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Call for Letters of Intent to Partner with PQA on Grant-funded Phase II Demonstration Projects to Improve Medication Use Quality in Community/Ambulatory Pharmacies

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EXTENDED Due Date: Monday, September 21, 2009 (5 PM EDT)

Background

The Pharmacy Quality Alliance (“PQA” www.pqaalliance.org) is a consensus-based, membership alliance with over 50 member organizations. PQA’s mission is to improve the quality of medication use across health care settings through a collaborative process in which key stakeholders agree on a strategy for measuring and reporting performance information related to medications.

In 2007-08, PQA funded five Phase I Demonstration Projects to: 1) collect data on a “starter set” of 15 medication use quality measures; 2) prepare pharmacy performance reports that presented the measures in useful ways; and 3) obtain and incorporate feedback from front-line pharmacists and managers on how to improve the value and utility of the performance reports and measures. The Agency for Healthcare Research and Quality (AHRQ) funded an independent evaluation of Phase I; both the contractor and AHRQ have been involved with the demonstrations since their inception. The evaluation will be completed by the end of 2009.

Funding for Phase II Demonstration Projects

Because the preliminary results from Phase I are quite encouraging, PQA has initiated a three-year, multi-million dollar plan to initiate multiple Phase II demonstration projects. PQA devotes significant time and resources dialoguing with prospective funders, including: AHRQ on current requests for applications (RFAs) and program announcements (PAs), nonprofit philanthropic organizations, corporations and corporate foundations. These prospective funders have encouraged PQA to collaborate with researchers and demonstration sites, emphasizing their desire to marry scientific expertise and practice-based research at the local level with PQA’s capacity to develop, refine, test, validate, maintain, disseminate, and promote pharmacy quality measures nationwide (and explore promising additional measures), as similar alliances of hospitals and physicians have successfully done. To this end:

PQA seeks letters of intent from teams, led by at least one PQA member, wanting to partner with PQA on joint grant proposals for Phase II demonstration projects, with the PQA member as lead investigator and PQA as a collaborator supporting the project in several ways.

Two AHRQ Program Announcements Now Open to Phase II Partnership Proposals

In our extensive dialogues with AHRQ, we have identified two Program Announcements that hold promise for funding Phase II demonstration projects in partnership with PQA:

- ***Researching Implementation and Change while Improving Quality Grants, PAR-08-136 (R18 RD&D grant)*** (maximum of \$900,000 over 3 years at \$300,000/year). See Attachment A for a summary. Read the full PA at: [www. http://grants.nih.gov/grants/guide/pa-files/PA-08-136.html](http://grants.nih.gov/grants/guide/pa-files/PA-08-136.html)
- ***Health Services Research Demonstration and Dissemination Grants, PA-09-071 (R18 RD&D grant)*** (maximum of \$2.5 million over 5 years at \$500,000/year). See Attachment B for a summary. Read the full PA at: <http://grants.nih.gov/grants/guide/pa-files/PA-09-071.html>

Primary Research Interests

PQA primarily seeks to partner with researchers who could leverage the results, tools, data and lessons learned from the Phase I sites into Phase II Demonstration Projects that:

1. Test and determine the effectiveness of one or more pharmacist interventions to improve patient medication use by measuring some or all of PQA's initial 15 Quality Measures in ambulatory/ community pharmacy settings
2. Create or refine standardized pharmacy performance quality reports that will enable pharmacy managers and payors to determine the cost and effectiveness of the tested interventions, and
3. Produce the data necessary to enable PQA to build the case for reimbursement of the most cost-effective medication quality improvement services.

Such projects would be of particular interest to prospective funders if they also pursued one or more of the following related objectives:

- **Pay-for-Performance:** Test a pay-for-performance model or other financial incentive that reimburses the pharmacist's time to provide the intervention(s), or develop the specifications for actuarial modeling of a pay-for-performance model.
- **Causes of Low Performance Scores:** Determine the main underlying causes of low initial pharmacy provider level scores, e.g., causes of poor adherence.
- **Health Outcomes:** Further validate the measures by evaluating the impact of improved scores on established patient-health outcomes or medical measures (e.g., by linking to medical claims data).
- **Negative Impacts:** Measure any negative effects of providing the intervention, such as impact on pharmacist workload or medication errors.
- **Multi-site Testing/Scalability:** Evaluate the feasibility of deploying the PQA measures in a large plan or network

PQA is Open to Different Partnership Models

PQA seeks partners to apply *jointly* for grants under one or a combination of the following partnership models:

Collaborative Model: One Phase II Partner as Principal Investigator ("P.I.") on One Joint Grant Application that includes PQA and could include other proposed Phase II Teams/Sites
PQA is open to having a Phase II partner serve as the P.I., with PQA and other interested Phase II sites as collaborators. PQA has a well-qualified grant writer who would be made available to provide grant writing support if needed.

