EPISCOPAL HEALTH FOUNDATION

2021 Grant Guidance

Improving Health, Not Just Healthcare in Texas

In 2021, the Episcopal Health Foundation (EHF) will continue work aligned with our five-year **Strategic Plan**, which you are encouraged to read before applying for a grant. This document expresses EHF's core beliefs and explains the commitment of our philanthropic giving to outcomes-focused approaches. The following guidance is organized according to the Goals, Outcomes, and Strategies listed in the Strategic Plan.

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STRATEGY 1:	**Dollars & Sense:** Support change in healthcare financing to incent investment in improving community health

This Strategy is designed to achieve transformation of the health system that is currently structured to prioritize the delivery of medical services over the attainment of improved health outcomes for our communities. Transformation to a value-based system that rewards quality and volume is slowly taking hold in the U.S. EHF desires to work with institutions that are willing to look at new ways of paying for improved health outcomes. We invite proposals that address innovative programs to pilot, transition, and scale approaches that change the way in which positive health outcomes are financially rewarded.

Under this strategy, organizations may request funds to support efforts to incent investment in improving community health; examples include, but are not limited to the following:

- **Pay for Success initiatives:** piloting models that incent spending on prevention by inviting private sector investors to bear up-front costs as well as risk of failure
- **Incenting investment in social determinants of health:** working with Texas Medicaid, local governments, managed care organizations, and other payors to align value-based payment program incentives and other payment structures with interventions that address social determinants of health
- **Multi-sector, health-focused community collaboratives:** supporting the development of collaboratives focused on improving health, not just healthcare; this may include work to incorporate a shared understanding of social needs as well as efforts to employ creative funding mechanisms to sustainably finance multi-sector investments in the social determinants of health

Support for Community-based Clinics

EHF has invested considerable resources in community-based clinics because of their unique role in providing comprehensive care in urban and rural medically underserved areas, creating access to healthcare, and addressing the social determinants of health (SDOH). We are committed to help clinics implement features of high-quality, high-performing comprehensive primary care[1] and support clinics to implement and maintain equally robust business models that sustain operations beyond the current fee-for-service payment system and allow for reinvestment of financial returns in infrastructure, innovation, new models of delivery, and partnership development. We believe that clinics with strong primary care and business infrastructures will be able to participate in alternative payment models that support population health management strategies and pay for community prevention efforts.

Our grant making under Strategies 2 and 3 below continues to support clinics to improve and expand care, integrate behavioral health models, and engage community partners to collaboratively address community health issues.

STRATEGY 2: **Working Upstream:** Support community-based clinics in addressing the social determinants of health

Social determinants of health are broadly defined as "the conditions in which people are born, grow, live, work, and age" and may include economic stability, neighborhood and physical environment, education, food, community and social context, and the healthcare system.

Clinics addressing SDOH: EHF is interested in incenting clinics to target these upstream factors that influence population health, beyond what the healthcare system has historically been able to address on its own. In the spirit of population health management, we envision grant investments that focus on equipping clinics to serve as the trusted community partner capable of connecting and addressing both medical and non-medical needs.

[1] "The 10 Building Blocks of High-Performing Primary Care", Bodenheimer, Thomas, MD, et. al., Annals of Family Medicine, www.annfammed.org, Vol. 12, No. 2, March/April 2014.

Community Centered Health Home: The Community Centered Health Home (CCHH) practice supports community clinics to engage in community-wide prevention strategies and other efforts that improve health conditions in a community by developing partnerships with a variety of community-based organizations. Examples may include aligning clinic goals with other social sector partners, applying a health lens to local policies and ordinances, working with partners to improve the built environment, or working with private sector businesses to shift organizational practices to better support health. More than a dozen clinics have participated in the CCHH program since 2016. In 2021, we will extend the opportunity to additional clinics, as described below.

For clinics currently participating in the CCHH practice: We encourage participating clinics to continue their CCHH work developed as part of the original initiative and to consider ways in which that work can advance policy, systems, and environmental changes (PSE) where appropriate. Key features of the initiative such as webinars, trainings, and peer learning remain available to these clinics that are interested in advancing their existing projects to build capacity and infrastructure for PSE interventions and strategies for PSE change, and to measure and evaluate PSE change-related outputs and outcomes.

