15,000		**$ 15,000**
Retirement			$ 1,500	**$ 1,500**
Life Insurance			$ 2,000	**$ 2,000**
Dental Insurance			$ 1,100	**$ 1,100**
Vision Insurance			$ 100	**$ 100**
Travel	National Annual Meeting 2@ $250=$500; Learning Community Conference 4@ $500=$2,000; Personnel Travel to community site airfare,transportation,lodging 5@ $500=2,500	$ 5,000		**$ 5,000**
Equipment	software $3,900; computer equipment 2@900=1,800		$ 5,700	**$ 5,700**
Supplies	office supplies; meds supplies	$ 3,600		**$ 3,600**
Contractual/Consultant Services				**$ -**
Training	training 2 day $1,700; federal grants management training $1,000	$ 2,700		**$ 2,700**
Evaluation	evaluation/research contract	$ 8,300		**$ 8,300**
Other Costs				**$ -**
Criminal History Checks	average $66/person	$ 400		**$ 400**
Recruitment			$ 1,100	**$ 1,100**
				$ -
				$ -
				$ -
Federally approved indirect cost rate (not to exceed 10% of subtotal)				**$ -**
Subtotal - budget year 1		**$ 250,000**	**$ 273,616**	**$ 523,616**
Year 2 Total Budget		$ 250,000	$ 250,000	**$ 500,000**
TOTAL EXPENSES - Year 1		$ 250,000	$ 273,616	**$ 523,616**
Funding percentages		48%	52%	**100%**

Sample

Methodist Healthcare Ministries' Sí Texas Project Budget

Budget Period: May 1, 2015 to April 30, 2017

Organization Name:	ABC Organization
Project Title:	Building a Better Community

SUMMARY OF FINANCIAL REQUEST	
Total organizational operating budget	$ 1,250,000.00
Grant Request to Organizational Budget Ratio	20%

Reminder: Grant request may not exceed 25% of the organization's total operating budget.

LIST MATCH SOURCES	**Status**	**Type**	**Amount**
Mr Smith	Cash	Private	$ 100,000.00
Oil and Gas Company	Cash	Local	$ 150,000.00
	Select	Select	
	Select	Select	
	Select	Select	
	Select	Select	
	Select	Select	
Total Matching Funds			**$ 250,000.00**

Total Matching Funds must equal Total Expenses in "Amount from Matching Sources" column above

OTHER FEDERAL SOURCES OF FUNDING (does not count toward match)		**Amount**
Name of Federal agency		
Total Federal Source Funds		**$ -**

Executive Summary *Salud y Vida* 2.0: Enhancing Integrated Behavioral Health for Individuals with Diabetes in Rio Grande Valley

University of Texas Health Science Center at Houston — Belinda M. Reininger, DrPH
School of Public Health, Brownsville Regional Campus — Tel: +1 (956) 755-0654
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Brownsville, TX 78520 — Belinda.M.Reininger@uth.tmc.edu

Requested Amount Funding: $851,829 year one and $1,007,272 year 2 ($1,859,191 total budget)

The School of Public Health (UTSPH) regional campus is located in Brownsville. It provides graduate level education and community-based research on Hispanic health, particularly diabetes. UTSPH leads the free of charge, evidence-based chronic care management program, Salud y Vida (SyV) designed to integrate primary and behavioral healthcare with home-based wraparound services provided by community health workers (CHWs), SyV serves low income, uninsured individuals who have uncontrolled diabetes. Over half of the nearly 3000 participants from the Rio Grande Valley are now controlling their diabetes. Some patients, however, still struggle with the disease due to behavioral health, primary health care access issues, and other social and environmental barriers to making lifestyle changes. We will enhance the SyV program through two initiatives. **Enhanced Primary and Behavioral Health care** (EPBH) will provide Medication Therapy Management (MTM) for participants with low levels of medication adherence and behavioral health services (BHS) for participants who do not qualify for services with the mental health authority, but need behavioral health support. We will also enhance SyV by ensuring access to **Community-based Lifestyle Programs** (CBLP) across the Rio Grande

Executive Summary *Salud y Vida* 2.0: Enhancing Integrated Behavioral Health for Individuals with Diabetes in Rio Grande Valley

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Abbreviations

BWC Brownsville Wellness Coalition
BHS Behavioral Health Services
CAB Hispanic Health Research Center's Community Advisory Board
CBLP Community-Based Lifestyle Program
CCM Chronic Care Management
CHW Community Health Worker
DSME Diabetes Self-Management Education
EPBH Diabetes Enhanced Primary Behavioral Healthcare
FQHC Federally Qualified Health Centers
HCB Healthy Communities of Brownsville
IBHM Integrated Behavioral Health Model
MEND Mind, Exercise, Nutrition, Do it!
MTM Medication Therapy Management
PLSG Peer-led Support Group
RGVHIE Rio Grande Valley Health Information Exchange
TTBH Tropical Texas Behavioral Health
UTSPH University of Texas Health Science Center at Houston-- School of Public Health
VBHS Valley Baptist Health Systems

Valley for the participants and their loved ones through peer-led support groups, capacity building cooking classes, a healthy food choices customized smartphone application, and an obesity treatment program.