Independent Model: Each Phase II Partner Submits an Individual Grant Application as P.I. with PQA in a Supportive Role as a Collaborator on Each

This model gives each partner the autonomy to pursue funding *for independent projects*. PQA would be a collaborator on each independent project to ensure consistent use and reporting of PQA's measures across all projects and to maintain communication, coordination and collaboration among all of the partners.

Role of PQA as a Partner in Phase II Projects under Both Models Above.

As several prospective funders have indicated, PQA must be an active partner on all Phase II demonstration projects so that it can continue its lead role in growing the pharmacy quality movement while providing several necessary functions and services:

- **Supply and maintain the current starter set of 15 PQA measures through a contract with NCQA or other measure developer.** Measure development and maintenance must be centralized to ensure measure integrity, to ensure that the same versions are used by all demonstration sites, and to help produce data that is comparable across pharmacies, health plans, software vendors, and other users. Entities that independently alter PQA measure specifications will dilute the value of all demonstration site research. PQA will work with NCQA to maintain the measures, including ensuring that the technical measure specifications are up-to-date, the NDC lists used within the measures themselves are current, the performance of the measures across the demonstration projects are properly “captured,” and the measures remain current with respect to the evidence-based literature and any and all clinical practice guidelines.
- **Move current and newly PQA-endorsed measure concepts through the measure testing and validation process with NCQA or other measure development organization.** This is a complex and time-consuming process that may include testing and validating measures resulting from Phase II project work.
- **Solicit funding for an independent evaluation of Phase II.** PQA continues working with AHRQ to build a case for Agency funding of an evaluation of Phase II under a contract similar to the current evaluation of Phase I. The Phase I AHRQ evaluation was supported with \$525,000 of AHRQ funding in 2008-2009.
- **Monitor and liaison with demonstration projects, conduct site visits, coordinate a learning network and communication across sites, identify and troubleshoot problems, support the independent evaluator, interface with other stakeholders, provide periodic reports to the PQA Research Coordinating Council on the status of the projects, and provide related scientific functions.** These services would be provided by the PQA Director of Research and Practice Improvement who will serve as the central, nationally recognized locus of all scientific information on PQA measures and related best practices. That includes coordinating measure concept development, measure testing and NQF endorsement, supporting the demonstration sites in real-world use, and collaborating with them and the proposed AHRQ evaluator.
- **Submit the current (and any newly established) PQA measures for endorsement to the National Quality Forum.** Like the effort to validate and test PQA's Initial Starter Set of Measures, this is a similarly complex and time-consuming process that increases the credibility, value, visibility and use of PQA measures.
- **Maintain PQA as the alliance for the development of meaningful and appropriate evidence-based measures pertaining to the safe use of medication and medication management services.**

How PQA Can Deploy Its Own Resources to Further Benefit Its Phase II Partners

For Phase II demonstration sites who partner with PQA on joint proposals (under either of the two models above), PQA will deploy its own resources to provide its partners with several additional benefits:

