Strategic Plan & Call for Proposals Updates for 2016

November 4, 2015

Dear Trustees,

It's been little more than six months since we began to implement the strategic plan crafted at our March 2015 retreat. Our first Call for Proposals (CFP) is completed and it is already time to begin planning our 2016 programming: time flies! We thought the November board meeting would be a good time to reflect on what we learned from our first CFP and all of the other work we've been engaged in over the last six months, in order to continue to strengthen and focus our work.

We are proposing no major changes for 2016: the strategic plan grew out of a year of thoughtful, in-depth work by the board and staff. We think that we got the fundamentals right. The robust response to the 2015 CFP and our work with organizations around Montana validates our decision to focus on Behavioral Health, American Indian health, and Partnerships for Better Health: each of these areas allows us to begin working on major, long-standing challenges in Montana, and organizations around the state are ready and eager to partner with us to address them. Making progress in these areas will require a stable, enduring commitment over many years, though: we believe, therefore, that the focus areas should continue to guide our investments for the foreseeable future. That said, as stated in our first strategic plan:

> *This strategic plan is our starting point: it is a synthesis and summary of many months of data collection and investigation, not a comprehensive, detailed accounting of the health challenges in Montana. As such, there are undoubtedly many important issues not reflected in the discussion above, and many others about which we have much to learn as a new foundation. … our strategic planning process will continue, and will drive the evolution of our programming in the coming months and years.*

Each year of programming provides an opportunity for us to learn and refine our strategy and tactics.

Reflecting on the six months since our retreat, here are three observations:

1. **Policy, Partnerships, and Leadership:**
   Beyond our grantmaking, direct efforts by MHCF staff are proving to be a powerful way to pursue our strategic objectives. The Foundation has already started to lead and convene critically needed policy and strategic conversations within our focus areas.

We expected this would be a slower process, occurring in tandem with our first few years of work on these issues. Instead, we've found that stakeholders including DPHHS, the tribes and IHS, non-profit networks such as the Primary Care Association, and major health systems such as the Billings Health System are already seeking our counsel and looking to us to help convene and lead strategic discussions. Over the next year, we'll need to focus our efforts on the most promising opportunities, because there are many.

2. **Medicaid Expansion:**
   The Medicaid expansion presents an important opportunity to make progress in each of our focus areas. While we are engaged in many activities related to the expansion, over the next few months we need to do some careful planning to consider the most strategic needs in terms of how to set the new program up for success through efforts to support enrollment, sensible use of the new benefits by patients, successful billing and reimbursement for tribal health programs, and establishing a framework to support a strong evaluation of the program as required by the HELP Act.

3. **Call for Proposals:**
   The CFP worked very well overall, but we see some small opportunities to move toward an even better process in 2016.

In the following pages, we start by giving an overview of the staff's direct work in support of our objectives. As we head into 2016, we anticipate that the Foundation's staff will continue to play a lead role in envisioning and guiding the changes Montana needs. Since this is a part of our programming that can fly under the radar but supports our grantmaking strategy, we thought this would be a helpful place to start our thinking about next year.

Next, we outline a draft plan for programming in 2016. As you will see, there are a number of relatively small changes to the way we did things this year. With the introduction of structured initiatives and suggested areas of focus for our larger grants, we are beginning to move toward a more structured, strategic approach to grantmaking, but still leaving plenty of room for to respond to new ideas.

As always, it is such a privilege and pleasure to work with all of you to develop the foundation and plan our programs. We look forward to all of your ideas next week!