NEED a. Service Area. Nearly 90% of Rio Grande Valley residents are Hispanic.[1] The majority of SyV participants are in Cameron County where 27% are obese and in Hidalgo County where 31% are **obese**. In both counties another 50% are overweight.[2] According to the 2012 Regional Health Partnership 5 Needs Assessment (which includes Cameron, Hidalgo, and Willacy counties), an estimated 31% of adults have diabetes, 28.6% of adults suffer from depression, and 30% of adults have anxiety.[2] Many individuals suffering from mental health issues report that they do not have access to professional help. Previous research suggests that "depression and anxiety have a negative influence on the behavioral management of diabetes and glycemic control."[3] b. **Access to behavioral health care.** Those served by SyV 2.0 will be primarily low income, uninsured residents of the Rio Grande Valley whose access to or utilization of behavioral and primary health care is limited. For example in Cameron County 35% of residents live below the federal poverty line, 69% have no health insurance[2,] and 33% are without a high school education.[4] In Hidalgo County 35% percent of residents live below the federal poverty

line, have similarly low rates of insurance as Cameron County and 37% have not graduated from high school..[5]

c. Staff Training. MTM training and certifications will be provided to new and existing pharmacists who do not currently have it. CHWs will receive training on behavioral health and Motivational Interviewing strategies. Peer leaders will be trained to facilitate PLSGs. Personnel hired through service agreements to provide EPBH and CBLP services will be trained on all components of SyV and its foundational Wagner's Chronic Care Management model.

PROJECT DESCRIPTION a. **Description of Behavioral Health Integration.** Based on the history of collaborative work, our stage of behavioral health integration is Level 4: Close collaboration onsite with some system integration. The decade of collaboration across partners, including the recent programmatic integration of services with SyV (details in collaboration section), includes co-location of program staff. We plan to enhance services by adding two components to the current repertoire of SyV resulting in SyV 2.0. This work is innovative in its comprehensive programming and its unique combination of EPBH and CBLPs (see Table 1). SyV2.0 will deliver increased access to crucial care, data sharing across institutions, cost effective Medication Therapy Management (MTM), behavioral health services (BHS), peer led support groups (PLSGs), and other programs that support lifestyle changes and help participants better control diabetes. SyV 2.0 will utilize technology hosted at the Rio Grande Valley Health Information Exchange (RGVHIE) to integrate clinical, behavioral health and SyV information from separate facilities into a participant's aggregate health record. Comprehensive patient data will increase the efficiency of care management, reduce unnecessary tests, and improve communication and care coordination across facilities.

Table 1: Salud y Vida Existing and Enhanced Program		
	Program and Evidence	**Description**
I B H M O D E L	Existing Primary & Behavioral Health Care – Strong Evidence	SyV is based on the six pillars of CCM of the Wagner Model,[6]which is a tested model being implemented in clinics nationwide.[7, 8, 9,10] 1. Delivery system redesign (changes in the organization of care delivery, inclusion of behavioral health screening and referral); 2. Self-management support strategies; 3. Decision supports; 4. Information systems (changes to facilitate use of information about participants, their care and their outcomes, shared data); 5. Community linkages; and 6. Health system supports. SyV program for individuals living with uncontrolled diabetes.
	Enhanced Primary Behavioral Health Care (EPBH) – Preliminary Evidence	Establish MTM services for individuals who have uncontrolled diabetes/behavioral health issues in order to address low medication adherence caused by barriers including cost, symptoms, health literacy, side effects, and multiple conditions. Provide individuals MTM working with medical homes to improve adherence. Additionally, the mobile clinic will offer free basic health care services to participants. BHS will be established through psychological or psychiatric evaluation and treatment for the non-priority population who do not otherwise qualify for services.
	Community Based Lifestyle Programs (CBLP) – Preliminary and strong evidence	Bring people together with type 2 diabetes to reflect on and share their self-management experiences. PLSG participants provide emotional support, engage in problem solving, hold one another accountable for self-management, and provide strategies for stress management. Offer six-week courses to build capacity for healthy meal planning and preparation. Take ingredients to-go for preparation at home. Establish relationships with restaurants to have "diabetes-friendly" meals & feature healthy options on smartphone application Offer a ten-week program to empower participants' families in an evidence-based obesity intervention that integrates education, discussions, and activities for healthy nutrition and physical activity.