- **Continue seeking joint funding from foundation and corporate funders as approved.** With our partners' approval, we will continue pursuing joint grant funds for independent Phase II sites from those foundations and corporations with whom we have or are building relationships.
- **Represent the Phase II demo sites to new prospective PQA members, policy makers, the media, allied groups, and other stakeholders on an ongoing basis.** This includes promoting the interim and final results of all Phase II partner projects.
- **Advocate for pharmacy quality project support through federal legislation.** PQA has already begun discussions with key Senate offices on whether and how a meaningful pharmacy quality measurement and improvement program could be included and funded through the pending health care reform legislation.
- **Help recruit partners for Phase II projects.** With our many large professional association members, we have a huge network to draw on to assist Phase II teams in identifying potential partners from academia, professional practice, health plans, chains, and elsewhere.
- **Present collective data to CMS, health plans, PBMs and other payors, and make the case for compensation of pharmacist quality improvement services.** PQA has positioned itself to begin this process through the active participation of CMS, America's Health Insurance Plans, and several other major payors in PQA, as well as our outreach to additional payors.
- **Provide grant writing assistance.** PQA has a consultant with significant experience in federal, foundation and corporate grants who is available to our Phase II partners to provide support as needed.
- **Disseminate Phase II research results widely.** Through our national organizational members, we have the capability to promote results from Phase II projects to hundreds of thousands of professionals, including nearly all thought leaders in the pharmacy quality movement. This will be especially valuable for AHRQ-funded projects, which require a robust dissemination plan.
- **Coordinate the funding strategy for Phase III.** Results from Phase II will be disseminated to major funders to support a coordinated Phase III program in which we take the best practices, tools and interventions from Phase II, build a model training program around them, and test a full package in a variety of settings.
- **Design, fund, and implement a Phase IV that promotes the best practices from Phase III and a related educational program throughout the profession.** Only a national alliance that has the outreach and training power of major associations like APhA, NACDS, AMCP, NCPA and AHIP can deliver to AHRQ, foundations, corporate funders, CMS, major health plans and PBMs the ultimate goal of pharmacy quality improvement, including profession-wide dissemination, training and uptake of proven quality measures, best practices and training programs.

Required Elements of the Letter of Intent to Partner with PQA

If you are interested in partnering with PQA on one or more joint grant proposals to fund your proposed Phase II Demonstration Project, please submit a Letter of Intent by 5 PM EDT on Monday, September 21, 2009 with the following elements:

- 1. Team Members:** List the names, degrees, job titles, affiliations, and addresses of the leader and key members of your research team. A PQA member must lead the team, but the others may be non-PQA members. Phase I Demonstration Grantee involvement is encouraged but not required.
- 2. Experience (1 pg. max.):** Summarize the team's relevant experience. Attach the team leader's resume or CV, which must list the title, funder, amount, date and role (e.g., P.I., Co-P.I., subgrantee) of all recent grant-funded research. You may also include a similar list of grant-funded research by the other key team members. Prior research funding, especially by the federal government, is not required but strongly encouraged.
- 3. Project Description (2 pgs. max.):** Summarize your proposed project, which research interest(s) listed above you will address, and how you will use the PQA measures.

Use of PQA's Measures: Employing all 15 PQA measures is not required.

Use of Phase I Data, Tools and Work Product: Partners may propose how they will use from Phase I relevant data, technical specifications of existing measures, results, tools, best practices, work products, materials and/or reports, which would be provided by PQA under a contractual agreement.

- 4. Role of Any Payor Partner(s) (½ pg. max.):** Summarize the role, if any, that a health plan, managed care plan, pharmacy plan, employer, PBM, state Medicaid program or other payor will play as a team member. While payor participation is not required, it is strongly encouraged.

Factors Viewed as Favorable by Funding Organizations

- Financial incentive(s) to pharmacies/ pharmacists for tested interventions (which must be funded solely by the payor(s), not from grant funds secured for the research).
- In lieu of a financial incentive, the use of project data to feed an actuarial model for the payor partner(s) to develop a workable incentive.
- Multi-payer involvement.
- Access to and use of the payor(s)' medical administrative/claims data or other data sources to demonstrate health outcomes of the proposed intervention(s).

- 5. Ambulatory/Community Pharmacy Participation (½ pg. max.):** Summarize the number, type(s) (e.g., independent, chain) and general location(s) of the pharmacies on your team. All sites must have direct access to pharmacy administrative data. If you plan to team with a corporate pharmacy chain, you must include a letter of intent from the corporate pharmacy executive demonstrating the chain's commitment to the project.

Factors Viewed as Favorable by Funding Organizations

- Multiple pharmacy sites
- Inclusion of underserved/vulnerable patient populations, Medicare enrollees, and/or Medicaid patients
- Sites that own the data rather than require data use agreements

6. **Matching Resources** (½ page max.): Specify the amount of matching dollars, if any, that team members will dedicate to the proposed project. List any concrete in-kind personnel resources (e.g., professional, administrative, IT, finance) you will devote to the project, and estimate the amount of time each will contribute in FTEs.
7. **Collaboration with PQA on Jointly Cultivating Funders** (½ page max.): PQA will devote significant resources to pursuing major funders on behalf of its partners, but this must be a true team effort. Therefore, identify the approximate number of hours any team member(s) could devote over the next six months to collaborate with PQA in cultivating donors jointly. Also indicate your willingness, if any, to collaborate with one or more other Phase II Demonstration teams where a potential funder expresses an interest in entertaining a proposal to fund multiple teams.