For clinics interested in joining the CCHH practice: Multi-year funding will be used to create a glidepath to assist clinics in learning and adopting the principles and practices related to the CCHH practice. We anticipate that during the first year clinics will learn to: recruit and engage clinic leadership including physicians, staff and board members, identify and outreach to community service agencies with whom to partner, and analyze data from research on population/community health issues and the social determinants that impact them that will form the basis for developing a plan that moves the community to action. Clinics will have access to the following online resources and tools:

- CCHH Logic Model
- CCHH Principles and Practices
- *Healthy Places Toolkit: A Practical Guide to Improving Community Health*
- CCHH Management Academy Training Guidelines
- Access to academic and foundation articles relating to community health models and community resource referral platforms
- Access to community engagement facilitation tools and resources
- Connection with current CCHH participating clinics who can support new clinics with their learning and serve as a trusted resource to answer questions
- Coaching from physician leaders in CCHH and other community health models
- Customized trainings and webinars based on clinics' needs

In proposing work that addresses community health and the social determinants that affect it, special attention should be paid to attaining organizational buy-in and internal culture change conducive for this work's long-term success. We recommend that this work begins with meaningful involvement of the community in the planning, development and/or implementation of CCHH-type programs and strategies.

Clinics interested in adopting the CCHH practice must speak with a Program Officer in advance of submitting a Letter of Inquiry.

OUTCOME 2:

Low-income and vulnerable populations access comprehensive care in their communities

STRATEGY 3:

Comprehensive Clinics: Support community-based clinics to provide comprehensive services, continuity of care, inclusivity, and efficiency in delivery of care

Clinics Pathway Approach: Building Clinics' Capacity for Financial Sustainability and Community Prevention.
In 2020, we offered community-based clinics the opportunity to apply for enhanced multi-level funding through the new Clinics Pathway Approach (CPA). The CPA builds clinics' fundamental capacities for population health work and value-based payment system design and will expand to include additional stakeholder partners and health system engagement based on three levels of development as part of a pathway to clinical transformation. The CPA is designed as a significant funding opportunity over a multi-year period. Over time, participating clinics are expected to progressively build their capacities to become fiscally and programmatically sustainable agents for community prevention.

Participating clinics began their CPA efforts in Fall 2020 through their participation in curated learning cohorts. These clinics will receive grant support to continue their work in early 2021. Please note, clinics currently participating in the CPA learning cohort do not need to reapply for continued CPA funding. Your Program Officer will reach out in late 2020 to assist with any necessary modifications to your existing application prior to consideration by the EHF board.

Clinic Pathways Approach

No new applications will be considered at this time for participation in the CPA. *However, for clinics interested in this work, funds can be used to build the capacity and necessary infrastructure that advances the clinic toward the aims of the CPA as high-functioning primary care clinics and is described below.*

Supporting High-Functioning Primary Care Clinics:

Funds may be used to build the capacity of clinics in key infrastructure and care processes that are core competencies of the CPA and high-functioning primary care clinics. Key competencies include the infrastructure to engage in population health management, incorporate patients' unmet social needs in care planning, and engage with health system payors to sustainably finance community prevention activities such as:

- **Patient attribution and activation:** integrating key data management processes and reporting functions necessary to successfully implement patient attribution and activation efforts; develop risk attribution methodologies to enhance empanelment of patients and for better care coordination and care management
- **Change management, practice transformation and clinical integration:** strengthening the elements necessary for population health management, including practice operations transformation, patient empanelment, team-based care, optimizing staffing and budgeting for successful new delivery models of care, and developing and implementing health risk assessments (HRAs) to aid in patient risk stratification
- **Use of data and information:** enhancing data analytics capabilities and infrastructure necessary to track client and service information to inform payment and service delivery model enhancements; this includes optimizing health information technology (HIT) to ensure interoperability, allowing for clinical decision support and use of automation tools that facilitate case management, analyzing claims data, and developing risk attribution methodologies
- **Clinic financial and operational analysis, management, and strategy:** building capacity to evaluate likely financial outcomes associated with at-risk financial compensation terms, engaging with MCOs to explore and define partnerships, including developing and implementing risk-based contracts, establishing and managing performance-based incentives
- **Clinic-centric organizational leadership and partnership development:** implementing formal and informal network structures (Accountable Care Organizations, Independent Practice Associations, and Management Services Organizations) to leverage emerging models of care delivery and reimbursement
- **Care management:** improving individualized care, most often for high-risk, high-need patients, by practicing risk stratification, empanelment, and transition from acute to preventive care and by doing intensive case management for chronic disease management and serious mental health illness
- **Clinical care team transformation strategies:** evolving the practice setting to implement new clinical management strategies, including high risk case management, emergency department/ inpatient follow-up and/or creating and using disease/preventive care registries