b. Describe Integrated Care Model. i. Integration of primary medical and behavioral health care. SyV's approach is innovative in that it integrates primary medical and behavioral health with multiple partners to transform the delivery of chronic care for persons with uncontrolled diabetes (HbA1c levels > 8). The key to this integration is the on-going, systematic communication between hospital, clinic, mental health case managers, and the team of CHWs who are following up with participants in their homes and at community-based educational

sessions. Bi-monthly case review meetings and a shared, secured web-based system called Chronicle Diabetes allow for coordination of participant services, advocacy, education, and care. SyV's nearly 3,000 participants have statistically significant reductions in their HbA1c levels over time, the majority (over 70%) of whom are uninsured. SyV 2.0 aims to increase the effectiveness of the existing SyV program by heightening the level of integration through two evidence based program enhancements. **First,** EPBH will provide MTM and BHS. MTM will build the capacity of our clinical partners' pharmacies currently serving SyV by providing training and staffing to implement this evidence-based approach to improve medication management and adherence, since this has been an identified barrier to diabetes control among SyV participants. The capacity will also be enhanced through a partnership between UTSPH and VBHS to provide free clinical services through a mobile health clinic, much needed for the uninsured who are on wait-lists at local indigent care clinics and do not have a medical home. These individuals are often in urgent need of medication and attention for their diabetes. Additional BHS for SyV will be delivered by Su Clinica and the Rio Grande State Center by expanding their BHS capacity for participants who do not otherwise qualify for services at TTBH, but are expressing behavioral health issues. The **second** evidence based expansion is that of CBLPs across the service region to provide long-term support to SyV participants, their families, and ultimately to the general population with diabetes. We will establish face-to-face and telephone based PLSGs. Referrals to PLSGs will come from all SyV partners. The CBLPs will also expand successful participant education programs including hands-on cooking classes (Cocina Alegre) and a customized "Healthy Food Choices" smartphone application to provide actionable opportunities to practice and apply food choice behaviors taught in DSME classes and by CHWs. We will also expand MEND (Mind, Exercise, Nutrition, Do It!) sessions which

intervene to reduce obesity found in children and their family members. The changes adopted by the SyV participants through these programs will inspire their families to lead healthier lives. EPBH and CBLPs together will round out a fully integrated system to provide an even more comprehensive approach to address behavioral health and diabetes control through SyV2.0 in both clinical and community-based settings. **ii. Use of team-based, integrated model.** Our SyV team members represent many organizations and coordinate care across the primary and behavioral health needs of our participants. Behavioral health has been integrated into SyV since its inception, with RN enrollment personnel, CHWs, and DSME instructors trained to administer a behavioral health assessment to make direct referrals to one of two full-time SyV behavioral health case managers from Tropical Texas Behavioral Health (TTBH). Participant behavioral health issues are addressed at biweekly multi-disciplinary case review meetings and there is continuous communication back to the patient's medical home providers, with home-based follow-up by the case manager and CHW applying evidence-based practices including motivational interviewing. However, SyV 2.0 adds additional integrated components of BHS that will be provided for participants who do not have a qualifying diagnosis for TTBH services but are experiencing moderate to severe symptoms of anxiety and depression. Currently within SyV, approximately 8.5% of total participants have been referred for behavioral health care services but only 22% of those referred have a qualifying diagnosis for TTBH services. Moreover, in our region, federally qualified health centers (FQHC) have limited in house behavioral services available for those patients who do not qualify yet still have unmet behavioral health needs. MTM will help coordinate medication management across systems, which is often fragmented for those being treated for a behavioral health issue and diabetes. Additionally a longer-term support and maintenance gap was identified that will be addressed by

creating a PLSG system. Referrals to support groups will come directly from the primary care setting, as well as from behavioral health staff, CHWs, and the integrated chronic care management (CCM) team. Therefore, SyV 2.0 deepens current partnerships and expands partnerships to include new services for individuals with diabetes, particularly those with behavioral health issues. CBLP expansion brings this support into the community setting.

iii. Innovative components. SyV2.0 is innovative because few programs provide the scope of services extended to participants through the EPBH and CBLP expansions of this project. This project extends care from clinic to community with seamless connection. This innovation is crucial in order to address the many unmet needs of a mostly uninsured, low-income population. Furthermore, the combined initiatives provide a unique and comprehensive approach to empowering uninsured and low-income participants with diabetes to gain control of their health. We are extending care from a clinical setting into the home and community by providing options for behavior-change support and sustainability beyond program participation.