Process, Scoring and Timeline for Reviewing Letters of Intent to Partner with PQA

An independent Review Selection Subcommittee of the PQA Research Coordinating Council will review the letters of intent. Letters will be scored based on:

<i>Experience and expertise of PI and team:</i>	<i>30 points</i>
<i>Strength of environment and organizational capabilities:</i>	<i>25 points</i>
<i>Objectives alignment with PQA Phase II objectives:</i>	<i>25 points</i>
<i>Willingness to collaborate with PQA:</i>	<i>10 points</i>
<i>Established or existing relationship with a funding agency:</i>	<i>10 points</i>

After scoring, PQA will then hold conference calls with the top-ranked teams to evaluate potential joint funding opportunities and partnership model.

There is no established number or limit to potential partnerships at this time. This will depend on the number of letters of intent received, the breadth of the proposals, and demands on PQA resources.

PQA would like to establish as many partnerships as its resources can accommodate.

The research plan and plan to seek joint funding with each partner will be expressed in a *Memorandum of Understanding*.

ATTACHMENT A

Summary of AHRQ's RFA *Researching Implementation and Change while Improving Quality (R18) PAR-08-136*

Grant Category: R18: Research Demonstration and Dissemination Projects

Eligible Institutions: Colleges and universities, 501(c)(3)'s, and other nonprofits.

Deadline: Sept. 25 and Jan. 25, 2010 for next "cycles"

Maximum Amount of Funding/Number of Years: \$300,000/year for up to 3 years in total costs (directs + indirects) or \$900,000 in total.

Letter of Intent vs. Full Proposal Required: Full proposal

AHRQ's Main Focuses

AHRQ seeks research on the factors affecting successful/failed implementation of a Quality Improvement (QI) strategy, related organizational changes, and their impact on health care that are generalizable to other systems/settings. It specifically wants study of:

1. **Success or Failure:** Did the study sites succeed or fail in implementing the QI strategy?
2. **What key organizational features and factors ("contexts") impacted the successful or failed QI strategy implementation** (i.e., "what worked and what didn't in improving health care"), such as:
 - a. availability of resources/support for Quality Improvement Implementation (QII) (staff support, technical support)
 - b. organizational culture
 - c. leadership commitment
 - d. clinician participation/staffing levels
 - e. infrastructure
 - f. reimbursement
 - g. participation in other QI strategies (e.g., pay for performance, office redesign)
3. **What facilitative changes at the payment, policy and organizational levels were necessary to improve quality or sustain the QII effort?**
4. **What organizational (intended and unintended) changes occurred during implementation?**
5. **What clinical/health/patient outcomes and economic results were associated with specific settings and setting characteristics?**

AHRQ's Additional Focus Preferences

AHRQ encourages proposals that also focus on:

- clinical or organizational areas of QI listed in any of 7 AHRQ/IoM reports (at least three of which address pharmacy practice: 1) *To Err is Human*, 2) *Priority Areas for National Action: Transforming Health Care Quality*, and 3) *Crossing the Quality Chasm*.
- large system changes
- policy-level interventions
- collection/analysis of data on the impact of factors on the above
- QI strategies that apply to more than one clinical condition, practice setting, city and/or state
- Implementation/coordination of outpatient care *across* settings or patient populations, and/or
- building capacity for sustainable QI efforts

Other Favorable Factors AHRQ Will Consider

- Ability to produce results in 12, 24 or 36 months
- Matching funds/resources

Candidate Research Sites

1. Health policy environments
2. Health care delivery organizations
3. Clinical units that give (e.g., outpatient clinics, EDs, hospitals) or
4. Combination of all three

The Proposal's Six Required Main Components:

(1) **QII Plan** that is being implemented.

(2) **Quality Measures and data** to support them to capture the level of improvement attained. Must be one or more of IoM's main domains: **safety, timeliness, effectiveness, efficiency, equity and/or patient-centeredness**

(3) **Research Plan** that identifies the contextual and process variables to be analyzed at the appropriate (local, regional, and/or state) level and the method(s) of study. Must have the most rigorous research design for evaluation and use comparison groups. Use of explicit logic models is strongly encouraged.