EHF will continue to devote resources to support clinics to provide the full spectrum of comprehensive primary care including:

- **Access and continuity:** increasing access to the primary care team through expanded hours or other alternatives to traditional office visits
- **Comprehensiveness and coordination:** focusing on the depth and breadth of services offered including specialty care referral systems and networks to lower overall utilization and costs, reduce fragmented care, and achieve better health outcomes, and ensuring access to a full range of contraceptive options for women across their reproductive years as well as timely prenatal care
- **Patient and family engagement:** increasing patient engagement in the design and improvement of their own care and incorporating patient input to structure responsive services and collaboratively set patient goals; this includes providing client-centered reproductive health counseling
- **Comprehensive women's services:** increasing access to, expanding accountability, and improving quality of preconception, prenatal, postpartum, and pediatric care; work may include adopting policies and practices that improve the organization and integration of health systems that focus on the caregiver and child together as the unit of care and that integrate care and services across the health continuum
- **Integrated behavioral health services:** bringing behavioral health services into a primary care setting, bringing primary care services into a behavioral health setting, or bringing substance use disorder (SUD) services into either a primary care or a behavioral health setting. The SAMHSA (Substance Abuse and Mental Health Services Administration) Center for Integrated Health Solutions has developed a framework to help primary and behavioral healthcare provider organizations improve outcomes by helping them understand where they are on the integration continuum. Applicants interested in applying for this priority should review this website when developing their proposals, as they will be asked to rank their current level of integration according to SAMHSA's framework in their application.
- **Organizational Partnerships:** for clinics interested in partnering with other clinics to optimize service delivery, operational strength or improve financial stability, proposals should outline the partnership and path towards service consolidation. Before such a grant is approved, a Memorandum of Understanding between/among the clinics must be executed.

Rural Health

STRATEGY 4: **Rural Health:** Expand and strengthen community-based clinics in rural areas

This strategy is aimed at increasing the availability of basic preventive, primary, behavioral, and oral health services to those living in smaller towns and rural areas. We seek to work with communities to help them optimize healthcare infrastructure, including communities that have depended on rural hospitals whose futures may be in jeopardy. EHF is interested in work that leverages and is connected to the broader community and health system.

Examples of this work include but are not limited to:

- **Offering** technical assistance or operating support for rural health clinics to provide outpatient primary care services
- **Developing** approaches to recruit and/or retain provider staff including nurse practitioners and other mid-level providers
- **Enhancing** use of information technology and data analytics
- **Supporting** other practices that improve the sustainability and function of rural health clinics

EHF will support grants for behavioral health services in non-integrated settings because we recognize the relative lack of behavioral health services in these locations.

STRATEGY 5:

Health Coverage and Benefits: Improve health coverage for low income and vulnerable populations

EHF will fund clinics and community-based organizations to help low-income populations gain access to care through enrollment in insurance and other health-related programs, including those offered by federal, state, and local governments. Funds will support dual approaches that expand coverage and improve enrollment of eligible beneficiaries, and advocacy efforts to increase health insurance coverage in Texas including the expansion of Medicaid. EHF is particularly interested in proposals that use innovative approaches to track newly enrolled beneficiaries through their first use of those benefits, most commonly through a visit with a medical provider.

To expand the ecosystem in which enrollment organizations operate, funds may be used to extend outreach enrollment activities to other places, such as schools, to find children and family members who could be eligible for health insurance coverage and other community benefits. Organizations may also consider community engagement strategies to enhance consumer understanding of health benefits, identify health issues, and develop local priorities and expand enrollment to new service areas.

GOAL 2:	Activate communities by strengthening organizations and congregations to build health-promoting communities.
OUTCOME 3:	Community and congregation members actively shape healthy communities and influence health systems to improve health equity
STRATEGY 6:	**Community Voice:** Support organizations to raise the voices of community members to influence community health

EHF may issue an update to this Goal in April 2021, 30 days prior to the Letter of Inquiry which is due in May 2021.

EHF's grant making supports community-based organizations to develop the capacity to engage community members, particularly low-income populations, to become advocates for health, and to support communities in adopting new ways of problem solving. All efforts should have a goal of developing positive influence on the health of community members.