c. Evidence Based Interventions. Several studies have positive results that apply to the proposed components of the EPBH. For MTM services two studies serve as preliminary evidence and followed a single-site QED and a multi-site QED, implemented by organizations other than UTSPH but similar to our proposed MTM service delivery model. For BHS two studies serves as preliminary evidence and followed a single-site RCT, implemented by organizations other than UTSPH but that is similar to our proposed BHS delivery model. Several studies apply to the proposed components of the CBLPs. For PLSGs, four studies have positive results and serve as preliminary evidence, all from different organizations than UTSPH. Two followed a single-site QED, one followed a multi-site RCT and another a single-site RCT. All studies are similar to our proposed PLSGs design. For the Healthy Foods Application, one

study serves as preliminary evidence and followed a single-site QED, implemented by an organization other than UTSPH but similar to our proposed application design. The Cocina Alegre cooking courses are based on preliminary evidence and followed a multi-site QED, implemented by an organization different than UTSPH but similar to our proposed cooking course design. For MEND, one study serves as strong evidence and followed a multiple-site RTC, implemented by organizations outside of UTSPH but that is identical to our proposed MEND delivery model. (See evaluation support document attachment for complete list of references) **d. Tracking Outcomes and Results:** EPBH results will be determined by the number of participants with improved HbA1c levels who received MTM services. Providers will measure the number of referrals and follow up visits of participants in need of BHS. MTM and BHS will be documented appropriately by the refinement / addition of modules in our protected data sharing system overseen by RGVHIE, providing seamless integrated primary and behavioral health care. Participation in CBLPs will be tracked by the number of participants engaged in PLSGs, Cocina Alegre cooking courses, and MEND programs. We will track the number of Healthy Food Choices smartphone application downloads. **e. Outcome Achievements:** The program timeline (see Table 2) describes the first two years of the SyV 2.0 implementation divided quarterly. Year 1 describes the layout from completing administrative duties from UT Health's head special projects administration, hiring staff, kick off of EPBH, identification of locations for CBLP activities, and training. Year 2 expands on some of the current Year 1 expected timeline outcomes for EPBH and CBLP activities, evaluation of program outcomes, and continued training.

Table 2: SyV2.0 Timeline								
	Year 1				Year 2			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Subcontracting; Hiring Staff, data system refinement	X							
Staff Training	X		X		X		X	
Provide EPBH Services		X	X	X	X	X	X	X
Provide CBLP Services	X	X	X	X	X	X	X	X

f. Core competencies. SyV 2.0 will expand shared patient scheduling, treatment planning, service provision, goal setting, and shared record keeping around the provision of MTM and BHS. The existing workflow of SyV has these core competencies in place so we will build on existing integration for the 2.0 services. For example, the Chronic Care Case management review meetings include representatives from primary care, behavioral health, community health workers, and program management to ensure integrated team care provision. All decisions in these case reviews are documented through our protected data sharing system. During the case review process, referrals to the proposed enhanced programs will also occur, thus ensuring integration between primary and behavioral health care across the EPBC and CBLPs.

g. Scalability. SyV 2.0 program is scalable to a variety of entities in South Texas and beyond. It will provide a unique set of services that expand continuity of care to the home, resulting in better health outcomes and cost savings in a highly uninsured population. As accountable care organizations, clinics, and hospitals face stricter expectations for improving health outcomes, SyV 2.0 is a likely program to assist with meeting these outcome and care provision measures, as well as helping FQHCs to meet their Patient Centered Medical Home standards. EPBH: MTM is a service currently covered by Medicaid, with Medicare soon to follow. Therefore, as we demonstrate integration of care and technology support for MTM and results point to increased medication adherence, additional clinics will adopt the same approach. Some BHS are reimbursable by Medicaid/Medicare. As we demonstrate that BHS are also cost effective for

uninsured individuals to avoid Emergency Room visits or other costly interventions, more support for these services should arise. CBLS programs are scalable because they can be integrated into system changes within primary care to help individuals make permanent lifestyle changes, thus saving money. Outcome measures from this program will provide cost effectiveness evidence.