(4) **QII and Research Teams** must include experts in multiple fields. AHRQ strongly encourages one or more experts in QII, behavioral/social/mgmt science, business, economics, organizational theory, cultural anthropology, operations management

(5) **Partners:** One or (preferably) more implementation sites/organizations that provide real personnel, expertise, money, equipment, facilities, etc. Must be from two different sectors (e.g., purchasers, providers, payers, community groups). AHRQ encourages:

- a. rural partners
- b. public hospitals
- c. primary care providers, e.g., CHCs
- d. group of citizens

(6) **Dissemination plan** beyond peer-reviewed journal articles

AHRQ's Six Review Criteria for Evaluating Proposals

- 1) **Significance:** Does study address an important problem? Will knowledge, clinical or organizational practice, or QI be advanced? Will it impact the profession's concepts, methods, technologies, treatments, services, or QI strategies?
- 2) **Approach:** Are the framework, design, methods, and analyses strong? Will they yield findings generalizable to other systems and settings?
- 3) **Innovation:** Is the project original, e.g., does it challenge existing practices or critical barriers to progress, or employ novel approaches tools, or technologies?
- 4) **Investigators:** Are the PI and personnel strong?
- 5) **Environment:** Does the scientific environment have unique features, populations, or collaborative arrangements?
- 6) **Priority Populations:** Which ones are covered?

ATTACHMENT B

Summary of AHRQ Health Services Research Demonstration and Dissemination Grants (PA-09-070/R18) (major RD&D grants)

Areas of Focus/Activities to be Funded:

This is the second of AHRQ's two largest annual "global" grant programs and serves as a companion to their more basic science-oriented R01 PA. As such, AHRQ seeks to fund the clinical and practice aspects of its six "portfolios," three of which fit PQA (in this order):

1. **Comparative Effectiveness of different clinical services authorized in the *Medicare Prescription Drug, Improvement, and Modernization Act*.** The projects should focus on generating evidence, creating and comparing clinical tools in diverse health care settings, or comparing the effectiveness of interventions for the priority conditions of the Medicare, Medicaid, and SCHIP programs under the Act, which include
 - Arthritis
 - Diabetes
 - Obesity
 - Asthma/Pulmonary disease

Applicants are encouraged to partner with existing AHRQ networks, including CERTs.

2. **Prevention/Care Management to improve the quality, safety, efficiency, and effectiveness of evidence-based chronic care management in ambulatory care settings;** and specifically, to improve primary care and clinical outcomes through clinical-community linkages, self management support, and care coordination. AHRQ said it is “very interested in research that involves non-traditional ambulatory health care sites that serve the uninsured, Medicaid, and other vulnerable populations.” Partnerships between community-based health care sites and academic institutions are encouraged.
3. **Patient Safety** along the lines above.

Opening Deadline: March 9, 2009, then May 25, Sept. 25, and Jan. 25, 2010

Maximum Funding: \$2.5 million (\$500,000/year for up to five years).

Here is how AHRQ describes its “Comparative Effectiveness Portfolio” and “Prevention Care Management Portfolio:”

Comparative Effectiveness Portfolio

In FY 2009 and FY 2010, AHRQ intends to support research grants focusing on comparative effectiveness of different clinical treatments and services, as authorized in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) Section 1013. The intent of these grants is to support research focusing on the generation and translation of new scientific evidence and analytic tools in an accelerated format and the integration of evidence into practice and decision-making in the health care system. New applicants are encouraged to partner with institutions well versed in systematic review methodologies or with research centers and integrated health care delivery systems capable of performing accelerated clinical effectiveness and outcomes research and the translation and dissemination of evidentiary information for health care decision-making.

Existing examples of such AHRQ networks include, the Evidence-based Practice Centers (EPCs), the Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) network, the Centers for Education & Research on Therapeutics (CERTs), and the John M. Eisenberg Clinical Decisions and Communications Science Center. A listing of these research networks under AHRQ’s Effective Health Care program can be found at: <http://effectivehealthcare.ahrq.gov/aboutUs/index.cfm>.

The grants can have either a clinical or methodological emphasis, but must focus tightly on the study and/or the use of comparative effectiveness research. For grants with methodological emphasis, the goals should be to advance study designs and methods to fill specific knowledge gaps and to enhance the consistency, applicability, and generalizability of the comparative effectiveness studies.