Examples of this kind of work include but are not limited to:

- **Building the capacity of community-based organizations by helping them assess their strengths and opportunities and to undertake organizational development activities that address health-related factors**
- **Support organizations to develop/strengthen business models for financial and programmatic sustainability**
- **Increasing the number and reach of grassroots community organizing groups that advocate for community health**
- **Expansion of work to new service areas**
- **Supporting the development of new leaders within communities**
- **Ensuring that client-facing community partners have the skills and resources needed to actively engage those they serve as influential beneficiaries**
- **Strengthening existing health coalitions**
- **Strengthening ability to advocate in furtherance of community health and advancing Medicaid expansion**

STRATEGY 7:	Support congregations to address community health

We recognize the important role that the faith community can play in creating conditions to promote community health. EHF supports our congregations in this work through the efforts of our congregational engagement team, however, we do not provide funding opportunities for congregations through this application process. To learn how congregations may access financial support, please visit the "For Congregations" section of our website.

GOAL 3:	Build the foundation for a healthy life by investing in early childhood brain development.
OUTCOME 4:	Health systems and families implement best practices for early childhood brain development during pregnancy and the first 1,000 days of life

EHF plans to issue an update to this Goal in June 2021, 30 days prior to the Letter of Inquiry which is due in July 2021.

Through its grant making EHF supports community-based clinics and community-based organizations to embrace the importance of early childhood brain development and prioritize primary prevention work with low-income families beginning before or at the birth of their children. We are interested in programmatic approaches that:

- **Lead with brain building science and share that knowledge with caregivers**
- **Include maternal health and timely prenatal care, especially as it relates to building a foundation for optimal infant brain development**
- **Offer and/or support opportunities for caregivers to practice new brain-building skills with the child or children in their care**
- **Are consistently informed by and influenced by clients of the programs**
- **Take an asset-based approach when supporting and sharing learning with parents and caregivers**
- **Have evidence of or attempt to measure change in caregiver/child relationship and/or interaction**

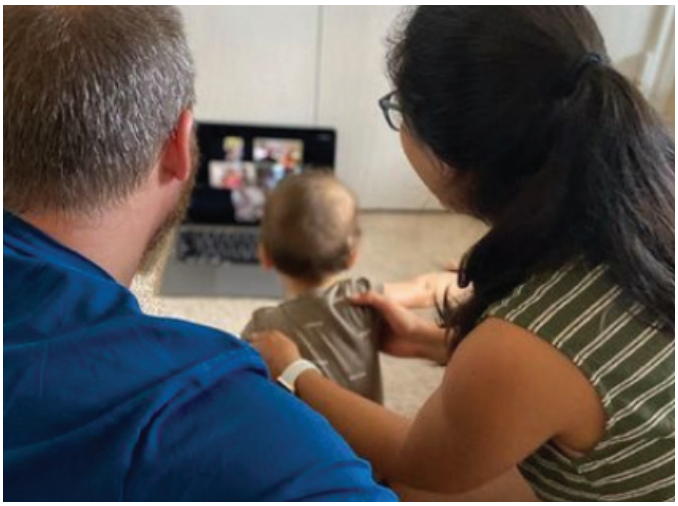
STRATEGY 8:

Building Brain Development-Providers: Providers support early childhood brain development

EHF will prioritize funding to support:

- **Practices and tools designed to help healthcare providers implement effective physical, social, and emotional developmental screening, referral to services, and follow-up as indicated**
- **Identifying and addressing instances of parental depression or other behavioral health issues**
- **Educating pregnant women and parents about early childhood brain development and connecting parents to programs and resources that build skills for and support "serve and return" practice within the parent/child relationship from infancy**

STRATEGY 9:



Building Brain Development-Community Organizations: Community-based organizations provide training to families for early childhood brain development beginning at or before birth

Funds may be used for programs that:

- **Impact the relationship between adult and child from the first days of infancy forward**
- **Emphasize the importance of the caregiver-child relationship and serve and return interactions**
- **Use evidence-based or promising screening or evaluation tools to measure critical factors in adult/child attachment, relational health, and/or bonding**

We recognize that measuring impact at this critical developmental age is difficult, and we welcome input from applicants identifying the best indicators of success in this work.