EVALUATIVE MEASURES a. Evaluation Capacity. We have strong capacity for evaluation with the most recent example found in our evaluation of the SyV program. We currently examine process and outcome metrics and report to Texas Health and Human Services including HbA1c improvement overtime. Data for these metrics are extracted from the secure, web-based system called Chronicle Diabetes. Data are validated. We run analyses tracking the program such as: % of participants receiving/completing referrals to outside organizations; # of withdrawals; % completing DSME, % reduction in HbA1c at each time point. We also determine statistically significant associations between program exposure elements and health outcomes **b. Experience with External Evaluator.** All of the partners on this proposed project have experience working with external evaluators to document program impacts, assess quality improvement initiatives, measure meaningful use, and/or publish results. c. **Logic Model.** The logic model describes the Social Cognitive Theory and the Transtheoretical Model and application for the layout of EPBH and CBLP. The model also includes the expected goals for the near-term (Year 1-2) and mid-term (Year 3-5) impacts. The model fulfills physical health and behavioral health SMART goals that include achieving an HbA1c level below 9% and receiving BHS. **d**. **Lead Evaluation Personnel.** The principal investigator will work closely with the evaluator liaison. Dr. Reininger is a professor of Health Promotion and Behavioral Science with a 20 year history of conducting evaluation and research. She has conducted evaluations using

mixed methodology ranging from single programs to statewide initiatives. Staff will work closely with the external evaluator to carry out tasks as directed by the external evaluator. **e. Progress Tracking.** The long term outcome of HbA1c control among SyV2.0 participants will be achieved by integrating care for individuals through EPBH services and CBLP demonstrating intermediate outcomes. The logic model (see attachment) describes the theory of change using Social Cognitive Theory and the Theory of Action using Transtheoretical model. Existing tools measuring Transtheoretical constructs will be implemented with participants before they begin services and at the end of the services. **f. Data Collection.** The SyV program collects data electronically including demographics, medical history, anthropometrics, behavioral and program delivery measures across time, and delivery points through the RGVHIE. Authorized and trained personnel access our HIPAA protected system with a unique username and confidential password. To maintain high quality data, several data entry filters are in place to prevent errors. In the event hard copies of data collected from participants, they are maintained and kept in a locked file cabinet both during transport and in the office. When data are used for reports, personal identifiers (e.g., name, address, phone number, etc.) are not included. To document which SyV 2.0 programs are referred to and delivered to participants, the RGVHIE will enhance the current electronic data capture program. EPBH: Pharmacists, floating pharmacists, and pharmacy technicians will document MTM services in an enhanced electronic medical record platform. Pharmacy technicians will prepare the patient's medication history. Pharmacist/floating pharmacist will deliver the MTM session. MTM participants will have access to their records. . BHS: professional clinic staff will document BHS such as referrals and follow up appointments in their respective electronic medical record platform with information pushed to the RGVHIE. Clinic staff also provide input and treatment recommendations at the

SyV case review meetings which are documented in Chronicle Diabetes. Referrals to CBLPs can be tracked on the current SyV shared web-based data system and linked to participant outcomes for final evaluation. Process evaluation measures will be documented (participation, # referrals, location of services etc.). **g. Data Capture System.** We currently use a shared and secured web-based, HIPAA protected, customized system to capture data from SyV called Chronicle Diabetes. This is a third party platform that is managed by our partner, RGVHIE and seven other partners enter their information relative to SyV into this system. Chronicle Diabetes data is shared with the HIE so that exchange occurs with other connected clinical partners including hospitals, clinics, and behavioral health providers. **h. Comparison group.** Past research studies conducted by faculty at the UTSPH have used Laredo, Texas as a comparison population. The applicant has ties to several clinics, community groups, CHW networks as well as a UT Clinical Research Unit poised to facilitate data collection on a comparison group.

COLLABORATION **a. Formal and Informal Collaborations.** The partners have a history of collaboration which evolved into the proposed project. SyV program services are delivered by 8 of the partner organizations (UTSPH, PJD, TTBH, RGVHIE, MHP Salud, Su Clinica, Rio Grande State Center, and VBHS) and 3 take referrals for provision of services (INFA, BWC, and HCB). A new partnership has been established with UTPA/UT Austin Cooperative Pharmacy program to offer MTM services. All entities have been engaged in collaborative community work for over a decade. Several of our partner organizations physically co-locate including TTBH, HCB, BWC, and UTSPH. Su Clinica, Rio Grande State Center, and VBHS also provide office space for SyV team members to enroll participants. **b. Shared Goals.** The majority of partners on this application have worked together for over a decade through the Community Advisory Board (CAB). Together the partners have implemented a community-wide campaign,

"Tu Salud ¡Si Cuenta!", a large, collaborative Cancer Prevention (CPRIT) initiative reaching over 5,000 residents of South Texas, a county-wide Community Transformation Grant (CTG), and more recently several CMS 1115 waiver projects.