Thank you,

Aaron and staff

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Policy, Partnerships, and Leadership

In our work over the last year, MHCF has come to be regarded by our partners as a trusted and valued and trusted source of expertise. We are leading and supporting a number of key discussions that have the potential for statewide, systemic change in support of our objectives. Here is a quick summary of some of these efforts:

1. Behavioral Health:

   There is strong evidence (as common sense would suggest!) that integrating care for people with mental illness, addiction, and chronic medical problems is a great way to improve outcomes. Montana's system is fragmented (as is the case in many states), with different payment structures and delivery systems, and marked gaps in mental health and addiction services in many parts of the state. To address this issue, we have:

   - Identified the SAMHSA grant opportunity for Certified Behavioral Health Homes, and convened leadership at DPHHS and the behavioral health community to submit an application. In the course of the application, Scott led stakeholder discussions that have already put plans in place for significant programmatic changes at DPHHS.
   - Convened a community-wide strategic planning meeting in Billings to address the region's crisis-level challenges in treating behavioral health issues. We have helped get Billings Clinic interested in supporting a community-wide planning effort, and will contribute to this with grant funding.
   - Begun to support integrated behavioral health pilot projects around Montana through intensive outreach followed by grant funding for training, technical assistance, and pilot projects.
   - Commissioned an in-depth research report on the behavioral health landscape and opportunities for systems-level improvement.
   - Begun discussions with Medicaid to support payment reforms for addiction treatment in order to strengthen the system of care in communities around the state.

2. American Indian Health:

   We have established strong working relationships with every tribe in Montana, three of the Urban Indian Health programs, and several tribal non-profits. In turn, tribes, the IHS, and the state government are now looking to us to help serve as a bridge between stakeholders and provide ideas and strategic guidance on how to make progress on health disparities among Montana's American Indians. Staff activities in support of our objectives include:

   - We worked with the Governor's office and tribes to develop the executive order on American Indian health as a formal response to tribal demands for a strong state commitment to address health disparities.
   - We were invited by Richard Opper and Tara Veazey to facilitate the state's government-to-government consultation with tribes on implementing the executive order, establishing the Office of American Indian Health, and on the

use of funds appropriated by the legislature for American Indian youth suicide prevention.
- In-depth work with the Blackfeet and Confederated Salish and Kootenai tribes to develop grant proposals to strengthen tribally-run health programs.
- At their request, helping to form and convene a group of tribal health directors to improve collaboration and coordination among the tribes on key issues such as the Medicaid expansion.
- Convening a series of meetings between leadership of DPHHS, the IHS, and several tribes to plan a response to the problem of drug use in pregnancy.

3. Partnerships for Better Health:

   Our work in Partnerships has increasingly focused on the opportunity provided by the transition from paying for services to paying for "value" in healthcare. As we'll describe in more detail below, the current focus on health care system payment and service delivery reform is focused on how to improve both patient outcomes and system efficiency. Again, we are involved in helping lead and shape a number of key conversations in Montana:
   - Aaron was appointed to the Governor's Council on Healthcare Innovation and Reform, which met for the first time this week. This council will oversee the design and implementation of a state plan to contain costs and improve health system performance through innovations in the way services are delivered and paid for by public and private payers.
   - We planned and co-convened the first Montana Healthy Communities meeting, along with the Federal Reserve Bank of Minneapolis and the Office of Rural Health. The meeting was attended by 230 health leaders, community developers, banks, foundations, and others, and focused on opportunities to improve health and contain healthcare costs by collaborating to address upstream factors such as housing and education. Working groups formed on day two and will continue to pursue opportunities identified through the meeting.
   - We are beginning to work with DPHHS, the Governor's office, and members of the coalition that supported the Medicaid expansion to identify ways to support the successful expansion of Medicaid.

4. Public Health Institute (PHI):

   Our strategic plan proposed a feasibility study to establish a PHI that would support policy and structural improvements in Montana's health system. In 2015, Aaron Wernham, Ted Madden, and Scott Malloy have been able to bring their expertise and creative leadership to a number of critical challenges in the state, and we believe this will continue to be one of the most powerful ways to make progress on our goals. Ultimately, a PHI may still prove valuable for Montana, particularly for larger policy questions that may ultimately require legislative action. A PHI would benefit from a broader base of support in the planning phase, though, and it we suggest holding off on pursuing this idea until the new CMC Legacy Foundation is established.

