**ADVANCING BEHAVIORAL HEALTH EQUITY – REQUEST FOR APPLICATIONS**

**APPLICATION NARRATIVE QUESTIONS**

We recommend working in this document and uploading your final version to the Application Submission Form. Please limit responses to no more than 7 pages (shorter preferred), using at least 11-point font and 1-inch margins. See suggested length for each item.

**Sections:**

1. Commitment to Equity
2. Behavioral Health Integration in Primary Care
3. Strategy Alignment
4. Spread and Scale
5. Quality Improvement Experience
6. Data Collection and Measure Reporting
7. **Commitment to Equity** **(<1.5 pages):** CCI strives to ensure that “everyone has fair, just, and inclusive opportunities to be healthy.” Similarly, “CHCF is working with a wide range of partners to break down structural barriers to care and create a health care system that is designed to redress, not perpetuate, the inequities brought about by barriers to care such as race or ethnicity, immigration status, income, or ZIP code.” Throughout this program, participants will rigorously examine and address barriers within their system, considering anti-racism and trauma-informed practices. Please address the following:
	1. Describe steps your organization has taken to mitigate the impact of racism, stigma, and discrimination on the patients and community you serve and reduce barriers to access, engagement, and outcomes. These might include changes to clinical care, workflows, patient outreach, staffing models, or services provided by your organization or through community partners.
	2. How do you identify patients at greatest risk for care gaps or poor health outcomes, and how do you address their needs and preferences?
	3. How are you addressing equity within your organization?
	4. What priority subpopulations do you plan to focus on in the learning collaborative? Participants should identify one to four subpopulations such as: Black, Latinx, Asian American / Native Hawaiian and Pacific Islander, American Indian and Alaskan Native, LGBTQ, those who are seriously and persistently mentally ill, and adolescents and transition-age youth). (Note: This program is not focusing on children as a subpopulation.)

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| *Commitment to Equity*  |

1. **Behavioral Health Integration in Primary Care (<1.5 pages):** Please refer to [this graphic](https://www.careinnovations.org/wp-content/uploads/Behavioral-Health-Integration-Levels-Table-SAMHSA.pdf) to answer the following questions.
	1. Describe your current level of behavioral health integration. Include the titles and roles of those on your behavioral health integration team and how you communicate, collaborate, and co-manage your patients. Describe how integration has changed in response to the COVID-19 pandemic.
	2. Which behavioral health conditions do you currently treat (e.g., depression, anxiety, PTSD, SUD, trauma, domestic violence)?
	3. Which social needs (e.g., food insecurity, housing instability) do you routinely address?
	4. What level of integration do you hope to reach by the end of this 20-month program?
	5. What services, supports, approaches, or treatments do you hope to add to your current program?

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| *Behavioral Health Integration in Primary Care* |

1. **Strategy Alignment (<0.5 pages):**
	1. How do the goals of this program align with your organization’s current goals on behavioral health integration, social needs, and health equity? What specific aspects of the learning collaborative do you think will help you be successful?
	2. What other current initiatives and grants do you hope to align or integrate with this learning collaborative so you can concentrate your efforts?

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| *Strategy Alignment* |

1. **Spread and Scale (<0.5 pages):**
	1. How many sites (physical locations) does your health center operate?
	2. Which sites will participate in the learning collaborative, either initially or as spread locations?
	3. How many patients are currently served at each of these sites?

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| *Spread and Scale*  |

1. **Quality Improvement Experience (<0.75 pages):**
	1. Please describe a clinical or operational improvement project you implemented in your organization over the past one to two years. What was the aim statement?  What measurable level of improvement did you achieve?
	2. What data did you collect to assess progress and how often did you collect it?
	3. Describe one small test or prototype you did and what you learned.
	4. If you use a consistent performance improvement, human centered design, or change management method, what is it?

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| *Quality Improvement Experience* |

1. **Data Collection and Measure Reporting (<1 page):**
	1. Please describe the data you currently collect to identify and manage your patients with behavioral health needs. Are these data standardized by any operational process? If so, please list the names of the systems you use.
	2. What behavioral health measures are you regularly reporting to funders or state or federal agencies?
	3. Please list the names of any data systems you use to manage your behavioral health and/or social need data and referrals (e.g., registry names, electronic health record vendor names, population management solution systems).
	4. What information are you collecting on social needs screening and referrals? Please list any specific measures or tools that you use?
	5. What measures, if any, are you currently using to assess equity in care delivery?
	6. What types of patient characteristics do you use to assess equity? Where are characteristics data stored? Briefly describe how these data are used in identifying and managing patients, and if relevant, in your internal or external reporting activities.

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| *Data Collection and Measure Reporting* |