Organizational Effectiveness

Within any goal or strategy, an applicant may request funds for organizational effectiveness to strengthen the internal systems that enable them to do their work better and enhance their impact. Areas of capacity building include but are not limited to strategic planning; leadership transitions; board development and governance; communications planning; community engagement; diversity, equity, and inclusion; and financial planning. This support can also be used to increase post-pandemic stability that includes:

- **Organizational resilience:** as organizations re-imagine operations in a post-pandemic environment, EHF encourages thoughtful consideration of necessary capacities to ensure organizational resilience and emergency preparedness; capacities may include equipment and/or infrastructure needed to operate in a greatly changed environment, connectivity for patients/clients and staff, efforts to ensure digital literacy, data capacity to inform evolving operations, and other proactive measures to mitigate against future emergencies.
- **Mergers and acquisitions:** to remain viable in an increasingly complex environment, EHF acknowledges that some agencies may be considering consolidation of their organizations with others to achieve a wider scope of services, broader geographic scope, deepen market position, and to create synergies and efficiencies no longer sustainable as a single agency. EHF will fund the necessary technical assistance, legal fees, and consultants for organizations from initial planning through to mergers and acquisitions.
- **Health equity:** EHF believes that by making health equity a shared vision and value, increasing community capacity to shape outcomes, and fostering multi-sector collaboration, solutions can be developed that foster equal opportunity for health, which is the foundation for a vibrant, healthy community. EHF's funds can be used to pay for consultants to help nonprofit advocacy organizations and community clinics understand and analyze the racialized histories and root causes of policies that foster health inequity, develop structures and processes that support equity, and develop strategies that eliminate disparities and improve the health of all groups.

During the Letter of Inquiry process, an applicant may identify its organizational effectiveness needs.

Application Process

Episcopal Health Foundation's strategic plan is based on three goals, four outcomes, and nine strategies, shown in the graphic below.

STRATEGIC FRAMEWORK 2018-2022

VISION: HEALTHY COMMUNITIES FOR ALL

GOALS

Strengthen Systems of Health
by catalyzing health systems to be accessible, equitable and deliver health, not just healthcare

Activate Communities
by strengthening organizations and congregations to build health-promoting communities

Build the Foundation For a Healthy Life
by investing in early childhood brain development

TARGETED OUTCOMES

Resource allocation and system reform in the health sector reflect the goal of improving health, not just healthcare

Low-income and vulnerable populations access comprehensive care in their communities

Community and congregation members actively shape healthy communities and influence health systems to improve health equity

Health systems and families implement best practices for early childhood brain development during pregnancy and the first 1,000 days of life

STRATEGIES

Support
change in healthcare financing

Work
upstream

Support
comprehensive clinics

Strengthen
rural health

Expand
health coverage and benefits

Raise
community voices

Support
congregations in action

Build
brain development - providers

Build
brain development - community organizations

2021 Submission Deadlines

The grant cycles for 2021 correspond to our three goals according to the following schedule:

	LOI DUE	APPLICATION DUE	BOARD DECISION
CYCLE 1/GOAL 1 Strengthen Systems of Health	01/15/21	02/26/2021	05/13/2021
CYCLE 2/GOAL 2 Activate Communities	04/09/2021	05/14/2021	09/16/2021
CYCLE 3/GOAL 3 Build the Foundation for a Healthy Life	07/23/2021	09/24/2021	12/16/2021

*Please note – LOIs and Applications are due by **noon (12:00 p.m.) CST** on the dates indicated above.*

EHF has a two-step grant application process:

STEP 1 – Letter of Inquiry (LOI)

Access and review the LOI form from the EHF website. Choose the EHF goal and strategy to which your proposed work applies. Then complete and submit your LOI by the appropriate deadline. Please note that for clinics applying under the Clinics Pathway Approach, a separate Readiness Assessment tool will need to be completed in conjunction with the LOI; please refer to the "Summary of Requirements" under the Approach section above. We encourage potential applicants to contact an EHF program officer before completing this stage of the process. Please send inquiries to **grants@episcopalhealth.org**.

STEP 2 – Application

We will notify you via email whether your LOI has been approved. If your LOI is approved, you will receive a link to our online application form in that approval notification email. Please complete and submit your application by the appropriate deadline. You will be notified of the Board of Directors' decision regarding your request via a phone call and email shortly after the Board Decision dates listed above. Depending on grant contract finalization and electronic payment enrollment, EHF is usually able to distribute funds no later than four weeks following the Board Decision date.

If you see alignment with your work and would like to discuss any of your ideas with a member of our staff, or have questions about the application process, please email us at **grants@episcopalhealth.org**.

If you are interested in applying for more than one goal or more than one strategy, you MUST email us in advance for consultation at grants@episcopalhealth.org. In your email, please include a written description (no more than 250 words) summarizing your ideas for potential funding. A Program Officer will follow-up with you to discuss your proposal and the application process.

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