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Montana Healthcare Foundation 2016 Programming

Our total budget for grants and other programming in 2016 will be approximately $2.2 million. Considering that many 2016 grants will have a 2-year term, we anticipate committing approximately $3.4 million in 2016. The program budget is as follows:

	2015	2016
Total new grant commitment (incl. 2nd year)	*$2,945,796*	*$3,400,000*
Total NEW grant budget	$1,040,000	$2,200,000
Payout from prior year commitments (incl. FHM)	$470,000	$1,400,000
Subtotal annual grant disbursement	**$1,510,598**	**$3,600,000**
Grant-related expenses	$773,000	$1,000,000
Total 2016 required payout	***$2,283,598***	***$4,600,000***

Changes and plans described in detail below include:

- Implementing a single-step application for smaller grants, to encourage applicants to "right-size" their requests, and to allow us to be more streamlined and opportunistic in our responses.
- Increasing the maximum grant award from $100,000 to $150,000.
- Focusing on some of the most valuable opportunities we've identified, through:
  - Creating structured initiatives that support work in integrated behavioral health and possibly drug use in pregnancy.
  - Targeting our larger grants on high-value topics within our focus areas.
- Clarifying the "value-based" focus of Partnerships for Better Health.
- Leaving room for work to support the Medicaid expansion that we expect will be better defined by early next year.
- Continuing to conduct focused research to support progress on key health challenges in Montana.
- Updates to the selection criteria to help applicants understand our focus on strategically valuable, sustainable programming.
- Introducing program related investments (PRIs) as one vehicle for funding.

Here is a rough budget for 2016 programming for new grants, conferences and sponsorships:

Program	2016	2017	Total
Small grants	$500,000	$250,000	$750,000
Large grants (incl. initiatives)	$1,200,000	$800,000	$2,000,000
Discretionary, sponsorships	$150,000	n/a	$150,000
Medicaid	$350,000	$150,000	$500,000
Total	***$2,200,000***	***$1,200,000***	***$3,400,000***

1. Implement a single-step application for grants up to $50,000, and continuous funding decisions through the year:

   Proposal:

   - Create a single-step application for grants up to $25,000 for one year, or $50,000 for two years. The focus areas and selection criteria would be the same as for larger grants. We would emphasize that this category is appropriate for smaller projects and planning grants.
   - There would be two discrete grant cycles in 2016, with an optional third:
     - Open Feb 1, decisions by May 1
     - Open May 1, decisions by Aug 1
     - If needed: Open Sept 1, decisions by Dec 15
   - The CEO would have authority to make awards up to $25,000; board approval required grants above $25,000. The board would have the opportunity to review and request discussion on any proposal before the CEO awards the grants. Staff would present write-ups to the board by email, and board members could request discussion of any proposal prior to the final decision.
   - The CEO Discretionary Fund would remain in place (up to $10,000/up to $100,000/year) to allow flexibility for smaller, short-term opportunities, but we anticipate that this initiative would largely take the place of that fund.
   - Budget: $750,000 ($500,000 in 2016, $250,000 in 2017).

   Rationale:

   The two-step process we used in 2015 took roughly six months from the date the CFP opened to announcing the final grant decisions, and applicants could only apply during a single two-and-a-half-month window. The two step application process may deter some applicants for applying, because completing these steps is a lot of work for a smaller, shorter-term project. The short window for accepting applications may limit our ability to capitalize on short-term opportunities.

   A one-step application process that is open at two to three times over the year would allow us to be more nimble and capitalize on strategically valuable project ideas that need a quicker decision. The more rapid decision approach would also create an incentive for people to apply for smaller grants when they are adequate to support the proposed project, rather than “going for the max.”

   Finally, this approach may help applicants make a clearer distinction between grants focused on planning and those focused on implementing a new project. We received quite a few planning grant proposals, and some in which it was clear that planning would be a major component before the project could be successfully implemented. Planning proposals tend to be simpler, yet many have the potential to lead to important, larger-scale projects. Implementing this one step process would provide a streamlined way for us to support strategically important planning efforts. In turn, this may

encourage applicants that could be tempted to apply for a larger grant for a project that isn't quite ready to launch to focus more seriously on planning, and set the stage for stronger, more sophisticated large grant proposals in future years.