RESOURCES/CAPABILITIES **a. Organizational Expertise.** UTSPH and our partners have a high capacity and the experience and readiness necessary to carry out the plan. As the lead organization for this application, the UTSPH represents a multidisciplinary team of faculty and staff who have dedicated the past decade to addressing obesity and chronic disease, and 3 years to jointly designing the SyV program. Because the integration of behavioral healthcare is an essential component of SyV, TTBH partners were included in the initial design and implementation of the SyV program. **b. Organizational Structure.** SyV current organizational structure will be used for SyV 2.0. There are two decision making bodies for SyV. First is the SyV Coalition, led by Dr. Reininger (UTSPH) with leadership from numerous collaborator organizations, that monitors program progress and serves as the learning collaborative. The second decision making body is the CCM team that address participant care through reviews of participant to address barriers to better health. Both groups are made up of diverse representatives from partner institutions and will be expanded to include the new Si Texas partners. c. **Governing Board.** The governing body for SyV will remain in place for the proposed 2.0 expansion. There are 4 member organizations that are new to the program (BWC, HCB, IFNA, UTPA/UT Cooperative Pharmacy Program), but not new to collaboration on other projects. The directors of these organizations will join the SyV coalition for meetings every 6 months and staff will participate in the Chronic Care Case Management team's bimonthly meetings. The decision to submit this grant was approved by the coalition members. **d. Proposed Systems. i. Electronic Medical Records.** We manage SyV participant data through the

RGVHIE and a product called Chronicle Diabetes along with other products of the HIE. We will expand the data capture platform with modules to track MTM referrals and services. BHS will be tracked by the respective clinic homes and data pushed the HIE as appropriate for that type of service delivery. The CBLS referrals will also be tracked by HIE. **ii. Health Information Exchange. All data from the SyV and 2.0 will be pushed to the** RGVHIE **iii. Tracking Patients.** Participants are tracked for service referrals through the common data capture platform. We examine aggregate data from SyV for disease management eligibility, status, and compliance. **iv**. **Telehealth.** We do not offer telehealth at this time.

SUSTAINABILITY a. Recruitment & Retention Plan. The UTSPH recruits, hires and retains staff through the Human Resource Department of UTHealth. The partner organizations also have supports, policies, and personnel to support employee recruitment and retention. Staff recruitment will take place during the first three months of year one, and support for staff will be ongoing through training and existing employee review process. **b. Health care reimbursement.** Medicaid is rolling out MTM service delivery as a billable service. Currently, the clinics have limited staff trained in MTM and do provide the service but only for those participants with the most severe issues. BHS are also billable. Ultimately, the issue of providing clinical and behavioral health services to uninsured, impoverished populations is incredibly complex but intervention earlier in the disease process is cost-effective. **c. Collections & Reimbursements.** Currently, all services provided by the SyV program are free to participants with no collections, reimbursements, sliding fees, or billing occurring, with the exception of some qualified health services through TTBH and regular co-pays for clinical services. All SyV costs are funded through the 1115 waiver or regular services offered by the partner organization. SyV 2.0 services for those individuals with without insurance will also be free. For those with

insurance, receiving a billable service, their medical home will bill and collect fees.

BUDGET NARRATIVE a. Personnel. Dr. Reininger, Professor of Behavioral Sciences, will serve as **principal investigator** and have overall responsibility for the direction and conduct of the project. Two **Floating Pharmacists** will be hired in year one and three in year two. Two **pharmacy technicians** in year one and three in year two will work under the supervision of a licensed pharmacist. A **physician assistant** will provide health care and prescriptions for project participants. A **medical assistant** will perform administrative and clinical duties under the supervision of the physician assistant. Two **program coordinators** will implement project activities and gather data. A **program manager** will develop, plan, and manage all activities and will function in a leadership capacity for the program. Three **outreach workers** will identify participants enrolled in SyV who need MTM services and refer participants to the PLSGs. A **communication coordinator** will create and release media. A **data manager** will be responsible for data collection and management. An **evaluator liaison** will be the point person for the external evaluator and will carry out tasks as directed by the external evaluator. **Other Direct Budgeted Costs:** For travel and mileage $22,197 for year 1 and $21,880 for year 2. For training and resources $22,600 for year 1 and $8,650 for year 2. For computers, equipment, and software $15,127 for year 1 $1,503 for year 2. For criminal history checks, $850 for 17 new employees in year 1. Service contracts will be established with the following partners: BWC ($41,052 y1; $39,012 y2), HBC ($56,100 y1; $54,000 y2), Rio Grande State Center ($125,000 each year), Su Clinica ($125,000 each year), TBN clinic location ($125,000 y2), RGVHIE ($100, 000 each year), PJD ($4,000 y1; $8,000 year2), MHP Salud ($4,000 y1; $8,000 year2), TTBH ($4,000 y1; $8,000 year2), and INFA ($20,000 each year). For PLSGs associated costs $5,250 for year 1 and $16,200 for year 2. For appreciation retreats and incentives $2,000 in year