For projects with a clinical emphasis, the goals should be to develop new scientific evidence that fills important knowledge gaps and to generate critical insights on the clinical effectiveness and comparative clinical effectiveness of health care interventions. . . . Such clinical research projects also need to be informed by the information needs and inputs from various stakeholders (e.g., policy-makers, providers, and patients) to ensure the most appropriate outcome measures for assessing the effectiveness of the interventions and outcomes of importance to stakeholders are included in the study. Research projects should also be organized around a set of priority conditions of importance to the Medicare, Medicaid, and SCHIP programs as mandated by the MMA section 1013. The current list of conditions includes:

- Arthritis and nontraumatic joint disorders
- Cancer
- Cardiovascular disease, including stroke and hypertension
- Dementia, including Alzheimer's Disease
- Depression and other mental health disorders
- Developmental delays, attention-deficit hyperactivity disorder and autism
- Diabetes Mellitus
- Functional limitations and disability
- Infectious diseases including HIV/AIDS
- Obesity
- Peptic ulcer disease and dyspepsia
- Pregnancy including pre-term birth
- Pulmonary disease/Asthma
- Substance abuse

In terms of R18 Research Demonstration and Dissemination Projects, AHRQ interests include, but are not limited to:

- Development and evaluation of strategies for incorporating evidence into decision-making for patients, providers, and policymakers.
- Evaluation and comparison of different methods to implement effectiveness and comparative effectiveness information and tools in diverse health care settings and/or among practitioners or various populations.
- Effectiveness of different types of evidence-based information and specific tools in changing behavior of practitioners, patients, and organizations.
- Evaluation of the effects of specific effectiveness and comparative effectiveness information or other tools on health outcomes.
- Strategies to test the role of informatics in dissemination of evidence-based information on effectiveness and comparative effectiveness, and its impact on patient and clinician behavior.
- Evidence-based research translation strategies to improve practice at the policy, health systems, and clinical practice levels.
- Effective dissemination strategies of comparative effectiveness research findings to impact public health and policy.
- Strategies that increase the potential for translation of comparative effectiveness research

Prevention/Care Management Portfolio

The mission of the Prevention/Care Management Portfolio is to improve the quality, safety, efficiency, and effectiveness of evidence-based preventive services and chronic care management in ambulatory care settings. We are interested in grants that will support two broad strategic goals. The first goal focuses on preventive services. . . .

The second strategic area of interest is based on the Care Model (Wagner 1998; Barr, et. al.; 2002). AHRQ is interested in supporting grants with the aim of improving primary care and clinical outcomes through health care redesign, clinical-community linkages, self management support, and care coordination. We are less interested in funding research on specific conditions, but rather seek to support grants that are focused on system redesign in ambulatory care, the results of which would be generalizable across health conditions. Examples of grant applications that would be considered under this strategic area include, but are not limited to, research on the effectiveness, efficiency, and/or implementation of:

- new models of delivering primary care, especially for individuals with multiple chronic conditions;
- methods of linking primary care practices with community resources to improve the delivery of preventive services and care management;
- the effectiveness and implementation of models of self management support;
- care coordination methods, especially during transitions among care settings;
- system and organizational policy change that support the Care Model; and,
- interventions to stimulate practice change, including practice coaching, training, toolkits, and collaboratives.

Research questions of interest for R18 applications related to the second strategic area include, but are not limited to:

- How can the Care Model be spread to diverse settings, especially those serving uninsured, Medicaid, immigrant, geographically or economically disadvantaged, and other vulnerable populations?

- What is the impact of using a Depression Tool Kit on patients' ability to self manage their other chronic conditions and on patient outcomes? How can use of a Depression Tool Kit be integrated into the delivery of primary care in diverse settings?
- What are the organizational and workforce needs in primary care, i.e., staffing, training, role descriptions, needed to implement effective self-management support programs?
- What are the best methods for determining priority processes of self-management support based on health outcomes, treatment effectiveness and cost-effectiveness?

Generally, we are very interested in research that involves non-traditional ambulatory health care sites that serve the uninsured, Medicaid, and other vulnerable populations. Vulnerable populations, as defined by the IOM in 2002, include the uninsured, low-income, under-insured, Medicaid beneficiaries, minority population, immigrant populations and geographically or economically disadvantaged communities. Partnerships between community-based health care sites and academic institutions are encouraged.