2. Increase the maximum grant size; focus on "high value" topics for large grants:
   Proposal:
   - Increase the maximum grant size to $150,000.
   - Limit numbers of larger grants explicitly, through CFP language that says, for example, "MHCF will offer up to 10 grants of up to $100K, and up to 3 grants between $100K and $150K."
   - For the larger grants in this category ($75,000 and up?), emphasize "skin in the game," include requirements for a strong sustainability plan, and consider requiring a business plan.
   - Define specific topics that we will prioritize for funding. We did this in the 2015 CFP, and would update the list based on what we've learned. This is less structured than the "structured initiative" approach discussed below, but will begin to focus our work on areas we have identified as particularly promising, within our broader Focus Areas. See Appendix A for a list of potential topics.
   - Budget (incl. structured initiatives) $2 million ($1.2 million-2016; $800,000-2017).

   Rationale:
   Based on the CFP response and continued discussions around the state, it is clear that some projects may require more than our 2015 maximum of $100,000 for success. These larger investments may be warranted for well-developed proposals on strategically important topics. Staff believes that offering a small number of grants up to $150,000 will create an incentive for organizations capable of implementing complex, high-value initiatives to apply.

   Strengthening our requirements for matching contributions would help ensure that the applicant and partners are invested in the project's success.

   Calling out the specific "high value" topics under each focus area is similar to the way we worded the last CFP, but we would strengthen the language a bit, and make the focus areas more specific. This additional focus will help us begin to form structured initiatives for 2017 and beyond.

3. Structured Initiatives:
   Proposal:
   - Explore the use of a "structured initiative" approach, in which a group of grantees would carry out similar projects with close coordination and support from MHCF. These initiatives would focus on an important health issue,

implement a consistent set of interventions, and seek to build on the work of individual grantees to achieve statewide changes. In MHCF's initiatives:
    - We would contract with experts to provide technical assistance and evaluation for the grantee cohort
    - We would build on the work of individual grantees to try to support changes at the state level through, for example, organizing conferences to spread the core concepts, advocating for payment reforms and other policy changes that would better support implementation statewide, and/or extending the initiative through a multi-funder collaboration.
- How do we decide when something is ready for this approach? In general, we would use structured initiatives to address a prominent problem when a well-defined solution exists and when there is a high potential for bringing about widespread changes that would be self-supporting after our grants are completed.
- Integrated behavioral health is the most likely candidate for a structured initiative. Staff will finalize the structure before launch of the CFP.
- Comprehensive care for pregnant women with substance abuse disorders may be ready for this approach as well, but we'd like to meet with this year's grantees first, to consider how this would look.
- Total budget: part of the Large Grant budget in the CFP.

Rationale:
This more structured approach to funding is intended to increase the reach and impact of our programming by raising the prominence of the issue across Montana, demonstrating viable solutions, and bringing other resources and partners to bear.

Our 2015 CFP took a relatively "responsive" approach: within our three focus areas, we did not restrict or define the types of projects people could propose. Responsive grantmaking was a great way to get to know the needs, opportunities, and capacity of organizations around the state.

4. Focusing Partnerships for Better Health on "Value-Based Care":
Proposal:
    - Update our description of this focus area to more explicitly link it with the value-based care conversations that are happening around Montana.
    - Define specific examples of value-based initiatives that are likely to be competitive, such as:
        - Innovations in community-based care coordination and outreach, such as our grant for the Park County Connect program and the Glacier County community paramedicine project.