1 and $2,500 in year 2. For liability insurance for floating pharmacists and mobile van associated costs $27,000 for year 1 and $29,000 for year 2. A total of $10,000 per year has been budgeted for evaluation resources. A detailed budget justification is available upon request. **b. Matching Funds Capability.** Our organization has not secured the match although we are aware of The Legacy Foundation commitment to consider matching dollars. We have identified some of the match through the difference charged by our organizational 54% indirect rate on projects and the set 10% indirect rate. **c. Data Management.** A data management position will be created and will be responsible for data collection and management. An evaluation liaison will be the point person for the external evaluator and will carry out tasks as directed by the external evaluator. The liaison will also will attend quarterly in-person evaluation collaborative meetings in addition to regularly scheduled virtual meetings/calls. **d. Internal Controls and Financial Systems.** We are governed by the University of Texas System policies for fiscal management and The State of Texas Financial Law. We comply with Federal, State and foundation reporting requirements and maintaining compliance with OMB circulars. The award will not put us over the threshold requiring a first time A-133 audit. We have an award from MHM to expand CycloBia (open street initiatives) in Brownsville. **e. Key Personnel.** Dr. Reininger, Professor of Behavioral Sciences UTSPH is a behavioral scientist with experience designing and evaluating community-based projects to working with minority populations on topics such as obesity prevention. A program manager will be hired to develop, plan, and manage all activities for this grant proposal and will function in a leadership capacity in the program. Other personnel information is included in a detailed budget justification available upon request. **f. Basic financial controls.** All basic financial controls are in place across the recommended topics.

REFERENCES: See evidence supporting documents attachment for complete list of references.

FIVE YEAR - WORK PLAN

University of Texas Health Science Center at Houston - School of Public Health, Brownsville Regional Campus
Salud y Vida 2.0: Enhancing Integrated Behavioral Health for Individuals with Diabetes in Rio Grande Valley
August 1, 2015-July 31, 2018

Focus Area 1: Enhance current Salud y Vida (SyV) integrated behavioral health by designing and piloting EPBH and CBLP			
Goal 1: Pilot Enhanced Primary Behavioral Health Care (EPBH) and Community Based Lifestyle Programs (CBLP) with two clinic locations and 6 community sites within the first 12 months.			
1. EPBH			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Prepare and develop outcome measures for EPBH	Program Manager, EPBH Program Coordinator; Evaluation Liaison; Data Manager	Y1	Obtain input and feedback from partners
Implement and assess pilot MTM services	Program Manager, Floating Pharmacists, Pharmacy Technician, EPBH Program Coordinator; Evaluation Liaison; Data manager	Y1	Obtain input from primary and behavioral health partners (Rio Grande State Center and Su Clinica) and participants
Conduct leadership trip to Asheville, NC to visit established MTM program	5 community leaders	Y1	These leaders will be representatives from the communities in which the MTM program will be implemented and will include professionals in the field
Establish software platform to track MTM services and BHS	HIE partner entity	Y1	Rio Grande Valley HIE will serve as partner entity
Conduct initial MTM Certification training for pharmacists from 4 partner entities in Y1 and 6 in Y2.	Contracted MTM certification trainer	Y1-Y2	Pharmacists will receive certification to implement MTM services
Booster training and Continuing Education Units for pharmacists	MHM Grant Partner Pharmacists & Floating Pharmacists	Y2-Y5	Will be held semiannually as needed; training for pharmacists to remain MTM certified

Conduct behavioral health training outreach workers	Program Manager, CBLP Program Coordinator	Y1-Y5	As needed, will provide behavioral health continuing education hours for CHW certification and to improve assessment and referral to behavioral health services (BHS)
2. CBLP			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Prepare measures and outcome metrics for CBLP	Program Manager, CBLP Program Coordinator; Evaluation Liaison; Data manager	Y1	Obtain input from primary & behavioral health partners and participants
Implement and assess pilot peer-led support groups	CBLP Program Coordinator	Y1	Obtain input from primary & behavioral health partners and participants
Peer leader training for PLSGs	Program Manager, CBLP Program Coordinator	Y1-Y5	Potential peer leaders will have fully completed the SyV program & possess a good understanding of how to manage and control their diabetes
Train facilitators for *Cocina Alegre* cooking course	BWC	Y1	Training of trainers to build capacity for expansion efforts.
Conduct initial and follow-up trainings for MEND	Program Manager, CBLP Program Coordinator, INFA	Y1-Y5	Will hold semiannually