  - Interventions that address social determinants of health, such as supportive housing and Housing First, or community-based asthma care.
  - Trauma-informed educational policies and school-based health services to improve education and health outcomes.
  - Partnerships between hospitals, clinics, health departments, and behavioral health providers to better coordinate services and improve outcomes for "super-utilizers" and other high-needs groups.
  - Partnerships that strengthen substance abuse treatment and prevention, given the prevalence of substance abuse among high utilizers.
- For large grants, include a requirement for a business plan focused on shared savings and/or third party reimbursement as a means to sustain the project.

Rationale:
As stated in last year's CFP, Partnerships for Better Health supports:

Collaborative, systems-based solutions to the most challenging health problems facing Montanans. In particular, we will emphasize new partnerships among the organizations and agencies that serve a given community that have a high potential to become financially self-supporting through using existing resources more efficiently and effectively.

The issues described here are coming to prominence in Montana, catalyzed by several initiatives focused on what is often referred to as "value-based care". These initiatives include the HELP Act (which has many provisions focused on improving clinical outcomes and reducing costs through data sharing, care coordination, and other innovations in care delivery); the CMS State Innovation Model (SIM) grant through which the state will work with payers, hospitals, and providers to design multi-payer payment and delivery system reforms; and federal insurance reforms such as the Medicare readmission reduction initiative and Patient Quality Reporting System.

These initiatives seek to realign incentives in our current healthcare system to pay for better outcomes rather than the volume of services delivered. In turn, hospitals and clinics are increasingly interested in finding ways to accomplish this goal. As hospitals, clinics, and payers explore ways to improve outcomes, our grants can catalyze innovation through piloting, evaluating, and demonstrating the success of models that are workable in this state.

5. Medicaid:
   As described in the Introduction above, the Medicaid expansion presents an unprecedented opportunity to advance the Foundation's core objectives. Staff is in the process of defining where there may be gaps in state and other stakeholder plans to support the expansion, and where MHCF can play the most productive role.

6. Sponsorships, Events, and Discretionary Funding:
   Proposal and Rationale:
   MHCF is already playing a leadership role by convening discussions important health issues in Montana, and helping sponsor other gatherings that bring important partners together. Larger events like the Healthy Communities meeting are a powerful way to raise the prominence of health improvement efforts in discussions around the state; sponsorship for smaller convenings—such as bringing tribal health directors together or convening stakeholders around an issue such as the behavioral health system in Billings—are strategically valuable and often arise on fairly short notices. This budget also includes CEO discretionary grants, and a budget for research topics, which are discussed in the next bullet.
   - Budget: $150,000.

7. Research Topics:
   Staff will continue to identify topics for applied research, with a focus on specific questions that address a high-priority health challenge and identify feasible solutions, and on bringing important health issues to light that have had relatively little attention to date. We have not chosen final topics and will continue to identify them throughout the year. These are examples of potential topics for 2016:
   - Strengthening Montana's finance and delivery system for the treatment of substance abuse disorders, and identifying opportunities to make progress toward unifying substance abuse and mental health treatment.
   - Strategies that other states and foundations are using to support value-based transformation, and healthcare sector investment in education, housing, and other health determinants.
   - Success stories from Indian country: a series of brief snapshots highlighting successes in building strong health systems and addressing the needs of tribal communities.
   - Community-based prevention among tribal health departments, specifically to support DPHHS' proposed Medicaid Health Improvement Program plan amendment.
   - Collaboration between behavioral health and criminal justice to reduce incarceration rates and improve correctional and health outcomes in rural communities.

8. Program-Related Investment (PRIs):
   Foundations can provide low-cost loans that count toward their required five percent annual distribution, but which can be paid back. This can be a powerful vehicle to help non-profits finance critically needed projects such as supportive housing, wellness

centers, or crisis diversion facilities. Staff are evaluating the potential of using PRIs as a vehicle to support our work in our focus areas. We will prepare and present a white paper for board consideration in 2016.

9. Updates to the Selection Criteria:
   Proposal and Rationale:
   Based on issues that came up commonly in the course of last year's CFP, we propose some fairly minor modifications to the selection criteria, in order to clarify issues of need, partnerships, and sustainability. The proposed changes are tracked:
   - **Importance of health issue to be addressed:** The proposed project will address an important health issue, as defined by the burden of suffering it creates in terms of prevalence in the population, severity of the outcomes, and costs to families and communities.
   - **Need:** The grant will fill a need that cannot be met by other resources available in the community(ies) served.
   - **Sustainability:** A short-term grant investment will catalyze improvements that endure long after the grant funding runs out. When funding will be used to establish or support new programming, the strongest proposals will demonstrate a clear, feasible plan to sustain the programming through third party reimbursement or shared savings within the healthcare system.
   - **Creating partnerships:** The proposed project will create or advance new and substantive partnerships that result in more efficient and effective use of resources, and partnerships between organizations that may not typically work together, such as healthcare providers (hospitals, clinics, behavioral health treatment centers), public health (local or tribal health departments), and other organizations (such as community developers, county Sheriffs, or schools). The strongest proposals will include specific plans for involvement of and collaboration with and among the major health resources in the community.
   - **Focus on at-risk populations and health disparities:** The proposed project will serve a region or population of high need, as measured by the existence of health disparities, poor access to healthcare, health professional staffing shortages, geographic remoteness, or other factors clearly described in the proposal. Health disparities are defined as the higher rates of illness experienced by certain populations, including socially or economically disadvantaged families, racial and ethnic minorities, children, and older adults. In all of our initiatives, MHCF seeks to decrease health disparities—and to improve health and well-being among those at greatest risk.
   - **Solutions exist:** Effective, evidence-based interventions exist to address the problem, but are not already being implemented.

- **Workable in Montana and culturally appropriate:** Infrastructure, community support, and strong partners exist to implement the intervention here; the intervention is tailored to work well within the community(ies) that will be served.
- **Feasibility and scale:** There is a high probability that this MHCF investment will lead to success. The strongest proposals will also have a high potential for being replicated successfully in other communities.
- **Contribution to a diverse grantee portfolio:** MHCF seeks to support a range of projects across Montana. We recognize that preparing a high-quality grant application may be more difficult for smaller communities that lack staff and resources. We may, therefore, also give preference to proposals based on their contribution to the overall diversity and balance of our portfolio, and in particular, to proposals from communities with the greatest demonstrated need.

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Appendix A—High-Value Topics for Large Grants

1. Behavioral Health:
   a. Proposals that strengthen the system of care and improve access to treatment for substance use disorders, through implementing collaborative projects that demonstrate sustainable, broadly applicable finance and staffing models and evidence-based practices.

2. American Indian Health:
   a. Strengthening the administration and financing of tribal health programs through efforts to enroll patients in Medicaid or other insurance, strengthen coding and third party billing, or other measures.
   b. Using Public Law 638 to assume responsibility for certain health services from the IHS.
   c. Developing school-based health services and implementing trauma-informed discipline policies in schools.
   d. Implementing programs to provide comprehensive, effective care to reduce the use of harmful drugs and alcohol in pregnancy.

3. Partnerships for Better Health:
   The foundation is particularly interested in projects that propose innovative ways to improve outcomes and reduce healthcare expenditures through addressing the needs of at risk populations. Proposals that will be given preference include:
      a. Supportive housing and "Housing First" initiatives that propose to fund housing co-located with services through shared savings or third party reimbursement.
      b. Collaboration between hospitals, health departments, community health centers, mental health centers, and others to implement care coordination, community-based paramedicine programs, or other approaches to addressing high-needs populations beyond the hospital and clinic.
      c. Developing school-based health services and implementing trauma-informed discipline policies in schools serving at-risk students.
      d. Strengthening substance use disorder treatment programs through new collaborations between or among hospitals, community health centers, addiction treatment centers, and public health departments in a community or region that has identified substance use as a high priority need.
      e. Novel approaches to value-based reimbursement, such as ACOs.
      f. Implementing programs to provide comprehensive, effective care to reduce the use of harmful drugs and alcohol in pregnancy.