Focus Area 2: Increase effectiveness of SyV by implementing EPGH and CBLPs.			
Goal 1: Reach 1,235 of SyV participants with EPBH and CBLP by year 2.			
1) Enhanced Primary Behavioral Health Care (EPBH)			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Continue recruitment and referrals of SyV participants for MTM services and BHS	CCM Team	Y1-Y5	
Deliver implementation of MTM services at host site partners with standing and floating pharmacists	Pharmacists, Floating Pharmacists; Pharmacy Technicians	Y1-Y5	
Add host sites for MTM services	Program Manager; EPBH Program Coordinator	Y2-Y5	Add new clinic location in year two

Advertise mobile van clinic, identify locations and implement services	Program Manager; Communications Coordinator; VBHS	Y1-Y5	
Provide BHS for SyV participants	Rio Grande State Center and Su Clinica	Y1-Y5	
2) Community Based Lifestyle Programs (CBLP)			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Deliver implementation of PLSGs and add additional partner host sites	CBLP Program Coordinator, Peer-leaders, TTBH, MHP Salud, PYD, INFA, Su Clinica, Rio Grande State Center	Y1-Y5	Host sites will recruit for and monitor PLSGs
Identify and create at least two specialized PLSGs	CBLP Program Coordinator, Peer-leaders, outreach workers	Y1-Y2	For example a group for individuals with depression and diabetes and/or a group for women with gestational diabetes.
Implement an Appreciation Retreat	CBLP Program Coordinator, Outreach Workers		Retreat held for peer leaders
Provide Guest Speaker Stipends	CBLP Program Coordinator;	Y1-Y5	Feedback obtained from participants from PLSGs will help decide what topics and guest speakers will appeal to the group;
Advertise and recruit participants for *Cocina Alegre* cooking courses	Program Manager, BWC	Y1-Y5	As part of contract services' responsibilities through BWC
Advertise and recruit restaurant/food business participants for Healthy Food Choices mobile application	Program Manager, HCB	Y1-Y5	As part of contract services' responsibilities through HCB
Advertise and recruit participants for Mind, Exercise, Nutrition, Do it! (MEND) children and family members physical activity and nutrition program	Program Manager, MEND Program Leader, INFA	Y1-Y5	As part of contract services' responsibilities through IFNA

Focus Area 3: Create evaluation of a fully integrated system chronic care management program with EPBH and CBLS or			
Goal 1: Design and implement evaluation and monitoring measures for EPBH and CBLS including measurement of the percentage of participants who lowered their HbA1c below 9 within the 12 month SyV program participation time-frame.			
1) Enhanced Primary Behavioral Health Care (EPBH)			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Receive technical assistance from Methodist Healthcare Ministries grant funders on evaluation metrics	MHM Regional Program Officer, Program Manager	Y1-Y5	At designated meeting dates and on as needed basis
Track agreed upon measures of MTM services and BHS.	EPBH Program Coordinator	Y1-Y5	Keep record of intended outcome measures
Conduct tracking of programs as directed by MHM external evaluator	Program Manager, Evaluator Liaison, MHM Evaluator	Y1-Y5	Track program referrals and participation in database.
Manage data collection and analyze data.	Data Manager	Y1-Y5	
2) Community Based Lifestyle Programs (CBLP)			
Key Action Steps	**Key Action Steps**	**Time Frame**	**Comments**
Receive technical assistance from MHM (grant funders)	MHM Regional Program Officer, Program Manager	Y1-Y5	At designated meeting dates and on as needed basis
Track expected measures of PLSGs	Program Manager, CBLP Program Coordinator	Y1-Y5	Keep record of intended outcome measures
Manage data collection and analyze data from PLSGs program	Data Manager	Y1-Y5	Keep record of intended outcome measures
Conduct tracking of programs as directed by MHM external evaluator	Program Manager, Evaluator Liaison, MHM Evaluator	Y1-Y3	Keep record of intended outcome measures
Goal 2: Produce a final report on overall functioning of programs that included outcome data related to participation, HbA1c (diabetes control) and other behavioral outcomes identified by MHM external evaluators by end of Year 2			
1) Enhanced Primary Behavioral Health Care (EPBH)			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Write final report on evaluation	Program Manager, EPBH Program Coordinator	Y1-Y5	Annual reporting; data manager will contribute data analyses and findings
Dissemination of evaluation & findings	Program Manager, EPBH Program Coordinator	Y1-Y5	Inform and update partners & collaborators, Community Advisory Board

2) Community Based Lifestyle Programs (CBLP)			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Write final report on evaluation	Program Manager, CBLP Program Coordinator; Data Manager	Y1-Y5	Annual reporting; data manager will contribute data analyses and findings
Dissemination of evaluation & findings	Program Manager, CBLP Program Coordinator	Y1-Y5	Inform and update partners & collaborators, Community Advisory Board